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CC File No.: XXX
Dates Seen: XXX
Date of Report: XXX

REPORT OF CASE CONCEPTUALIZATION & TREATMENT PLAN

Identifying Data & Presenting Problem

XXX is a XXX-year-old cisgender, White, XXX American, bisexual, middle-class female. XXX uses she/her pronouns. XXX lives in an apartment in Carbondale, Illinois, with her pet dog. XXX reported that she works at XXX, a 1-year work program to help disadvantaged people. She has been there for almost a month as of this report. She works at XXX, providing XXX to XXX. She reported that her job requires much self-direction but that she enjoys it. XXX also noted that she has her Bachelor of Arts in XXX from the XXX. XXX denied romantic relationships, reported having a few close friends, and having a good relationship with her parents.

XXX presented to the clinic with excessive and difficult-to-control worry, interpersonal problems, vocational problems, and uncomfortable physical anxiety symptoms. She reported wanting to learn strategies on how to manage her anxiety more effectively. Although she reported having these problems most of her life, she has become more aware and noticed the impairment it has caused in the last four years. She explained that she typically avoids situations that make her uncomfortable (e.g., small talk, managing her workload). She noted that it has been challenging for her to relax when around others and manage her work responsibilities. Behaviorally, when she is anxious, she typically reports chest tightness, heart palpitations, dizziness, an upset stomach, and shortness of breath. Cognitively, she reported not being present in conversations because of her anxiety.

History of the Present Illness

XXX reported that her dad is currently seeking therapy for depression, whereas her mother has successfully terminated therapy for her anxiety. She reported that her grandfather likely passed due to problems associated with alcohol use. Although the client reported experiencing excessive anxiety since childhood, XXX reported that her anxiety and worry became worse as she entered her sophomore year of college, when the classes became increasingly challenging. Around that time, and since then, the client has reported excessive anxiety and worry, as well as multiple physical symptoms of anxiety (e.g., racing heart). The client stated that these symptoms have not remitted and are stable. XXX reported that she has no previous history of mental health treatment. XXX reported that her current level of anxiety sometimes limits her ability to function interpersonally and vocationally, such as not being present around potential romantic partners and sometimes being too overwhelmed to go to work.

Social & Developmental History

XXX denied any birth complications or difficulties achieving developmental milestones. XXX reported that she grew up in XXX, Illinois, and that her family is still in the area. She reported that although her mother and father are divorced, she has a decent relationship with both and visits them once a week. She also stated that she has a good relationship with her XX-year-old sister. She stated that she no longer has friends in this area but has two close friends who live in other parts of the world. XXX denied any significant academic or social challenges in school; however, she reported having persistent anxiety and worry throughout school. XXX denied any significant trauma. However, she noted that her parents' divorce and grandmother's passing were significantly distressing.

Assessment Data

The clinician assessed for suicidal and homicidal ideation, and the client denied current and previous active suicidal or homicidal ideation. The client reported some passive suicidal ideation, but denied a plan, means, or intent. In addition, the client denied using illicit substances, but she reported drinking alcohol within normal limits (i.e., one glass a day) and using cannabis daily. Next, XXX completed the DIAMOND Screener, and then the clinician administered the DIAMOND. The result of the DIAMOND suggests that the client reports feeling excessively worried and anxious about responsibilities at work, romantic and social interactions, and the future (Criterion A). XXX reported she is aware her anxiety is out of proportion to actual threats, but cannot reduce it (Criterion B).

The client reported that these symptoms have been present since she was a teenager, that the symptoms became worse as she started her sophomore year, and that since her sophomore year, she has worried for more days than not. XXX reported numerous physical symptoms associated with GAD, such as restlessness or feeling "keyed up" or "on edge," getting tired or fatigued quickly, having difficulty concentrating, feeling irritable and cranky, muscle tension, and trouble falling asleep and staying asleep (Criterion C). These physical symptoms have been present in the past six months and for more days than not. XXX reported that these symptoms, anxiety, and worry cause a significant amount of distress and impair the client's ability to perform at work and interpersonally (Criterion D). I ruled out a medication change or a better explanation for these symptoms (Criterion E).

The clinician also noted subclinical symptoms of other anxiety and depressive disorders, including major depressive disorder, social anxiety disorder, panic disorder, and excoriation. Although the client endorsed some depressive and anxiety symptoms, her depressive and anxiety symptoms are likely a function of generalized anxiety disorder. Therefore, the client only meets the criteria for Generalized Anxiety Disorder (Criterion F; Marked).

Diagnosis

300.02 (F41.1) - Generalized Anxiety Disorder (Marked)

Case Conceptualization

The origin of the client's presenting problems may be explained by Barlow's (Barlow, 2000, 2002) Triple Vulnerability Model. The model suggests that a general biological vulnerability (e.g., neurotransmitter dysregulation) and a general psychological vulnerability (e.g., early learning that creates a belief system that the world is not safe) interact with each other to create a specific psychological vulnerability (e.g., neuroticism) to create the potential for a psychological disorder to emerge under the right conditions.

The client revealed details that might suggest several biological vulnerabilities. First, the client revealed that she had experienced low-grade anxiety her entire life, particularly around school. Moreover, the client reported that both her mother tended to react strongly to stressful situations and was prone to anxiety symptoms. Taken together, these two pieces of evidence suggest the client may experience some biological (e.g., neurotransmitters) and genetic (e.g., activation of specific gene combinations) vulnerability.

Researchers have established several potential genes that may enhance the likelihood of developing anxiety-relevant endophenotypes such as excessive worry and intolerance of uncertainty such as *5-HTT, NPSR1, COMT, MAOA, CRHR1, RGS2* (see Gottschalk & Domschke, 2016 for a review). Activating these genes may increase the likelihood of developing a serotonin and norepinephrine deficit associated with GAD (Maron & Nutt, 2018).

Furthermore, the client reported that her parents might have modeled how to respond to stressful situations by displaying symptoms of panic. Through observational learning and classical conditioning, XXX may have seen strong reactions to stress and anxiety symptoms associated with commonly occurring stressful situations. Specifically, as a child, XXX saw her mom react strongly and develop anxiety symptoms (i.e., unconditioned response) to their typically occurring stressful situations (i.e., unconditioned stimulus).

This learning may have led the client to react and develop anxiety symptoms (i.e., conditioned response) to her normally occurring stressful situations in adulthood (i.e., conditioned stimulus). Thus, the biological and general psychological vulnerability interacted to create a specific psychological vulnerability, which, for XXX, was neuroticism as described by the assessment sessions (e.g., high self-reported levels of distress and negative emotionality). This high neuroticism is associated with early learning experiences that influence a belief that the world is unpredictable and uncontrollable, which puts XXX at risk for developing anxiety-based psychopathology.

Although there are many empirically supported models of GAD, an Acceptance-Based Model may best explain this client's problem list (Behar et al., 2009). First, the client tends to react to negative internal experiences with intense distress and discomfort. Although people without GAD may view anxiety as unpleasant, individuals with GAD view anxiety as dangerous. Second, individuals with GAD make rigid attempts to control their anxiety, such as thought suppression, distraction, or ignoring emotions. Last, individuals with GAD engage in behaviors designed to avoid feelings of anxiety, but limit their behavioral repertoire, which is called behavioral restriction.

The clinician identified four precipitants that explain the client's presenting problems in terms of Generalized Anxiety Disorder. The initial precipitant was starting her sophomore year. The increased stress from the challenging classes led to physical symptoms of GAD and excessive anxiety due to the client's intense and distressing reaction to unpleasant internal stimuli. The client reported distress, such as intense anxiety and physical problems, at such a young age because she reported that she should be happy and physically healthy at this point in her life.

The second precipitant was her ongoing work-related stress. The workload maintains the client's worry in general, but mainly about work, inhibits the client from being present in romantic interactions, and disrupts relaxation. In addition, the ridged attempts to control unpleasant internal experiences and behavioral restriction (e.g., not communicating with potential romantic interests) may maintain the client's worry. Further, the client reported that it is difficult being a woman with anxiety in romantic.

The client also reported significant irritability and being short with friends and family. The client's intense, distressing reaction to unpleasant internal experiences may sustain this irritability. The third precipitant to the client's symptoms is the recent onset of intense anxiety. Although the client reports a relatively stable level of excessive anxiety, she reported numerous instances when her anxiety increases – described as "rushes" of anxiety.

Again, behavioral restriction (i.e., less time spent fully engaged in activities due to hair-pulling) and rigid attempts to control unpleasant internal experiences perpetuate hair-pulling. Further, the sudden onset of rushes of anxiety results in the client developing subclinical panic symptoms (e.g., feeling out of control or shortness of breath), maintained by an intense and distressing reaction to unpleasant internal experiences.

Treatment Rationale & Literature Review

The typical treatment of choice for an individual with generalized anxiety disorder is Acceptance-Based Behavioral Therapy (Millstein et al., 2015). However, the client reported numerous anxiety symptoms from multiple disorders, such as panic, trichotillomania, and social anxiety. There are two reasons why using Acceptance-Based Behavioral Therapy would not be as effective as a transdiagnostic approach.

First, the client reports numerous symptoms of anxiety from multiple disorders. A transdiagnostic approach would address the underlying mechanisms for all these symptoms, not just for generalized anxiety disorder symptoms. Second, there is a risk that the numerous subclinical anxiety and depressive disorder symptoms may develop into full disorders if the clinician only targets mechanisms of generalized anxiety disorder. A transdiagnostic approach will target the underlying mechanisms of generalized anxiety disorder and all the other disorders she may develop with time. Whereas Acceptance-Based Behavioral Therapy only teaches how to manage her anxiety. This choice means that a transdiagnostic approach may potentially prevent the development of future anxiety disorders.

The clinician decided that the best course of treatment for the client is the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorder (Barlow et al., 2011) to help target symptoms from multiple anxiety disorders and potentially inhibit the future development of other anxiety disorders since anxiety disorders are highly comorbid (McNaughton & Corr, 2016). The Unified Protocol is a transdiagnostic treatment approach to treating emotional disorders (e.g., panic disorder or major depressive disorder) by targeting underlying mechanisms, which are maladaptive responses to emotional experiences (e.g., emotion avoidance).

Numerous authors have noted and demonstrated the effectiveness of the Unified Protocol in the treatment of clients presenting with multiple anxiety disorders (Conklin et al., 2018; Laposa et al., 2016; Reinholt et al., 2016). These studies suggest that the Unified Protocol may help the client reduce her presenting symptoms from multiple anxiety disorders and prevent the further development of other anxiety disorders.

Researchers have demonstrated that the Unified Protocol is as efficacious as single-disorder protocols for anxiety (Barlow et al., 2017). First, this study found nonsignificant differences favoring the single-disorder protocol for both clinician-rated and self-reported anxiety immediately post-assessment and 6-month follow-up. Second, researchers have found that mindfulness is associated with significant reductions in physical (e.g., heart rate and skin conductance) and psychological (e.g., self-reported measures) indicators of anxiety (Hoge et al., 2018). The Unified Protocol also emphasizes mindfulness and emotional awareness. Therefore, choosing the Unified Protocol over the Acceptance-Based Behavior Therapy protocol may offer more sustained treatment gains.

Treatment Goals

Outcome Goal 1: Reduce Anxiety & Worry to a Minimal Range

- To reduce anxious anticipation as measured by the GAD – 7 to a minimal range
- This goal would indicate a reduction in distressing responses to internal states
- This goal would indicate a reduction in rigid attempts to control internal states (e.g., worry)

Outcome Goal 2: Reduce Behavioral Restriction

- Engaging in more communication with romantic interests
- Not calling off work more than once a month, unless sick with a cold.
- Not picking one's skin for more than 5 minutes per day total

Treatment Plan

Assessment (Session 1-2)

- **Goal:** The goals of these sessions were to gather evidence to clarify the client's presenting problems, confirm diagnoses, orient the client to treatment, and build rapport.
- Agenda Set, Informed Consent, Assessments (GAD-7 & PHQ-9)
- Client's Summary of Presenting Problem & Rapport Building
- Orientation to Treatment
- **Assessments:** The clinician administered the DIAMOND screener for diagnostic assessment. The clinician then completed the Generalized Anxiety Disorder, Social Anxiety Disorder, Panic Disorder, and the Trichotillomania & Excoriation modules, sections of the DIAMOND. Finally, the clinician diagnosed the client with Generalized Anxiety Disorder (Marked).
- **Homework:** The clinician assigned the client to read the relevant chapters in the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorder (Barlow et al., 2011).

Session 3

- **Goal:** The clinician and client worked together to identify treatment goals and observable behavioral changes if therapy was successful.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **interventions:** The clinician used the treatment goal-setting worksheet to identify one therapy goal, observable behavioral changes, and the steps to move from the achieved therapy goal to the present. This section helped orient the client to therapy and gave a common goal for the clinician and client, which increased rapport and strengthened the working alliance. In addition, this session helped maintain focus throughout therapy, which may increase the likelihood that the client will return.
- **Homework:** The clinician assigned the client to complete a second therapy goal, observable behaviors, and steps to reaching those goals.

Session 4

- **Goal:** XXX identified motivation for change. Although the client was motivated to make changes in therapy, her motivation could decrease as therapy became more challenging, particularly during exposures.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **interventions:** The clinician and client worked through one decisional balance worksheet to identify the pros and cons of changing and staying the same. The clinician used this session to motivate the client and refer to it later in treatment when the client began to lose motivation. This section was helpful because the client's stressful job sometimes prevented her from completing her homework.
- **Homework:** The clinician assigned the client to work through one decisional balance worksheet.

Session 5

- **Goal:** The client learned to identify the three parts of emotional experiences (i.e., physical response, thoughts, and behaviors).
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)

- **interventions:** The clinician provided psychoeducation on the three components of an emotion. The clinician and client worked through the three-component model of emotions worksheet to delineate three emotional experiences. This intervention reduced the client's intense and distressing reactions to unpleasant internal experiences by increasing awareness and making emotions less confusing. In addition, this module reduces physical symptoms, excessive anxiety, subclinical panic, and irritability in interpersonal relationships.
- **Homework:** The clinician assigned the client to complete four three-component emotion model worksheets.

Session 6

- **Goal:** The client learned about the ARC model of emotional experiences (i.e., identifying antecedents, responses, & consequences) and worked with the clinician to apply the model to her experiences.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **Intervention:** The clinician provided psychoeducation on each component of the ARC model. The client identified antecedents, responses, and consequences of three of her own emotional experiences using the Monitoring Emotions and EDBs in Context–The ARC of Emotions worksheet. This intervention reduced the client's intense, distressing reactions to internal experiences and behavioral restrictions by clarifying how the client's emotions influence behavior. This module may reduce physical symptoms, excessive anxiety, subclinical panic symptoms, difficulties in interpersonal relationships, work impairment, and hair-picking.
- **Homework:** The client will complete the ARC worksheet for 4-5 emotional responses over the next week.

Session 7

- **Goal:** The client learned mindful emotional awareness to increase her ability to identify her emotions and emotional responses to antecedents, and to modify her responses to emotional experiences (e.g., nonjudgment).
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **Intervention:** The clinician provided psychoeducation on mindfulness and mindful emotional awareness. The first intervention was a savoring activity in which the client closely examined the sensations elicited by a piece of candy. This intervention demonstrated the level of detail one should notice when examining one's emotions. The second intervention was a body scan to use the increased attention skill learned in the previous intervention to assess her body's physical state. Upon completion, the client responded to an emotionally provocative song nonjudgmentally using the Mood Induction Worksheet. This intervention allowed the client to practice responding to emotional experiences nonjudgmentally. The session finished by anchoring in the present moment. This session targeted the client's intense and distressing reaction to emotional experiences, which may lead to a reduction in physical symptoms, excessive anxiety, subclinical panic symptoms, and irritability in interpersonal relationships (PROBLEMS).
- **Homework:** The clinician assigned the client to engage in present-moment anchoring five times over the next week and to complete the mindfulness emotion awareness worksheet.

Session 8

- **Goal:** The goal of this session was to encourage the client to begin thinking more flexibly about her automatic appraisals of situations by increasing her awareness of thinking traps, identifying her automatic appraisals, and establishing the connection between her thoughts and emotions.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **Interventions:** The clinician provided psychoeducation on the importance of thoughts to understanding our experiences and the influence of thoughts on emotions. The first intervention will complete three downward arrow worksheets, which allow the client and clinician to explore the client's core beliefs and connect the core beliefs to the client's automatic appraisals. The second intervention was the Identifying and Evaluating Automatic Appraisals worksheet. In this intervention, the client identified situations that elicit automatic appraisals and then attempted to generate alternative appraisals. This intervention increased the client's cognitive flexibility, thereby reducing the client's intense, distressing reaction to unpleasant internal experiences. This intervention may reduce physical symptoms, excessive anxiety, subclinical panic symptoms, and difficulties in interpersonal relationships.
- **Homework:** The clinician assigned the client to complete the downward-arrow worksheet three times.

Session 9

- **Goal:** The goal of this session was to teach the client about the association between emotional solid experiences and behaviors and learn to prevent the engagement in emotion-driven behaviors.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **Interventions:** The clinician and client discussed the research on emotion-driven behaviors and how engaging in emotion-driven behaviors maintains anxiety. Using the Changing EDB worksheet, the client and clinician delineated the client's emotion-driven behaviors and generated new incompatible responses. This session reduced the client's rigid attempts to control unpleasant internal experiences and her behavioral restriction. This module may lead to a reduction in excessive worry, work impairment, excessive worry, hair-pulling.
- **Homework:** The clinician assigned the client to record seven emotionally driven behaviors she wanted to engage in over the next week and generate new incompatible responses.

Session 10-X

- **Goal:** The client engaged in interoceptive, imaginal, and in vivo exposures to apply the skills she has accumulated throughout treatment.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- **Intervention:** The clinician provided psychoeducation on the various types and functions of exposures. The clinician then sought consent. Session 10 involved building three exposure hierarchies (i.e., interoceptive, imaginal, and in vivo). The clinician and client worked through each of the hierarchies, starting with interoceptive, imaginal, and in vivo exposures. The client recorded her experiences on the Record of Emotion Exposure Practice before and after each emotional exposure.
- **Homework:** Throughout the exposure section of the Unified Protocol, the clinician assigned the client several exposures to practice in between sessions.

Session X+1

- **Goal:** Consolidate treatment gains, delineate potential barriers to using the skills learned in therapy, and affirm the client's progress.
- Agenda Set, Check-In, Assessments (GAD-7 & PHQ-9)
- Intervention: The clinician led a discussion to consolidate treatment gains, delineate potential barriers to using the skills learned in therapy, and affirm the client's progress. The clinician judged whether the client is ready to terminate therapy.
- **Homework:** The clinician assigned the client to continue to use her skills.

Note: This treatment plan provides the structure, evidence-based interventions, and maps the direction of treatment progression. Consider it to be a foundation for the treatment, not the definitive rulebook. There are so many client and clinician factors that shape the progression of treatment. For example, if a particular intervention is highly effective and we see value in continuing to engage with it before moving on to the next one, we will spend more time on it while continuously assessing its impact on treatment goals. Likewise, if something significant happens that requires priority in that session, we will redirect our attention to the urgent matter; flexibility is key.

We make constant adjustments in this process of continuously assessing the ability of the treatment plan to achieve the treatment goals to ensure the effectiveness and efficiency of the treatment. For example, if we are working on cognitive restructuring but the client has found more success with acceptance-based interventions, we incorporate more of those interventions. Finally, many factors that contribute to the success of therapy are not captured directly in the treatment plan, such as the client-clinician relationship, cultural factors, and client preferences. These factors are a required foundation that allows the evidence-based interventions to have their maximum effect.

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