

EXPOSURE-BASED COGNITIVE BEHAVIORAL THERAPY AND CLIENT  
CENTERED THERAPY: A PRAGMATIC CASE STUDY OF A TECHNICALLY  
ECLECTIC, INTEGRATIONIST APPROACH

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CBT AND CLIENT CENTERED THERAPY: AN INTEGRATED APPROACH

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ABSTRACT

For clients who present with multiple, complex, and unique presenting problems, it can be challenging to address diverse concerns when working solely from one manualized therapy approach. The author found this to be the case during his second year doctoral clinical practicum, when he treated “Rahul” at a university counseling center. Rahul initially presented with specific claustrophobic symptoms, but later in treatment disclosed broader personal and familial concerns. As a result, the manualized, Exposure-Based Cognitive Behavior Therapy (CBT) treatment that was initially employed by the therapist no longer was sufficient. This led to the introduction of a Client Centered approach into the existing therapy, to create a Technically Eclectic integrated treatment. The dissertation consists of a pragmatic case study outlining Rahul’s therapy and this unique treatment approach. The aim of this dissertation is to shed light on how a systematic case-based approach, which employs an individualized case formulation and an individualized treatment plan, can allow for the integration of two very different treatment modalities (perhaps even considered incompatible by some) to effectively address multiple and distinct presenting concerns of the client. In the description of the therapy process, particular attention is given to the development and maintenance of the therapeutic relationship as understood from each treatment modality, and how an attunement to this relationship can dramatically impact and inform the course of treatment.

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## **Chapter I: Case Context and Method**

The proposed dissertation will consist of a systematic case study of client who I will call “Rahul,” who received from the author a course of individual therapy, consisting of both Exposure-Based, Cognitive-Behavioral Therapy and Client Centered Therapy. The treatment ultimately consisted of two phases; phase 1 treating claustrophobic symptoms with Exposure-Based CBT, and phase 2 treating personal and familial concerns and claustrophobic symptoms simultaneously, through an integration of a Client Centered approach into the existing CBT work.

The case took place at a University Counseling Center for a total of 14 sessions under a brief therapy model, and at the time of the treatment I was a student in my second year in the doctoral school psychology program at Rutgers University. I was supervised throughout the case by counseling center staff therapist, Dr. Carlos Garcia, who was well versed in both Cognitive Behavioral and Client Centered approaches to counseling.

The focus of the case study is to explore how the utilization and integration of two distinctively different treatment approaches within the same course of therapy could best meet the needs of a client who presented with both symptom-specific claustrophobic concerns, as well as more general familial and personal difficulties that were initially withheld but later disclosed in treatment.

The case study will aim to shed light on how a systematic case-based approach, which employs an individualized case formulation and an individualized treatment plan, allows for a flexible and individually tailored treatment for a client who simply does not fit a treatment approach available in a widely accepted manualized treatment protocol. The case study will provide the reader with a step-by-step outline of how my



interventions came to fruition, as well as a detailed description of the varying levels of therapeutic success achieved in its implementation. It will also explore the development of the therapeutic relationship and relational dynamics between therapist and client as understood by each therapeutic modality, and how it impacted and facilitated the course of treatment. Ultimately, the goal of this case study is to contribute to the psychotherapy literature by providing both a rationale for and effective methods of integrating two very different treatment approaches concurrently in order to best meet the needs of clients with multiple, complex, and unique presenting problems.

## Chapter II: The Client

The client, “Rahul,” a university undergraduate student in his junior year, initially presented to therapy to address physiological symptoms of increased heart rate, chest pressure, sweating, nausea, and feelings of dizziness whenever he entered crowded, closed environments. Along with other manifestations of avoidant behavior, Rahul refused to utilize the university’s bus service, which transports students to classes across separate campuses. In addition, he would typically avoid other crowded environments, such as large lecture halls, elevators, and cars that were filled to capacity.

Rahul is of Indian background and is the only child of two traditional Indian parents, who he described as having very high academic expectations for him. Growing up, Rahul’s first experience of discomfort in crowded environments was early in high school while attending crowded basement parties. However, his discomfort was generally mild and did not lead to any significant impairment or avoidance at the time. This changed, however, during a significant precipitating event during his junior year of college when he rode on a crowded university bus that became stuck in traffic on the highway and did not return to campus for 45 minutes. During the ride, Rahul experienced increasing physiological symptoms of anxiety, as well as catastrophic cognitions including the conviction that he was going to vomit or pass out. Following this ride, Rahul chose to avoid riding the university bus until he self-referred to the counseling center for treatment the following academic year.

In addition to claustrophobic symptoms, in the middle of treatment Rahul brought up new concerns not initially mentioned in the intake session. These new issues consisted of certain personal and familial concerns, and revolved primarily around issues

of shame, competence, and perfectionistic self-expectations. In particular, Rahul held especially high and occasionally crippling goals for himself and his future career aspirations, as well as experiencing shame and anxiety at the prospect of receiving anything less than top marks in his current academic classes. It was the influx of addressing these new concerns into the existing treatment that made up the content of phase 2 of our work together.

### Chapter III: Guiding Conception

#### Phase 1 (Exposure Based CBT for Claustrophobic Symptoms)

Regarding treatment of Panic Disorder and Agoraphobia, Exposure Based Cognitive Behavioral Therapy has been shown to be equally as effective as any pharmacological approaches in the short term, and more durable in the long term (Barlow et al., 1998). The manual I utilized to treat Rahul's symptoms came from the *Clinical Handbook of Psychological Disorders: A Step-by-Step Treatment Manual*, (Barlow, 2014), and specifically its chapter related to treating symptoms of anxiety and panic (Craske & Barlow, 2014). Rather than rigidly adhering to specific tasks to be completed each session, the manual presents important components of Cognitive-Behavioral treatment to be addressed sequentially with the patient. These components include psychoeducation, self-monitoring, breathing retraining, applied relaxation, cognitive restructuring, and exposures to feared environments or circumstances. Of these, two primary mechanisms in the treatment of panic and agoraphobia are considered to be:

1. Providing a structured format to evaluate and question maladaptive and unrealistic cognitions related to being in anxiety provoking environments.
2. Direct exposure tasks to feared environments so clients can see for themselves whether they can endure feared environments without imagined catastrophic outcomes taking place (Barlow, 2014).

These components are important in treatment as they can directly address a negative feedback loop between a client's thoughts (e.g. catastrophic cognitions related to feared environments), feelings or physiological reactions (increasing anxiety symptoms)

and behaviors (avoidance), typically involved in exacerbating client difficulties with panic and agoraphobia (Leahy, Holland, & McGinn, 2012).

### **Phase 2 (Client Centered Approach for Addressing New Personal and Familial Concerns)**

In Client Centered work the therapist's primary task is to demonstrate acceptance (positive regard), congruence (genuineness), and empathic understanding toward the client (Rogers, 1951). The therapist generally does not actively direct the content of the session, leaving that for the client to decide, and instead focuses on the therapeutic encounter with the client characterized by the above qualities (Cain, 2010). Theory supporting this approach suggests that clients have an innate tendency toward growth, understanding, and actualizing their potential when they feel supported, understood, and given the space to self-direct the difficulties that they would like to work through together with their therapist (Cain, 2010). I felt this approach fit in addressing Rahul's new concerns for two reasons:

1. Rahul's preference for an open-ended discussion of these issues as compared to the structured approach for the claustrophobic concerns.
2. My intuition that a gentle, non-rushed, non-interpretive therapeutic approach would respect Rahul's sensitivity toward these new issues, as indicated by his decision to wait until later in treatment before disclosing them.

In working with Rahul in this way, instead of asserting a specific agenda we would seek to accomplish each session, as was the case in the Cognitive Behavior work we had been doing, I let him describe and direct the discussion with my focus on being empathic and supportive in processing what he chose to bring up. What eventually

developed from this approach were two main themes or content areas that we were able to process and explore together. To be discussed in a later section, the first included exploring his family dynamics and expectations placed on him growing up, and the second, his current academic worries.

### **Approaches to Integration**

Although the first seven sessions of therapy with Rahul consisted of fairly straightforward Exposure Based CBT, the introduction of new concerns in session 8 created the need for an integrated treatment. Psychotherapy integration is understood as an approach to psychotherapy that includes a variety of attempts to look beyond the confines of single-school approaches in order to see what can be learned from other perspectives (Stricker & Gold, 2013). When integrating two or more treatment modalities, either in regard to actual treatment techniques or in case conceptualization, there are various approaches or styles that can be utilized to do so effectively. Of these, four of the most prominent approaches to psychotherapy integration include assimilative integration, common factors integration, theoretical integration, and technical eclecticism (Norcross & Goldfried, 2005).

#### **Assimilative integration.**

In this approach, the clinician will have a firm grounding in one system of psychotherapy, but may incorporate certain principles or practices from other schools over the course of treatment (Messer, 1992). In other words, in assimilative integration there is a primary or foundational school of thought that guides the work of therapy, but at certain times a particular practice or concept from a different therapeutic modality could be utilized to facilitate treatment.

**Common factors integration.**

Clinicians using this approach will look to consolidate common factors or techniques that cut across theoretical lines (e.g. factors that are present and utilized in many different schools of psychotherapy) that are generally understood to be effective elements of change (Norcross & Goldfried, 2005). For example, factors such as the creation and maintenance of a strong therapeutic alliance, exposure of the patient to prior difficulties (either in imagination or in reality), a new corrective emotional experience allowing the patient to experience past problems in less threatening or more productive ways, and expectations by both the therapist and patient that positive change will result from treatment, among other therapeutic factors.

**Theoretical integration.**

In a theoretical integrationist approach, a clinician will look to synthesize or bring together the theoretical underpinnings of separate treatment approaches into a unified theory to guide therapy (Stricker & Gold, 2013). This is often considered the most difficult form of integration, as it requires integrating theoretical concepts from different approaches, and these approaches may differ in their fundamental philosophy about human behavior.

**Technical eclecticism.**

In Technical Eclecticism, the clinician may select a series of intervention approaches and techniques that are tailored to fit the client's presenting concerns and unique personal characteristics throughout the course of therapy, without necessarily an allegiance to one particular school of thought over all others (Norcross & Goldfried,

2005). This was the primary mode of integration I selected and carried forward with Rahul in our treatment together.

For Rahul, in “phase 1” of the treatment his presenting problem of claustrophobic symptoms lent itself well to Exposure-Based, Cognitive Behavioral Therapy. However, in “phase 2,” as new and sensitive information was disclosed that had been withheld at intake, I shifted to the open-ended, process-oriented approach of Client Centered Therapy to appropriately address these new concerns. However, because Rahul wished to simultaneously continue his work and progress from phase 1, I was met with the unique challenge of creating an overall treatment approach utilizing two different therapeutic modalities concurrently as a way to best address his distinct, complex, and evolving goals for therapy.

Ultimately, to accomplish this, the beginning of sessions were typically allotted for tasks related to Rahul’s claustrophobic concerns while the middle and endings of sessions were based in a Client Centered approach addressing his personal and familial concerns. To have time for both topic areas, the exposure based CBT work during phase 2 was streamlined to include only reviewing past exposure exercises, engaging in cognitive restructuring and problem solving when necessary, and determining subsequent exposure tasks based on Rahul’s successes from previous weeks. The structuring of these sessions in this specific way was co-created between myself and Rahul, as we were both looking to organize the work in such a way that felt for him both productive and challenging, yet simultaneously comfortable and supportive.

Ultimately, through the utilization of a Client Centered approach within the existing Exposure-Based, Cognitive Behavioral work, Rahul and I were able to begin a fruitful process of exploration into broad familial and personal areas of concern, while



simultaneously continuing his focused work and progress in decreasing his claustrophobic symptoms in a systematic way.

## **Chapter IV: Assessment of the Client's Problems, Goals, Strengths, and History**

### **Qualitative Assessment**

In clinically interviewing Rahul at intake, as might be expected, I learned that the severity of his panic symptoms and associated cognitions seemed to be proportional to the amount of time he would have to endure a crowded environment, and how crowded that environment was. In terms of relevant history, Rahul experienced his first symptoms of anxiety in early high school during a crowded basement party. While he remembered feeling uncomfortable and anxious about how little space there was to move, he did not experience any significant physiological symptoms of anxiety at the time. This was also the case upon first arriving at college; he experienced some discomfort during crowded parties and while riding the bus, but not impactful enough so as to cause him to avoid these environments.

However, as discussed above, a major precipitating event was during his sophomore year of college when Rahul was on a university bus that was especially crowded and became stuck in traffic for 45 minutes on the highway before returning to campus. This event was categorically different and more anxiety provoking for him both because of the length of time he had to endure the crowded environment, as well as the inability to escape the environment. Until this time, when a party became too crowded he could leave, and when a bus became too crowded he could get off at the next stop. When Rahul recognized there was no ability to escape the bus, he began to imagine possible catastrophic possibilities like passing out, losing control, or vomiting. He then began to notice physiological symptoms of anxiety and panic including racing heart rate, sweating, dizziness, nausea, and chest pressure. Rahul's negative cognitions and physiological

reactions remained heightened for the remainder of the ride until the bus eventually reached the campus center.

Following this event, Rahul chose to entirely avoid riding the university buses. Shortly thereafter, his heightened anxiety began to generalize to other crowded places on campus including crowded lecture halls, hallways, elevators, basement parties, and cars filled to capacity. At the time of seeking treatment the following academic year, Rahul had begun to actively avoid these environments or be present in such a way as to minimize claustrophobic symptoms (e.g. sitting on isle or end seats in a crowded lecture hall class). With regard to his goals for therapy, at intake Rahul described wanting to reduce his physiological symptoms of anxiety in crowded spaces and increasing his willingness and ability to face crowded spaces so as not to interfere with his daily functioning.

However, by the middle of treatment new goals emerged for Rahul with the disclosure of personal and familial concerns revolving around issues of shame, competence, and perfectionistic self-expectations. As Rahul would later describe, he grew up in a particularly strict household with two traditional Indian parents who had especially high academic expectations for him. Starting at an early age, he described having to study his academics uninterrupted for several hours each day after school. Over time, rigorous academic expectations left him feeling like “only the best was good enough.”

This manifested pretty concretely for Rahul, who explained that although he would study hard and consistently did well academically, he would still worry excessively what his grades would be, which had the added inconvenience of distracting him while he was studying. In addition, on the rare occasion he would perform below his

standards (grades below an A) he would feel ashamed and engage in rumination around the negative consequences of his performance.

### **Quantitative Assessment**

To quantitatively monitor progress throughout treatment, for each session the clinician utilized the Severity Measure for Panic Disorder-Adult (SMPD-A; Craske et al., 2013), which measured severity of panic and anxiety symptoms while the client was in tight or crowded spaces over the course of the past week, as well as the Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer & Williams, 2001), a depressive symptom measure. Average SMPD-A scores can range between 0 and 4. An average score of 1 indicates mild anxiety and panic, a score of 2 indicates moderate panic, a score of 3 severe panic, and a score of 4 extreme panic. At intake Rahul's average SMPDA score was 2.1, indicating moderate panic and anxiety (see Table 1). On the PHQ-9, total scores between 1-4 indicate minimal depression, 5-9 indicate mild depression, 10-14 moderate depression, 15-19 moderately severe depression, 20-27 severe depression. At intake Rahul's total score was 2, indicating minimal depression (see Table 2).

In addition, the clinician utilized the Outcome Questionnaire-45 (OQ-45; Lambert, Gregersen & Burlingame, 2004), a general symptom measure, at a two year follow up to assess the client's perception of his changes in functioning from prior to therapy to two years post therapy at the time of the interview. OQ-45 Total Scores can range between 0 and 180, with higher scores indicating more clinical symptoms and/or more impaired functioning. Rahul rated his pre-therapy perception of functioning at 52, indicating fairly normal adjustment with some difficulties related to stress and anxiety and relationships (see Table 3).

## Diagnosis

The first couple of sessions of treatment were focused on establishing therapeutic rapport, gathering history, and informally assessing for a diagnosis of Panic Disorder and Agoraphobia.

According to DSM-5 criteria, Panic Disorder is met when an individual experiences recurrent unexpected (or unexpected and expected) panic attacks with at least one of the panic attacks being followed by one month (or more) of one or both of the following:

1. Persistent concern or worry about additional panic attacks or their consequences (e.g. losing control, having a heart attack, “going crazy”).
2. A significant maladaptive change in behavior related to panic attacks (behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations.)

Of these, Rahul met both criteria in that he had persistent worry of additional panic attacks and would avoid unfamiliar situations if he believed they could become excessively crowded. Additionally, although typically his anxiety was expected and anticipated based on his environment or circumstances, occasionally Rahul would experience panic and anxiety symptoms unexpectedly, thus meeting criteria for Panic Disorder.

The typically related diagnosis, Agoraphobia, is met when an individual has a marked fear or anxiety about two (or more) of the following five situations:

1. Using public transportation (e.g. automobiles, buses, trains, ships, planes).
2. Being in open spaces (parking lots, marketplaces, bridges).
3. Being in enclosed spaces (shops, theatres, cinemas).
4. Standing in line or being in a crowd.
5. Being outside of the home alone.

In addition, the individual:

- A. Fears or avoids these situations because of thoughts that escape might be difficult or help might not be available in the event of developing panic-like symptoms or other incapacitating or embarrassing symptoms (e.g. fear of falling in the elderly; fear of incontinence).
- B. The agoraphobic situations almost always provoke fear or anxiety
- C. The agoraphobic situations are actively avoided, require the presence of a companion, or are endured with intense fear or anxiety.
- D. The fear or anxiety is out of proportion to the actual danger posed by the agoraphobic situations and to the sociocultural context.
- E. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
- F. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Of these criteria, Rahul feared public transportation (particularly crowded buses) as well as being in enclosed spaces (parties, crowded lecture halls) and met the lettered criteria above, in that he would work to avoid crowded environments, the crowded environments provoked fear and anxiety, caused him distress, and have lasted for more than 6 months; thus meeting a diagnosis of Agoraphobia.

However, Rahul did not meet criteria for Social Anxiety Disorder, Specific Phobia, or Generalized Anxiety Disorder. In particular, his anxiety was not specifically in response to feared social situations, as seen in Social Anxiety Disorder; nor to a circumscribed phobic object or situation, as seen in a Specific Phobia; nor in response to a variety of generalized events and activities, as seen in Generalized Anxiety Disorder.

### **Strengths**

Rahul had a number of strengths that he demonstrated throughout treatment. It was clear from the first session that Rahul was very bright and he was able to quickly comprehend and synthesize important concepts in phase 1 of treatment including

psychoeducation related to the nature of anxiety and panic, as well as cognitive restructuring around anxious thoughts in crowded environments. In addition, Rahul had a very high level of therapeutic motivation, particularly in regard to the behavioral work of treatment, which required him to bravely and continuously engage in exposure exercises to feared environments. Rahul was also psychologically minded, and was able to self-direct much of the content of the work in phase 2. This is an essential aspect of making Client Centered work productive and successful, and that which aided our process together in phase 2 of our treatment.

## **Chapter V: Formulation and Treatment Plan**

### **Formulation of Client Difficulties**

As gleaned from the intake and initial sessions, Rahul's claustrophobic symptoms seemed to be maintained by an interplay between catastrophic cognitions while in crowded spaces, his physiological symptoms of anxiety when they became aroused, and his approach and avoidance behavior patterns. Each of these three reactions would in turn influence the other two in a negative feedback loop. For instance, shortly after experiencing catastrophic cognitions of throwing up or fainting, he would notice his heart rate increase or he would start sweating and become dizzy, this would then reinforce his belief in his negative cognitions leading to more anxiety.

Avoidance played a significant role for Rahul in the maintenance of his claustrophobic symptoms. After the 45-minute bus ride experience, any time he considered riding the university bus thereafter he would begin to re-experience the anxiety he felt, suspecting he might either pass out or throw up were he to attempt to ride. He would then decide to avoid using the bus and figure out a different way to get to his destination, which would lead to an immediate short-term reduction in his anxiety. With avoidance as an effective short-term approach to managing his anxiety in crowded environments, he began to avoid other crowded spaces around campus as well, including crowded lecture halls and cars filled to capacity. Although avoidance was helping Rahul feel better immediately, over the course of several months his anxiety began to increase as he began to feel less confident managing crowded environments and having to increasingly work to avoid them.



With respect to the personal and familial problems Rahul later brought up in treatment, there appeared to be strong connections between his current difficulties regarding his crippling self-expectations and academic worries, to early childhood experiences. In particular, in growing up with two strict and traditional Indian parents, Rahul appeared to have internalized pressures to perform to a very high standard. Indeed, expectations of uninterrupted hours of daily studying in childhood, along with implicit messages about the importance of performance had carried over and become a regular part of Rahul's week in college, both in terms of his work schedule and ways of viewing his successes. While this had an upside of helping him succeed academically, it ultimately became over-determined when concerns over grades would negatively affect his studying, or when he would feel ashamed and ruminate excessively whenever receiving a grade lower than his expectations.

### **Treatment Plan**

For Rahul's claustrophobic symptoms, to break the cycle of avoidance that was serving to maintain his difficulties and symptoms, an Exposure-Based Cognitive Behavioral Treatment approach was chosen for two primary reasons. The first is that it provides a structured format to evaluate and question maladaptive and unrealistic cognitions including the mental list of potential disasters that he was envisioning which would increase his physiological symptoms of anxiety. The second is that the exposure tasks would provide a concrete behavioral test for him to experience for himself whether he could endure feared crowded environments without the imagined catastrophic outcomes taking place. If successfully navigated, Rahul would have the direct opportunity to shift a pattern of avoidance and anxiety to approach and self-confidence, with an expected reduction in symptomatology.

With his broader familial and personal difficulties surrounding issues of competence and perfectionistic self-expectations, along with his preference for a more open-ended and supportive discussion concerning these issues, I utilized a Client Centered approach during the second phase of therapy. With this approach, I worked to demonstrate empathic understanding, positive regard, and genuineness in the therapeutic relationship, thereby providing a safe and supportive environment where he could effectively process and explore these broader concerns for the first time. In providing this environment, Rahul could begin to evaluate and question his value system based in performance expectations, as well as process what the realistic long-term consequences would be from a single test or paper scored below top marks. In doing so, Rahul could still appreciate wanting to work hard and be successful, yet perhaps without an internal critic or voice of worry over the possibility of making a small error during a test or upcoming assignment.

## Chapter VI: Course of Therapy

Note: For each session I will outline both the content of the work, as well as the development of the relationship as it evolved over the course of therapy and subsequently informed the treatment plan.

### Phase 1

#### **Sessions 1 and 2: intake and assessment.**

##### *Content.*

Rahul presented to therapy with the specific goal of reducing his claustrophobic symptoms without describing other areas of concern or issues he'd like to address. As a first step, I gathered Rahul's history and the history of his presenting problem, with a particular focus on his significant precipitating event (the 45-minute stuck-in-traffic bus ride). A focus on this precipitating event was helpful for two reasons. First, it gave us a clear picture of his symptoms and the type of environment that causes them. Second, by obtaining detailed information about his thoughts, physiological reactions, and behavioral responses, I was able to store this information and use it in the following session to explain a rationale for an Exposure-Based, Cognitive Behavioral approach. Namely, through an explanation of the negative feedback loop between these three elements. In addition, I informally assessed for a DSM 5 diagnosis of Panic Disorder and Agoraphobia, and subsequently selected the Craske and Barlow treatment manual to guide our sessions, as explained in the guiding conception section above. Lastly, I spent considerable time normalizing his symptoms and reactions by beginning a discussion of psychoeducation around the nature of anxiety and panic and emphasizing his courage to engage in treatment.

*Relationship and process.*

Although the technical interventions in a Cognitive Behavioral Therapy are centrally important, it is a misconception to assume that the therapeutic relationship is not also an important aspect of treatment and related to treatment outcome (Beck, 2011). In CBT treatment, as far as the relationship is concerned, it is often helpful for the therapist to take on the role of a supportive coach (Elizur & Huppert, Chapter in Press). The more the client can come to trust and respect the “coach” the more likely he or she will put in the effort to successfully complete the tasks of the therapy work. Indeed, in my work with Rahul, our tasks of treatment in the first phase of our work involved providing new emotion regulation skills, shifting maladaptive thinking patterns, overviewing psychoeducation related to his condition, and moving from avoidance to approach of feared crowded environments. In my effort to be Rahul’s supportive coach in our relationship, my goal was to instill in him a sense of confidence to master difficult tasks, and trust in the therapeutic process to effectively address his presenting concerns for treatment.

In the first two sessions, Rahul presented as somewhat anxious and cautious. He sat back in his chair with arms crossed and only intermittently made eye contact. It was his first time in therapy, and also the first time he had openly discussed his anxiety in this way. Indeed, Rahul shared that he was somewhat embarrassed by his symptoms and had concerns of possibly being negatively judged for expressing them.

Instead of moving through the technical agenda of the CBT manual at this point, I slowed down and spent a considerable portion of the first two sessions normalizing Rahul’s symptoms and emphasizing his strengths and motivation for treatment. For instance, by sharing psychoeducation related to the fight flight response and how it has

actually been evolutionarily adaptive, Rahul was relieved to learn that his anxiety symptoms were just his body's natural response to a perceived threat. In this instance, as his "supportive coach" I worked to reframe Rahul's experience and understanding of his symptoms to a misattribution of a perceived threat as compared to the previous view that he had significant personal pathology. In addition to psychoeducation, I also wanted to help Rahul feel comfortable with me personally. On several occasions, I pointed out when I was genuinely impressed by him. This included me expressing his courage to seek treatment and describe his symptoms openly, my impression of him as bright in being able to pick up on the content of our discussions and his conversational style, and his dedication to his academics and extracurricular activities which he had begun to share with me.

As a new and training therapist, I remembered feeling slightly nervous at this point, as I was aware that I hadn't engaged in all of the tasks of the therapy manual and in the exact order that the manual presented them in. The part of me that was nervous was the part that wondered if the only way to have an effective treatment would be to follow the manual exactly, and any deviations from the manual (even if informed by Rahul's presentation) would represent decreases in treatment efficacy. However, another part of me that was informed by the basic therapeutic strategies class I had taken the semester prior, felt that the focus on establishing connection, confidence and trust together in the relationship would trump any minor content level shifts from the manual. In essence, I was choosing to prioritize the development of the "supportive coach" style of our relationship, aware of its importance in a CBT treatment.

Indeed, by the end of the second session with me, Rahul seemed to be noticeably relaxing in the room. I internally noted how he was making more regular eye contact,

and sat leaning back in his chair in a position that appeared comfortable. While the exact mechanism of change might be impossible to concretely pin-point, I think the focus on our therapeutic relationship before too quickly progressing with content-focused tasks helped establish his comfort in the room and his willingness to proceed with treatment.

### **Session 3: Psychoeducation and feedback loop.**

#### ***Content.***

I continued to engage in psychoeducation regarding the nature of Rahul's claustrophobic symptoms. We discussed the differences between fear and anxiety; times when his fight-flight response is activated; and finally the fact that panic symptoms, although uncomfortable and scary, are not dangerous. Also discussed was the negative feedback loop of Rahul's thoughts, physiological reactions, and behaviors that he described the previous session, and how to break the cycling with Exposure-Based CBT as a rationale for treatment. At this point, I had made a conscious choice to deviate somewhat from the manual by holding off on introducing a fear hierarchy or engaging in cognitive restructuring. As discussed previously, I wanted to move at a comfortable pace and focus on our rapport and establishing confidence in our treatment approach together, before rushing into the specific interventions.

#### ***Relationship and process.***

By the end of the third session, it was clear that Rahul's presentation and posture in the room with me had shifted compared to our first session together. Rahul was making more regular eye contact with me and tended to either sit forward in his chair leaning in, or sit back relaxed and with an open body posture. I was happy to see that Rahul appeared motivated for treatment, and I was actively synthesizing what Rahul was

telling me about his symptoms and then together overviewing a road map for our treatment. In this sense, we seemed to be establishing the supportive coach-like relationship together. Although I was slightly anxious about having deviated from the manual, it was reassuring noticing our increasing comfort level together, which I took as a sign that it was appropriate not to have rushed forward with treatment interventions.

#### **Session 4: Fear hierarchy and coping skills.**

##### *Content.*

I worked on creating a personalized fear hierarchy with Rahul. Activities that involved moderate anxiety included sitting in the middle of a crowded auditorium, walking through a crowded hallway, and riding the university bus for one short stop with only a few other people on the bus. Higher items on the hierarchy included going to a loud and crowded party in a basement and riding a bus on the highway. The highest item on his hierarchy involved riding a crowded university bus on a weekend night on the highway. In general, the longer Rahul had to endure a crowded environment and the more crowded the environment became, the higher it would be on his hierarchy. I also described that the crux of treatment involved repeated exposures to items on his hierarchy.

Additionally, as Rahul mentioned that he occasionally holds his breath when he becomes very anxious, I taught him breathing retraining. This involved teaching him to rely on his abdomen rather than chest muscles while breathing, and to count his breaths in and out. I then practiced this type of breathing together with him. Finally, I practiced progressive muscle relaxation with Rahul, another technique to help him cope with an anxiety-provoking situation. Homework for session 4 included practicing the breathing

exercise and the progressive muscle relaxation at least once each day until the next session, and adding any items to his hierarchy that he did not think of in session.

***Relationship and process.***

As compared to the first three sessions, by our fourth session I felt Rahul was prepared enough and confident enough in the outlined treatment to begin some of the active skills techniques outlined in the manual and to introduce homework. In the literature, in a time-limited CBT treatment, the work can often be conceptually divided into four different stages: Evaluation, Engagement, Intervention, and Termination (Elizur & Huppert, Chapter in Press). Within this model, by session 4 Rahul and I moved past the evaluation stage (primarily characterized by the therapist gathering relevant history, defining the presenting problem, and providing an outline and rationale for an effective treatment approach) and toward the engagement and intervention stage which direct the client toward active treatment interventions. Waiting until session 4 to make this transition was again tied to an attunement to and an awareness of our developing relationship. I wanted to wait until I was acutely aware of a good developing alliance before I introduced the potentially anxiety inducing task of producing a fear hierarchy together which we were able to accomplish in session 4.

**Session 5: Working with cognitions.**

***Content.***

I began active cognitive restructuring of Rahul's distorted cognitions related to his anxiety. Specifically, I focused on the exaggerated likelihood of Rahul's feared reactions to crowded environments, and the catastrophic outcomes he imagined would result if one of his specific fears of vomiting in public materialized. As an example, I asked Rahul to



explore what his own reactions would be toward someone who vomited in public. He acknowledged that although he would feel uncomfortable, he wouldn't judge them or look down on them in any way, especially if they apologized and mentioned they were sick. With this in mind, I had him re-evaluate what others might actually think of him if he were to vomit in public. This allowed Rahul to shift his thinking, admitting that it would not be the end of the world if it happened. He also added that he would not drop out of school if it happened, and that if his friends truly were his friends, they would not judge him if they found out.

***Relationship and process.***

In our 5<sup>th</sup> session Rahul demonstrated how he was an engaged and active participant in our work together. In fact, Rahul showed that he was comfortable enough to respectfully challenge me, which I encouraged. During our discussion of cognitive restructuring, Rahul pointed out that regardless of how we change our view about the possibility of a negative event occurring, to be accurate we must still accept that there is some non-zero percent chance of something still going wrong. He was right to assert this, and I verbalized how I agreed with him. There will always be at least a very minute probability of something going wrong (vomiting, passing out, etc.) during an exposure task. Once we were on the same page with this, we were able to move forward in the work by agreeing that nevertheless the probability is very small, and small enough that it is worth it for him to no longer avoid attending crowded environments. In essence, the benefits outweighed the risks.

As a training therapist, and in working with clients before Rahul, at first I had felt uncomfortable admitting where I made a mistake or accepting a critique or a challenge; I was worried it would make me lose credibility in my position as their therapist. With

Rahul, the opposite proved true. When I revised my initial statements and accepted his challenges we seemed to become closer, and then could move forward with treatment smoothly.

### **Sessions 6 and 7: Interoceptive exposures.**

#### ***Content.***

I began interoceptive exposures in session 6. Interoceptive exposures are exposures to the symptoms induced by a panic attack, rather than exposure to the actual environments that cause panic attacks. Creating the sensation of dizziness, for example, can be accomplished by spinning a patient in a chair. Heat sensations can be created by wearing multiple layers of clothing while exercising. The rationale for interoceptive exposures is that by exposing a patient to the physiological symptoms of their panic, and then helping them safely return to baseline functioning, they will learn that although the symptoms are uncomfortable, they are not dangerous.

Interoceptive exposures chosen for session 6 included rapid breathing and spinning in a chair, to induce hyperventilation and dizziness respectively. Rapid breathing I did together with Rahul, as we both sat facing each other taking quick and shallow breaths for one minute. For the spinning interoceptive exposure, I had Rahul sit in a swivel chair which I gradually spun. During these exercises, I asked Rahul to periodically call out his level of distress ranging from 1 to 10 and to watch as his distress rose, peaked, stabilized, and then eventually returned to comfortable levels. Homework for the week involved engaging in one interoceptive exposure task per day of his choosing.

In session 7, Rahul continued with repeated interoceptive exposures of spinning in a chair, except this time I had a YouTube recording of crowds talking loudly playing in

the background, in order to better approximate what he might experience during a live exposure on a crowded university bus.

*Relationship and process.*

I remembered having a considerable amount of my own anxiety as I prepared for these interoceptive exposure sessions. This was the first time I was to do anything other than sit motionless in a chair facing my client for the duration of a session. I was aware of two things in my preparation. The first was that the upcoming sessions would be demanding for Rahul in that I would be actively eliciting his anxiety in session. The second was that I wondered if it might be somewhat embarrassing for him, as I witnessed him engaging in the distressing exposure activities as I sat back collected and calm. And so instead I decided I would engage in some of the interoceptive exposures together with Rahul. I wanted to be right there with him in his anxiety rather than as an outside observer. And so when we engaged in our first interoceptive exposure of rapid breathing to induce hyperventilation, I told Rahul that I was going to be doing it with him. I then moved my chair so that it sat beside his, and together we engaged in over-breathing. At the end of our interoceptive exposure sessions Rahul mentioned that it was indeed very anxiety provoking (as it is meant to be for interoceptive exposures) but that he felt good about himself for being able to complete them, felt comfortable with me in our work together, and had confidence going into the upcoming in-vivo exposure work.

**Phase 2**

**Session 8: Changing the course of therapy.**

Session 8 was a significant moment in our therapy, and one in which I was caught totally off guard, as Rahul began the session by describing new concerns not previously

mentioned at intake and wondering whether we could work on them together. Among these new issues were stress and pressure from his excessive academic course load, as well as more general personal and familial concerns, primarily related to issues of shame, competence, and perfectionistic self-expectations as discussed in the previous section. As Rahul shared, I sat back and listened empathically (relying on the core counseling skills I had learned from my basic therapeutic strategies course) as a way to buy time and figure out how I wanted to proceed and deal with this new information in our treatment together. It was at this time that I remembered having two conflicting thoughts about how I was proceeding:

1. "I'm screwing up treatment by breaking significantly from the manual. I should just re-direct him back to treatment as usual."
2. "What he is saying now is important and deserves to be heard."

Eventually it was this second feeling that I let guide my action as a therapist during Rahul's disclosure, as I believed it stemmed from an intuitive felt sense that if I were to interrupt him or try getting back to the structured CBT exposure work that we were doing that it would rupture the therapeutic alliance. Ultimately, though, it was Rahul who made the decision of how to proceed clearer for me. After ten minutes of him describing his issues and me sitting back and listening and responding empathically, Rahul paused to mention how he felt comfortable and how he appreciated and found helpful having time to talk through and bring up these issues. He then asked whether we could continue to talk about these issues in this way as part of the remaining sessions, while still doing structured CBT work for claustrophobic concerns as well.

In wanting to meet him with his request, I mentioned that I believed we could try this out. When we ended the session I was then left with the question of how, exactly,

did I want to go about trying this? As I thought about this question and subsequently brought it to supervision, what my supervisor and I discussed was that it would be necessary to create an integrated treatment that continued to address his symptom-specific claustrophobic concerns, as well as allow space for open-ended processing of his new, more global concerns. As discussed in the formulation section, this was to take the form of a Client Centered approach for open-ended concerns, and continued Exposure-Based CBT for claustrophobic symptoms.

**Sessions 9-14: Utilizing principles of client centered work and exposure-based Cognitive Behavioral Therapy concurrently.**

In order to have time for both exposure based CBT and Client Centered work in phase 2 of our treatment, the exposure based CBT was streamlined in the second phase to only include reviewing past exposure exercises, engaging in cognitive restructuring or coping statements (e.g. “symptoms not dangerous, just uncomfortable” and “I’ve succeeded with past exposures and so I can get through this upcoming one”) when necessary, and determining subsequent exposure tasks based on Rahul’s successes from previous weeks.

After reviewing a past exposure and then assigning subsequent new exposure tasks as homework in the beginning of the session, we would then have the remainder of the session to discuss open-ended concerns. As is the nature of Client Centered work, I did not actively direct the content of this aspect of our treatment. Rather, I relied on Rahul to bring up and discuss what he felt comfortable with. Whereas in the CBT work part of my focus was directed toward our relationship and part directed toward the treatment interventions, in the Client Centered work all of my focus was on our relational process. It was helpful for me during this time to think about the concept of my “way of

being” in the room with Rahul. In essence, what were the principles that defined how I would behave and respond to him. To inform this “way of being” I used the core tenants of a Client Centered approach to guide my thinking. Namely, as Rahul shared thoughts or feelings I would work to respond in a way that demonstrated either empathic understanding or a form of positive regard, and also make sure they reflected congruent or genuine reactions that I was having as he expressed his experience.

*Client centered work.*

In the Client Centered work of phase 2, the content of our open-ended discussions guided by Rahul’s sharing developed into two main themes that we processed together:

*Theme 1: Relationship between family dynamics growing up and expectations of himself for the future.*

As Rahul explained to me, he had intensely high, and occasionally crippling self-expectations regarding academic or professional achievement. In terms of his future career, anything less than high achievement and wealth would represent a significant let down for him. Although this had the upside of motivating him to work hard, these expectations at times hindered him as he frequently felt overstretched in his work commitments. In particular, at the time I was seeing Rahul, he had taken on a significant leadership role in an extra-curricular organization, despite already being inundated with an expanded academic course load of difficult classes.

As a way of gaining insight into these intensely high self-expectations, we began to process together certain aspects of his childhood and upbringing that Rahul started to share with me. In particular, we explored his experience growing up in a particularly strict household with two traditional Indian parents who had especially high academic expectations for him. Starting at an early age, he described having to study his academics

uninterrupted for several hours each day after school. Over time, rigorous academic expectations left him feeling like “only the best was good enough.” By the time Rahul was in college, these expectations had become internalized, and he described experiencing intense shame when he would receive anything less than top marks in his classes. In this sense, on an emotional level, the expectation for rigorous work and performance had jumped from a parental requirement to a personal requirement.

Another aspect of this first theme of our work was when Rahul described how emotionally-laden topics were rarely discussed in the house. It felt to him like a taboo to discuss feelings or relationships openly among his family members. When he and his family had recently visited his sick grandfather in the hospital, for instance, there felt for him a silent expectation that strong feelings would not be brought up or discussed together during the visit. At the same time, though, Rahul described how it was not that his parents were distant, uninvolved or uncaring toward him, but rather that there were a certain set of expectations around the types of conversations that would happen in the house. Specifically, these typically included conversations concerning academic achievement, accomplishment, or taking on extra-curricular activities.

Relevant to Rahul’s exploration of this topic was Rahul’s recognition of his developing feeling of “needing to get to the top.” Once this was admitted, we began to process what it felt like to always “go after the highest rung of the ladder,” and then if he got there how he would always find another rung ahead of him. Although never actually making a concrete commitment to change these expectations, toward the end of therapy Rahul began to wonder aloud whether “letting go of some of these expectations might finally free me from the anxiety I’ve felt.”

In terms of our relationship and my own process with Rahul throughout the discussion of this theme, I was committed to letting Rahul guide the content. In this sense, most of my responses to him could either be classified into one of three categories:

1. A reflection that accurately expressed his thoughts and demonstrated that I was hearing him.
2. An open-ended question asking for clarification of his thoughts or feelings.
3. A statement demonstrating my positive regard for him and his experience.

For instance, when Rahul was explaining to me his overwhelming schedule of work and associated anxiety, I reflected back to him how stressful it feels for him “always having his plate full” and having to keep track of a never-ending to-do list. Upon hearing this, Rahul then unprompted began a discussion of what he feels motivates him to do this, and whether these motivations or assumptions might get in his way. For instance, the pressure he has felt to “make it to the top” or the expectation he’s felt that only the best is good enough, as discussed above.

Other times during our discussion I might ask open ended questions, not to purposely direct him to any specific insight, but rather to gain clarity into his thinking and understanding of a topic. When Rahul was explaining to me how he had to work very hard when he was younger, before we might quickly move to a different topic I asked for clarification of what was it like for him specifically. What did “working hard” look like and mean for him? At this point, Rahul described his pattern of school work and the amount of effort and diligence that he felt was required of him, which ultimately gave us a much clearer picture of his experience during this time. With this clearer picture of his experience in view, it then became easier for me to empathically react and respond to him.



Lastly, and potentially most importantly, I maintained my commitment to demonstrate my positive regard for Rahul during our discussions together. I validated his strong work ethic, expressed my sense of him as bright and also psychologically minded in his ability to make connections between his earlier childhood life and current feelings, and commended him in his courage and commitment to engage in the interoceptive and in-vivo exposure work of treatment. I also worked to express this positive regard non-verbally. I greeted him in the waiting room with a smile (I was always happy to see him), I would often sit forward in my chair leaning in toward him, and I frequently found myself nodding my head along with much of what he was saying.

*Theme 2: Current academic achievement and anxiety.*

Related to the first theme, Rahul described having anxiety regarding his grades in his undergraduate academic classes. The problem this had caused him had been twofold; not only might he worry excessively before an exam, but also if he were to receive a grade lower than his expectations this would be “crushing” and lead to shame and periods of ruminating on the consequences of performing poorly.

As we began to explore these concerns together, Rahul began to question what the realistic consequences would be if he received a few less-than-ideal scores. In particular, he wondered what the actual long-term effects would be if he were to make a minor mistake or error in his current work. It was interesting working through this issue with Rahul, as I noticed it took on certain elements of a CBT approach. Namely, Rahul was stepping out of his current anxiety, looking at his circumstances objectively, and then determining more realistic conclusions or thoughts as a result. In a sense, it was cognitive restructuring work. However, instead of me dictating an agenda and then directing him through structured cognitive restructuring exercises (as would be the case

in a CBT approach), it was Rahul who was gradually bringing up, directing and guiding the work with my gentle encouragement, reflection, and support.

While the fact that Rahul was able to shift maladaptive cognitions without my direct guidance may be a partial testament to the effectiveness of Client Centered work, certainly a strong contributing factor was Rahul's unique strengths as a client in being psychologically minded and bright. As I will discuss in a later section, there may have been some merit to my simply adopting a CBT approach to address these concerns, however, I ultimately chose to remain in a Client Centered model while working with Rahul in phase 2, as it felt more aligned with his preferences for treatment.

As we processed the concerns around his academics together, in line with the Client Centered approach I had adopted, I let my presence or "way of being" guide the way I approached the session. I looked to reflect back my understanding of his thoughts or feelings to demonstrate that I was hearing him accurately, ask open-ended questions for clarification of his feelings to help better understand him, and express genuine positive regard for his experience as he shared it with me. For instance, in session 11 when Rahul shared with me his frustration at receiving a grade lower than expected on one of his assignments and associated rumination afterward, I reflected back how it is clear he has a strong work ethic and drive to achieve highly, yet at the same time this very trait seems to get in his way during times when he falls short of his expectations. Rahul then affirmed that I understood this correctly, and then went on to describe other times in which his dedication to achieve highly has at times felt overdetermined. He explained that he had ruminated excessively either before or after several past exams related to the consequences of receiving a less than perfect score, which then impacted his ability to study or work on an upcoming assignment. In voicing this out loud and in

front of me, Rahul had the opportunity to become explicitly aware of both a negative pattern of behavior that he has engaged in, as well as an intention or goal to change the pattern. Indeed, one mechanism of change in Client Centered therapy is its ability to help clients better understand themselves and their experience, and the ways in which they'd like to change once they have voiced their sincere intentions (Cain, 2010).

I also maintained my commitment to demonstrate my genuine positive regard for Rahul. In session 12, for example, while he was sharing with me his commitment to continue in his leadership role in a service organization on campus (on top of the expanded course load of courses he had) I felt a strong feeling of respect for him. I then shared this explicitly. I explained that I respected his commitment to make a positive impact on campus, and how I thought it was very impressive how he has consistently been able to achieve in his classes while making a positive difference in a service organization at the same time. It was a genuine reaction I had, and I can only imagine that Rahul heard it as such based on my tone of voice as I shared it. Shortly thereafter, Rahul acknowledged my compliment and then paused before expressing a self-affirming statement. Speaking aloud to himself, Rahul mentioned that he has indeed done well, consistently well, for a long time. And that he thinks that if a future employer or graduate school program met him or saw his resume then they, too, might get a sense of this as well.

As Rahul was able to recognize and express aloud his strong track record of success and the unlikelihood of any minor upcoming grade or test score affecting him in a significant way, this came with some emotional and behavioral changes as he faced some of his final school assignments. Although he reported that he still experienced some anxiety, he was able to confidently assert, and rightly so, that he was very

accomplished academically and could have a successful career, regardless of his performance on any particular assignment or exam. In essence, Rahul was voicing how he could believe in himself and his achievement, and could believe in a future employer being able to see this. Ultimately, Rahul noted that this manifested concretely for him, who reported being able to study with less stress for his final exams at the end of our treatment together. In particular, he noted that he was aware that he was engaging in less rumination around the consequences of performing poorly, which he described as helping him ease his tension and stay focused during his exam preparation.

***Concurrent exposure-based, Cognitive Behavioral Therapy work for Sessions 9-14.***

As discussed above, in order to have time for both Exposure-Based CBT and Client Centered work in phase 2 of our treatment, the Exposure-Based CBT was streamlined in the second phase to include only reviewing past exposure exercises, engaging in cognitive restructuring and determining coping statements (e.g. “symptoms not dangerous, just uncomfortable” and “I’ve succeeded with past exposures and so I can get through this upcoming one”) as well as determining subsequent exposure tasks based on Rahul’s successes from previous weeks. Regarding exposure tasks, we would proscribe as homework in-vivo exposure tasks that gradually increased in difficulty and were higher on Rahul’s fear hierarchy with difficulties or obstacles discussed in session.

As an example discussed previously, when Rahul presented to one session with the recognition that he could never have an absolute guarantee that he would never pass out or throw up in a crowded environment (and the associated anxiety and fear this caused him regarding attempting future exposure tasks) we engaged in cognitive restructuring to determine the actual likelihood of this. To do so, we engaged in common cognitive restructuring techniques including “identifying distortions,” “examining the

evidence,” and “thinking in shades of grey” (Burns, 1999). For instance, when examining the evidence together, I asked Rahul to determine roughly the number of times he’s felt anxiety in crowded spaces and the number of times he has actually fainted. He explained how he’s probably felt anxious hundreds of times, and has never actually fainted. We also discussed common cognitive distortions including “jumping to conclusions” and “emotional reasoning.” For jumping to conclusions, we made explicit his pattern of making negative predictions before an upcoming uncomfortable event, and for emotional reasoning we questioned whether his feelings about a crowded environment reflected the objective reality of the danger that environment actually represented. Ultimately, this helped Rahul gain confidence that imagined disasters were very unlikely to take place, and gave him confidence to proceed with his in-vivo exposure homework tasks.

Regarding my use of session time management, these in-session discussions of exposure homework, coping statements, and cognitive restructuring when necessary, typically took place at the beginning of a session, followed by a transition into open-ended work for the middle and end of a session. Before a few particularly difficult homework exposure tasks, (e.g. riding the bus on the highway for the first time) Rahul and I would also spend the end of the session discussing his concerns to help reassure him.

There was measurable and significant progress throughout this phase of treatment between sessions 9-14. As discussed above, discussions and preparation for exposure tasks followed by exposure task homework defined the CBT aspect of this part of treatment. Specifically, Rahul steadily worked his way up from short rides on the university bus when the bus was not crowded, to a 25-minute bus ride with multiple

stops, including a highway section when the bus was crowded. Over this span of time, there were only a few instances when Rahul shied away from his exposure tasks. However, this was discussed in session and together with my guidance and encouragement, he was able to develop coping statements as mentioned above, and later engage in the missed exposure tasks. Throughout this time, Rahul was highly motivated and worked cooperatively with me. He was able to successfully complete his exposure task assignments and at the end of the treatment Rahul's claustrophobic symptoms had significantly reduced, both on the SMPDA, as well as informally through discussions with me.

## **Chapter VII: Therapy Monitoring and Use of Feedback Information**

I had case supervision after each client session for the duration of treatment. Stemming from detailed session notes taken at the end of each therapy hour, along with over-viewing audio-recorded sections of the session, supervision was used for case conceptualization as well as the decision to introduce a Client Centered approach into treatment and the ensuing process of therapeutic integration in phase 2. The option of simply adopting a CBT orientation to address the broader level personal and familiar concerns of phase 2 was also discussed. It is possible, for instance, that in phase 2 Rahul could have benefitted from my introducing thought records and structured exercises and homework to shift cognitive distortions and to actively determine more realistic and adaptive thinking patterns. However, to do so would run the risk of violating the concept of responsiveness. That is, the actions of the therapist being influenced and dictated by the emerging content of the therapy (Kramer & Stiles, 2015). The concept being that as new or emerging content arises, whether that be an introduction of new concerns, changing characteristics or behaviors of the client, new client preferences for treatment, etc., the actions of the therapist and the course of treatment shifts to best accommodate the changes. In Rahul's case, the decision to introduce a Client Centered aspect of treatment was influenced by two primary reasons as discussed previously:

1. The introduction of new presenting problems and Rahul's preference for an open-ended discussion of these issues as compared to the structured approach for the claustrophobic concerns.

2. My intuition that a gentle, non-rushed, non-interpretive therapeutic approach would respect Rahul's sensitivity toward these new issues, as indicated by his decision to wait until later in treatment before disclosing them.

To quantitatively monitor progress throughout treatment, for each session I utilized the PHQ-9 and the Severity Measure for Panic Disorder-Adult (SMPD-A) as discussed above. In particular, scores from these measures helped navigate when and what kind of homework exposures would be assigned to Rahul based on his previous progress and difficulty of upcoming exposure tasks. In addition, I used the OQ-45, a general symptom measure, at a two year follow up to assess Rahul's perception of his changes in functioning from prior to therapy to two years post therapy at the time of the interview.



## **Chapter VIII: Concluding Evaluation of the Therapy's Process and Outcome**

### **The Outcome of Rahul's Therapy on the Quantitative Measures**

Regarding Rahul's claustrophobic concerns, barring a few weeks when his panic symptoms spiked (the first few weeks of exposure homework) he showed consistently decreasing anxiety and panic symptoms as reflected in the SMPD-A over the course of treatment. Average SMPD-A scores can range between 0 and 4. An average score of 1 indicates mild panic, a score of 2 indicates moderate panic, a score of 3 severe panic, and a score of 4 extreme panic. As seen in Table 1, Rahul's anxiety and panic in claustrophobic environments dropped from the moderate panic range at the start of treatment (score of 2.1) to mild panic range (score of .7) by the end of treatment. In addition, Rahul's scores from the PHQ9, a depressive symptom measure, demonstrate very little depressive symptomatology throughout treatment as they remained consistently in the minimal depressive range for the duration of the treatment, as seen in Table 2.

During a 2-year post-therapy follow up with the client, the clinician also utilized the OQ-45, a general symptom quantitative measure, which asks about a broad range of functioning from self-esteem to interpersonal relationships to anxiety and depressive symptoms. For each individual question scores can range from 0 to 4, with 4 representing significant difficulty or impairment and 0 representing little to no impairment. OQ-45 Total Scores can range between 0 and 180, with higher scores indicating more clinical symptoms and/or more impaired functioning. Rahul's pre-therapy total score was a 52 and his post therapy score a 45, indicating an overall

decrease in impairment as seen in Table 3. In particular, across all questions Rahul either had the same level of functioning or improved functioning, with no decreases in functioning. Areas where Rahul noted an improvement in functioning included increased satisfaction in work, school and relationships; a decrease in claustrophobic symptoms; and an increase in self-esteem (See Table 3 for specific responses).

Of importance to note, however, is question 35 of the OQ-45: “I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.” Rahul noted that prior to therapy he was “almost always” afraid of crowded environments, as compared to “frequently afraid” of crowded environments two years post therapy. Although this is an improvement, it would not be as much as hoped, as an ideally successful treatment might represent a more pronounced change. In reference to this question, Rahul explained that particularly crowded areas still induce anxiety and in a consultation with a psychiatrist he obtained a prescription for Xanax. He explained that he rarely uses the medication, but has it as an emergency back-up if an environment were to become too overwhelming.

As will be discussed in the following section, it is possible that follow up or “booster” sessions could have been helpful for Rahul, as they could help consolidate treatment gains and learning that took place during our brief therapy together. Nevertheless, Rahul did mention that despite his anxiety he is more willing to approach rather than avoid crowded environments, and his successes from the exposure tasks proved to him that he can endure anxiety provoking environments without previously imagined catastrophic reactions taking place.

### **The Outcome of Rahul's Therapy Within the Qualitative Data**

Rahul was a motivated and bright client and by the end of treatment he expressed his sense of improvement in both his claustrophobic concerns as well as his more general concerns brought up in phase 2.

Although there were numerous components to our cognitive behavioral work together, likely of primary importance was Rahul's willingness and strong determination to engage in exposure tasks of continued difficulty during our treatment together. As such, Rahul was able to significantly reduce his level of behavioral avoidance of crowded environments as compared to the start of treatment. As discussed above, Rahul steadily worked his way up from short rides on the university bus when the bus was not crowded, to a 25-minute bus ride with multiple stops, including a highway section when the bus was crowded at the end of therapy.

In terms of the more general concerns brought up in phase 2, in our Client Centered work together Rahul demonstrated an ability to gain insight into these issues with associated emotional and behavioral changes. As discussed above, Rahul began to make connections between his early childhood family dynamics and household expectations to the pressure he places on himself to achieve to exceedingly high standards. While anxiety around performance was not eliminated in our work together, Rahul was able to objectively view his circumstance, recognize his history of achievement, and then subsequently feel less anxious about his performance on any upcoming assignment. At the end of our treatment, which coincided with his upcoming final exams for his classes, Rahul reported that he was able to study with less stress, rumination, and pressure.

In addition, during our 2-year post-therapy interview together, as Rahul looked back on our work he described two main components in our therapy that he found helpful and aided in our treatment. Rahul described how he appreciated both the behavioral exercises and exposure homework tasks he was able to complete during our treatment together, as well as our therapeutic relationship and alliance. In reference to the behavioral exercises (interoceptive exposures and in-vivo exposure homework tasks), he explained that completing them gave him confidence as well as teaching him that he can “stay” with his anxiety to get through it, as compared to avoidance which he had been engaging in prior to treatment. In terms of our therapeutic alliance, Rahul explained that he felt comfortable and trusting in his therapy with me. As a result, he explained how this allowed him to open up and disclose his thoughts openly, gain insight into his concerns, and aiding in his feeling of therapy as an overall positive experience.

### **Reflections on Therapy Process**

Rahul was a high-functioning, motivated, and brave client. Working with him was a collaborative endeavor, as we co-created and navigated a unique treatment approach that developed over the course of our therapy together. It broke up my conception of what a standardized short-term treatment could look like, as we deviated from a structured manual in key moments. This is not to say the manualized treatment plan wasn't valuable (indeed, without a manual to intermittently refer to I would not have known how to address and implement important intervention techniques that served to reduce Rahul's claustrophobic symptoms), but rather that by at times allowing myself to move away from the manual (informed by Rahul's inputs) created for us an opportunity

to address a broader range of concerns, not to mention improving our therapeutic relationship.

However, it is important to note that there were several factors that likely influenced the success of our Technically Eclectic treatment together. The first was the fact that Rahul, from the outset, demonstrated that he was both highly motivated for treatment, as well as being high functioning and a quick learner. In part, this allowed us (or at least made it much easier for us) to move quickly through difficult interoceptive and in-vivo exposure tasks without the need for extensive processing, encouragement, or scaffolding. It also likely contributed to the insight he obtained during the Client Centered aspect of our treatment, as he was able to self-direct the content of the session as well as express a range of interrelated thoughts and feelings openly and coherently.

Another contributing factor was Rahul's ability to advocate for himself. For instance, he was able to voice his preference for continuing with structured CBT exposure work for his claustrophobic symptoms, while simultaneously looking for space to discuss other broad issues in an open-ended way. As a result, it became significantly easier for me to stay attuned to his needs in treatment and structure and develop our therapy accordingly.

What this brings up for me, then, is how exactly this therapy might have looked for a client with similar presenting problems yet with a different characterological make-up? For instance, a client with lower motivation for treatment, or a less psychologically minded client. It is possible that it might have been necessary to stick solely to one treatment modality, as introducing two very different clinical approaches simultaneously could be confusing or overwhelming.

Another area that I question for possible future development would be the establishment of booster sessions post-treatment. Indeed, although Rahul across 14 sessions significantly reduced his anxiety and behavioral avoidance of crowded environments (total avoidance of riding the university bus pre-treatment to riding for 25 minutes including a highway section while the bus was crowded post-treatment) two years after therapy in our follow up interview he indicated that he has had frequent anxiety in especially crowded environments and appreciates having an emergency back-up medication on his person in case his anxiety were to become unmanageable. It is possible that with periodic check-ups or intermittent continued exposure tasks Rahul might have been better able to sustain treatment gains over time.

Nevertheless, it was a deep pleasure working with Rahul and engaging in treatment together. Co-creating a unique therapy with two separate treatment approaches was a fulfilling challenge for me as a young therapist. Staying attuned to his preferences and implementing separate therapeutic modalities to match his distinct presenting concerns felt appropriate and facilitative of treatment, even if doing so meant stepping outside of the “one size fits all” manualized approach and instead using it to encompass just part, but certainly not all, of our treatment together.

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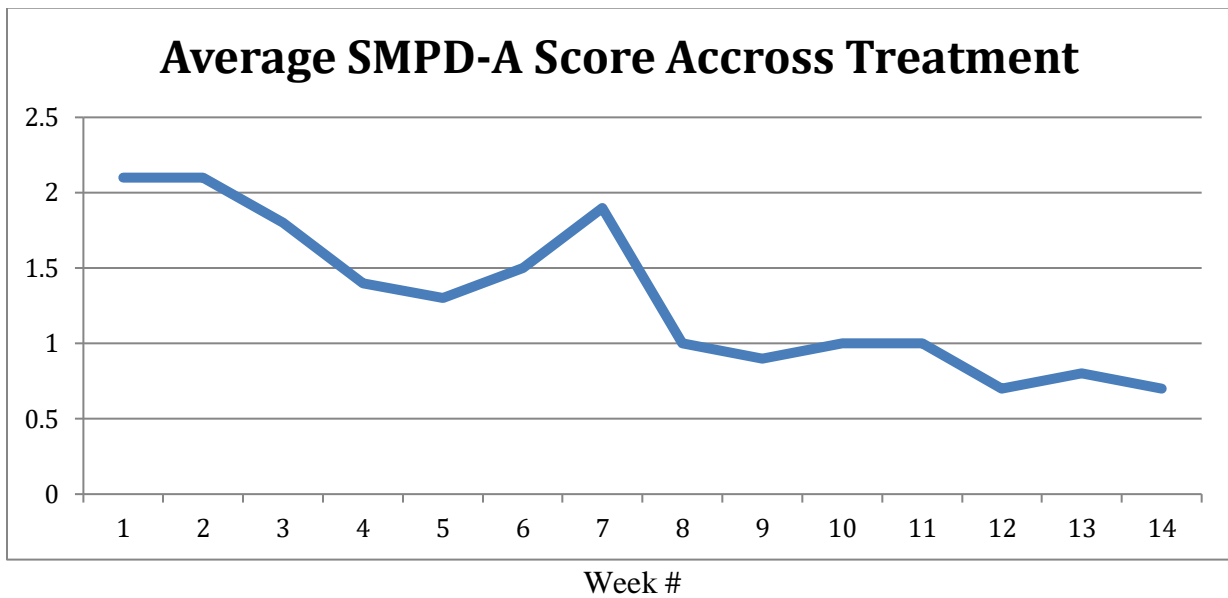
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**Table 1**

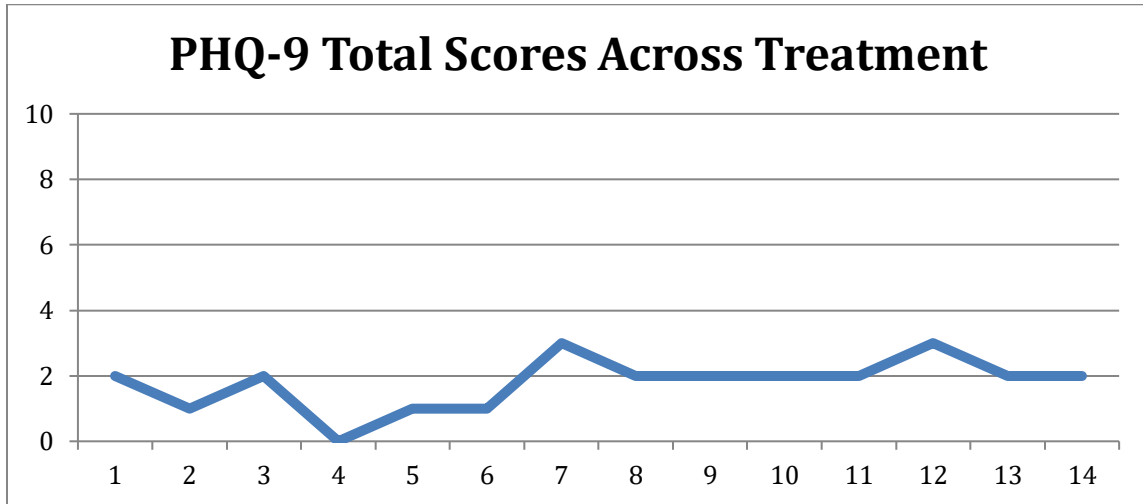
*Results on the Severity Measure for Panic Disorder – Adult (SMPD-A)*



(Note: Average SMPD-A scores can range between 0 and 4. An average score of 1 indicates mild panic, a score of 2 indicates moderate panic, a score of 3 severe panic, and a score of 4 extreme panic. Rahul’s scores drop from moderate to mild panic across therapy)

**Table 2**

*Results on the Patient Health Questionnaire-9 (PHQ-9)*



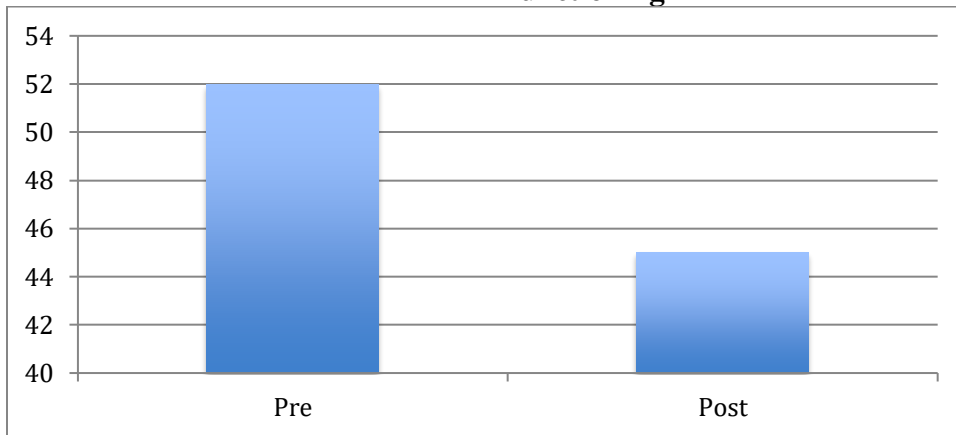
Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

(Note: Rahul’s scores from the PHQ9 demonstrate very little depressive symptomatology throughout treatment as indicated in the scoring guidelines above and remain consistently in the minimal depressive range for the duration of the treatment)

**Table 3**

*Results on the Outcome Questionnaire-45 (OQ-45)*

**OQ-45 General Symptom Measure Total Scores at Follow Up Comparing Pre-Therapy Perception of Functioning to 2-Year Post Therapy Perception of Functioning**



(Note: OQ-45 Total Scores can range between 0 and 180, with higher scores indicating more clinical symptoms and/or more impaired functioning).

Rahul’s specific subjective changes from pre-therapy to 2 years post-therapy as indicated on OQ-45:

- Pre: Sometimes feeling irritated → Post: Rarely feeling irritated.
- Pre: Frequently finding work/school satisfying → Post: Almost always finding work/school satisfying
- Pre: Sometimes feeling his love relationships are full and complete → Post: Frequently feeling his love relationships are full and complete.
- Pre: Almost always afraid of crowded environments → Post: Frequently afraid of crowded environments.
- Pre: Frequently feeling something is wrong with his mind → Sometimes feeling something is wrong with his mind.
- Pre: Sometimes having trouble falling asleep → Rarely having trouble falling asleep.
- Pre: Frequently being satisfied with relationships with others → Post: Almost always satisfied with relationships with others.