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CASE STUDY ✓ Open Access

Cognitive Behavioral Therapy for Generalized Anxiety Disorder with Agoraphobic Avoidance: A Clinical Case Report

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ABSTRACT

This case report describes the application of cognitive behavioral therapy (CBT) with a 44-year-old married male from Karachi, Pakistan, presenting with Generalized Anxiety Disorder, panic-like physiological symptoms and agoraphobic avoidance. The client reported excessive worry, disturbed sleep, irritability, low mood, fear of public places and public transport and reduced occupational and social functioning. Assessment was based on clinical interview, CBT assessment, DSM-5-TR diagnostic criteria, the Beck Anxiety Inventory and the Generalized Anxiety Disorder-7. The client obtained a score of 34 on the Beck Anxiety Inventory, indicating moderate anxiety and a score of 17 on the GAD-7, indicating severe anxiety. A formulation-based CBT intervention was delivered over 15 sessions through an online psychotherapy format. Treatment included psychoeducation, relaxation training, sleep hygiene, activity scheduling, mindfulness, grounding, thought monitoring, cognitive restructuring, downward arrow technique, Socratic dialogue, graded exposure, behavioral experiments, problem solving and relapse prevention. Improvement was observed in the client's understanding of anxiety, ability to identify and challenge automatic thoughts, willingness to face avoided situations and confidence in managing physiological symptoms. The case highlights the clinical value of individualized CBT for anxiety presentations involving chronic worry, panic-like symptoms and avoidance within a Pakistani cultural context.

Keywords: *Generalized Anxiety Disorder; Cognitive Behavioral Therapy; Agoraphobia; Panic; Cognitive Restructuring; Graded Exposure*

INTRODUCTION

Generalized Anxiety Disorder (GAD) is a long-term, debilitating anxiety disorder in which excessive, difficult-to-control worry is felt in a variety of life contexts, along with restlessness, fatigue, difficulty concentrating, irritability, muscle tension and sleep disturbances (American Psychiatric Association, 2022). Worry is a normal, human experience, but in GAD it is persistent, intrusive and interferes with daily life functioning. People often complain that they have anxiety and it is affecting their ability to work, their family life, their relationships with others, and their ability to make decisions. Sometimes worry can be coupled with a panic-like physiological response and avoidance of public places, which can further limit functioning and perpetuate a sense of vulnerability.

Cognitive models are a good way to think about the maintenance and development of anxiety. Beck, Emery and Greenberg (1985) suggested that anxiety is very much determined by the threat appraisal and the perceived coping response. In this context, anxious people tend to think that bad things will happen more often and/or be worse than they actually are and that coping abilities are less than they actually are. Clark and Beck (2010) also highlighted that anxiety is perpetuated by misinterpretations of internal and external cues, including physical sensations, social feedback or ambiguous future occurrences. Like-wise Barlow's (2002) model suggests that anxiety is a product of biological vulnerability, generalized psychological vulnerability and specific learning experiences. A person's worry may become problematic if in addition the negative beliefs about worry arise, that is, if the person believes worry is uncontrollable or negative as experienced from Wells (1995) metacognitive model.

CBT (Cognitive Behavioral Therapy) is an empirically supported, structured, collaborative approach that directly works with these mechanisms. CBT interventions for anxiety typically include psychoeducation, self-monitoring, cognitive restructuring, behavioral experiments, exposure, relaxation-based strategies, problem solving and relapse prevention. These techniques are designed to decrease catastrophic interpretations, maintain cognitive flexibility, minimize avoidance and enhance the client's sense of mastery. CBT has been shown to be effective for anxiety disorders, such as GAD, and avoidance behaviors through reviews and meta-analyses (Carpenter et al., 2018; Hofmann et al., 2012). CBT is also indicated as an essential psychological treatment for adults with GAD (National Institute for Health and Care Excellence, 2011).

Although there is good evidence from controlled trials, clinical case reports have their value in that they represent how theory is applied on an individual basis. They provide for focused analysis of the client's developmental history, personal meanings, maintaining factors, therapeutic decision making and response to intervention. Especially in a South Asian context, where culturally related beliefs regarding distress and stigma, as well as family expectations and occupational stress are likely to impact how symptoms present and how family members seek help. Studies on culturally adapted CBT indicate that cognitive-behavioral principles may be adapted to be relevant across cultures if therapists take cues from language, explanatory models, and family context and culturally relevant barriers to engagement (Naeem et al., 2019).

The present case report is about the use of CBT for a 44-year old male from Pakistan with GAD, panic-like physiological symptoms and agoraphobic avoidance. This paper demonstrates the incorporation of cognitive formulation, psychoeducation, cognitive restructuring, graded exposure, problem solving and relapse prevention into a culturally adapted CBT intervention.

METHOD

To describe the assessment, cognitive-behavioral formulation and therapeutic intervention of an adult male client who was presenting with generalized anxiety symptoms and agoraphobic avoidance, a single-case clinical report design was used. The study is descriptive and clinically interpretive in nature and does not attempt to prove causal efficacy, but rather to demonstrate the use of cognitive behavioral therapy within a particular clinical context for a particular individual. The identifying information was anonymized, and a pseudonym used to maintain the client's confidentiality. Case material was obtained from the clinical interview, CBT assessment, psychological screening measures, diagnostic evaluation, and therapy process notes, as well as homework review and clinical observations during the interview.

Participants and Clinical context

Here the client (Ahmad) was a married man from Karachi, Pakistan, aged 44 years. He was educated up to intermediate and working as an administrator in a medical center. He was part of a nuclear family with his wife and two daughters. The client presented with a pattern of persistent anxiety along with a pattern of physiologic symptoms that were similar to panic disorder, avoidance of public places, sleep difficulties, irritability, low mood and diminished social and occupational functioning, which led to his request for psychotherapy via the Internet and online sessions. His anxiety symptoms had been present for about 14 years, and he reported that these symptoms were particularly related to being in the public, riding public transportation, being concerned about his health, financial concerns and family responsibilities. His clinical work showed ongoing concerns about worry, avoidance, loneliness and decreased productivity, impacting functioning and confidence.

The outcomes of the assessment and the instruments used indicated that the content of the lesson plan is sound.

Clinical interview, CBT based assessment, DSM oriented diagnostic evaluation and standardized screening tools were used for assessment. Presenting complaints, onset and course of presenting symptoms, developmental and family history, occupational history, medication usage, previous therapeutic experience, maintaining factors, coping strategies and expectations from therapy were explored during the clinical interview. The CBT assessment focused on current problems, maintaining cycles, avoidance patterns, automatic thoughts, physical symptoms, safety behaviors and therapy goals.

The Beck Anxiety Inventory (BAI-21) was used to determine the severity of anxiety-related symptoms. The client's score was 34, in the moderate range of anxiety, and was indicative of clinically significant physiological and cognitive anxiety symptoms (Beck et al., 1988). The Generalized Anxiety Disorder-7 (GAD-7) was also used to screen the severity of generalized anxiety symptoms. This client scored 17, which is in the severe category and consistent with the clinical impression of persistent and impairing worry (Spitzer et al., 2006).

Diagnostic Impression

The diagnostic impression was based on clinical interview, symptom presentation, standardized screening results and DSM-5-TR criteria (American Psychiatric Association, 2022). The client's symptomology met criteria for Generalized Anxiety Disorder, noting that he worried excessively and found it difficult to control in several areas including health, financial, family and future. Sleep disturbance, irritability, physiological arousal, concentration difficulties and functional impairment were associated with his worry. A provisional diagnosis of Agoraphobia was also entertained given his marked avoidance of public places and public transport due to fear of panic like symptoms and that he felt he was unable to cope with anxiety in these places. Panic-like symptoms were clinically significant, but excessive worry and chronic apprehensive expectation were the dominant features of the presentation, and for this reason, GAD was a primary diagnosis.

CASE FORMULATION

Ahmad who was 44 years old, married male, presented with chronic and disabling anxiety with excessive worrying, panic like physical symptoms, avoidance of going to public places, insomnia, irritability, sadness and diminished functioning in social and occupational roles. He was an administrator in a medical center and had completed his intermediate education. He belonged to a nuclear family including his wife and their two daughters. He reported that his life functioning was disturbed and worsen since 2010 when he developed anxiety symptoms, although he was organized, responsible and academically attentive in the past.

First major anxiety episode was reported by the client while he was working at the stock exchange. Physiological symptoms were severe, such as "palpitations, sweating, rapid heartbeat, heaviness in the chest, and severe headache. There was reportedly no cardiac or acute physical reason for the event, but the event was very threatening for him. Cognitively, the episode seemed to become learned as a danger stimulus, and the client started to hyper-sensitize himself to his body sensations, and to think of anxiety related arousal as a warning or a sign that something bad might be happening or that he had lost control. This is similar to models of anxiety that suggest that threat appraisal and a sense of lack of coping lead to the continuation of anxious responding (Beck et al., 1985; Clark & Beck, 2010).

The client's anxiety has spread over time to other areas such as health, employment, finances, family responsibilities and uncertainties about the future in addition to the physical sensations. He didn't use public transportation or go to public places, out of fear of having a panic attack in front of people. In the short term avoidance led to relief, but in the long term it also meant he could not learn to handle such events, and thus reinforced his belief that public situations were unsafe and unmanageable. His avoidance also helped to create occupational restrictions, social withdrawal and decreased confidence. Client's thoughts often included catastrophic prediction, perceived helplessness and negative self-evaluation; such as "I will panic," "People will judge me," "I cannot manage this" and "I am useless."

Multiple contextual stressors seemed to exacerbate the client's vulnerability. At about the same time his anxiety symptoms started, his mother also started to develop Alzheimer's, and her death exacerbated his emotional problems. He also noted that there were family issues with his sisters after his mother had passed. In general, his marriage was a positive factor, but he felt pushed by his wife to find a better job, which increased his concern for financial responsibility and self-worth. These stresses combined with his anxious personality, limited coping strategies and frequent avoidance. Based on Barlow's (2002) framework, the case can be understood to have generalized psychological vulnerabilities, learned alarm reactions and specific anxiety cues related to public contexts and bodily sensations.

Metacognitive processes were also shown to be relevant. It wasn't just the external events that caused the client worry, he also feared the consequences of anxiety itself. He feared that the symptoms of anxiety would be out of his control, obvious or embarrassed to people. This "worry about worry" might have led to more monitoring of sensations and greater anxiety that one could not control or change, in line with Wells' (1995) metacognitive model. So there was an excessive worry, catastrophic interpretation of physiological arousal, avoidance, decreased self-efficacy and more worry, and that was the maintaining cycle.

Protective factors were the client's motivation to be in treatment, his intact insight, lack of substance dependence, and his willingness to participate in structured CBT tasks as well as his emotional connection to his wife and daughters. He had some prior experience with psychotherapy and this may have made him more receptive to psychological treatment in spite of his distress. The intervention thus included both, cognitive and behavioral maintenance factors: catastrophic interpretations, avoidance, physiological arousal, low self-confidence and relapse vulnerability.

Table 1

4Ps of Biopsychosocial in Case Formulation

Factor	Biological	Psychological	Social/Contextual
Predisposing	Possible physiological sensitivity to anxiety symptoms; long-term medication use for anxiety symptoms	Responsible, highly concerned personality style; tendency toward worry and negative anticipation	Family expectations; culturally shaped pressure regarding employment and financial responsibility
Precipitating	Initial panic-like episode with palpitations, sweating, rapid heartbeat, chest heaviness and headache	Catastrophic interpretation of bodily arousal; fear of losing control	Job-related stress; mother's Alzheimer's disease; later family strain after mother's death
Perpetuating	Ongoing physiological arousal; poor sleep; irregular routine	Avoidance, catastrophic thinking, low self-confidence, worry about worry, fear of public embarrassment	Avoidance of public transport and public places; occupational limitations; financial pressure; perceived judgment from others
Protective	No reported substance dependence; capacity to participate in treatment	Motivation, insight, willingness for CBT homework, hope for recovery	Wife and daughters as emotional supports; continued employment; access to online psychotherapy

THERAPEUTIC INTERVENTION

Therapy was 15 sessions of online psychotherapy using cognitive behavioral therapy. The treatment plan was based on the client's CBT case formulations and tailored to address excessive worry, catastrophic interpretation of physical sensations, avoidance of public spaces and public transportation, diminished confidence, difficulties with sleep and functioning. Treatment was delivered in a structured yet flexible format per the cooperative and problem-solving approach of CBT (Beck et al., 1979; Clark & Beck, 2010). Instead of using interventive techniques individually, each component of intervention was connected to a particular maintaining mechanism that was identified during assessment.

In the first step, the focus was engagement, clinical assessment and psychoeducation. Rapport building was emphasised due to the client's chronic anxiety and low self-esteem and uncertainty regarding the potential benefit of psychological intervention. The therapist clarified that therapy will be a process of understanding how thoughts, feelings, sensations, and actions are related and that therapy would be a collaborative process. History of clinical presentation was examined: onset of symptoms, panic-like experiences, patterns of avoidance, health-related fears, financial concerns, family stressors, medications and prior limited psychotherapy experiences. The client was asked to keep a written diary of worry events, events that trigger anxiety, physical sensations, and behaviors. This early self monitoring was designed to have two functions: to heighten the client's awareness of symptoms and its patterns, and to give the clinician some material to use later in cognitive restructuring.

Symptoms of anxiety were normalised using psychoeducation and the catastrophic interpretation of physiological arousal reduced. The client was informed that some of the symptoms of anxiety, including palpitations, sweating, rapid heartbeat, tension and disturbed breathing are normal responses to anxiety and do not necessarily mean that the person is in serious physical danger. The therapist presented a straightforward CBT model whereby triggering situations trigger automatic thoughts that prompt emotional and/or physiological responses and result in avoidance or safety behaviors. The client was able to identify that thoughts of "I will panic", "People will notice", and "I will not be able to manage" were common thoughts that were triggered by the situations of public transport, crowded places, health concerns and financial worries. This formulation facilitated changing the client's conceptualization of symptoms from being solely medical/out of their control to a psychological maintenance model.

The second stage of treatment involved symptom stabilization and behavior control. Slow breathing was incorporated as an initial coping mechanism to enable the client to control the physiological arousal prior to entering feared situations. The therapist clarified that the intention of the breathing exercises was to not immediately take away the anxiety but to keep the client in the moment so that he or she could respond more effectively. To help reduce tension and with awareness of the difference between tensions and release, relaxation training and progressive muscle relaxation were added. Sleep hygiene was also discussed as poor sleep was also leading towards irritability, low mood and vulnerability to worry. The client was advised to engage in a more uniform a bed time routine, minimise stimulating activities close to bedtime and monitor their sleep.

Activity scheduling was provided to address avoidance, inactivity and low mood. Together, the client and therapist were able to determine reasonable activities for him, such as walking for a short time, spending time with his daughters reading, or slightly interacting with positive people. Not only were activities chosen for enjoyment, but also to re-establish mastery and routine. Adding meal tracking activity for the client to see if he was eating irregularly and was noticing a physical sensation that he was attributing to danger of anxiety. Later, techniques of mindfulness and grounding were added, such as a short body-scan exercise and the "5-4-3-2-1" grounding technique. These strategies enabled the client to shift focus from catastrophic internal monitoring to sensory experience in the present moment. Coping statements were also co-created, for example, "This feeling is uncomfortable but it is not dangerous" or "I can feel anxious and still choose what to do."

The third phase focused on cognitive monitoring and restructuring. The client was given a structured thought diary that was first aimed at discovering the connections between situations, automatic thoughts, emotions, physical sensations, and behaviors and belief ratings. An entry from the client, for example, was anxiety when waiting to use public transport. He knew that he would panic, he would be judged and he would be stuck. This thought was accompanied with high levels of anxiety, palpitations, sweating and avoidance. The diary served to externalize the anxiety cycle, and to help the client see his thoughts as hypotheses instead of facts.

Client was then taught how to recognize automatic thoughts, and the cognitive distortion was subsequently introduced. The therapist explained common thinking patterns such as catastrophizing, mind-reading, overgeneralization, emotional reasoning and all-or-nothing thinking. Client identified himself as often assuming a lot of things going wrong or that he would lose control when in reality there was no evidence. Evaluation of evidence for and against distressing thoughts was then the focus of cognitive restructuring. For instance, the thought "If I panic, people will laugh at me" was explored in terms of past experiences, how likely he was to be noticed when he was panicking, and how there were other explanations for the sensations in his body. Balanced alternatives were encouraged to help the client, e.g., "Even if I start to feel anxious, I will not lose control" and "People may not notice my anxiety as much as I think." This was done to diminish threat overestimation and enhance perceived coping.

In the fourth phase, the deeper assumptions and core beliefs were discussed. The therapist guided the client in exploring the meaning associated with his automatic thoughts using the downward arrow technique. The client was asked what it would entail if someone noticed his anxiety and moved from surface level fear of embarrassment to deeper beliefs such as "I am weak," "I am not good enough" and "I am a failure." These beliefs were addressed in regard to his chronic anxiety, job failures, feelings of being judged by others and demands to be a productive family member. Questions were used with the intention of analyzing the accuracy, completeness and helpfulness of these beliefs, using the Socratic dialogues. Instead of challenging the client's beliefs, the therapist assisted the client in finding exceptions, strategies, and evidence of persistence, responsibility and caring of his family. The purpose of this work was to challenge the rigid negative self-evaluations and provide more adaptive beliefs about coping and self-worth.

The fifth phase involved exposure and behavioral experiments. Avoidance of public places and public transport was a significant maintaining factor, so exposure took place gradually and collaboratively. The therapist explained that this avoidance provides immediate relief but does not allow the client to learn that anxiety can build up and then decrease without disaster. Interoceptive exposure was applied to assist the client with tolerating anxiety related sensations (e.g., heart rate, increased breathing rate) in a controlled environment. The goal was to decrease fear of internal sensations and increase one's self-confidence that his/her body could handle the physical arousal. Then a hierarchy of behaviours in relation to situational exposure was planned, starting with behaviours of low to medium anxiety (going to a public place, going to a small shop) and moving toward higher levels of anxiety (waiting at a bus stop, taking a short bus ride).

Cognitive restructuring was combined with exposure using behavioral experiments. Client listed feared predictions prior to exposure tasks, including: "I will collapse," "People will judge me," or "I will not be able to return home." Following task completion, he examined what really happened, change in anxiety over time and whether the feared outcome occurred. This prediction/actual outcome comparison helped the client to examine catastrophic beliefs experimentally, not just through discussion. With repeated exposure, tolerance of uncertainty and reduction in avoidance as a safety strategy has been promoted in line with current models of anxiety and exposure-based learning (Craske et al., 2008).

Problem solving and relapse prevention were the final stages. Structured problem solving was used for practical stressors, especially financial and family issues. The client was instructed on steps of problem solving, which included: stating the problem clearly, identifying potential solutions, comparing the pros and cons of the options, choosing a viable solution, and breaking it down into small steps for action. This enabled the transformation of worry to planning as much as possible. Relapse Prevention was emphasized on the recognition of high risk situations, early warning signs, coping skills and a maintenance plan. Client created coping toolbox (slow breathing, grounding, coping statements, thought records, exposure practice, behavioral experiments and problem solving steps). He was encouraged to persist

with gradual exposure even after symptoms decreased, because avoidance can "return" when anxiety is lowered, but feared situations are not tested. Termination focused on the fact that relapse does not necessarily mean failure, it only means that learned strategies must be used again and early help should be sought if symptoms worsen.

OUTCOME AND CONCLUSION

Treatment success was assessed by clinical observation, homework, and client self-report and behavioral changes observed over the course of therapy. Although pre- and post-intervention standardized scores were not obtained, the client showed clinically significant improvement in several areas that were directly related to the original CBT formulation. He had a lot of worry, panic-like physical sensations, avoidance of going places and public transport and disturbed sleep, which limited his functioning at the outset of therapy, along with low confidence and catastrophic interpretations of anxiety-related sensations. During the later stages of treatment, he was more aware of the connection between situations, automatic thoughts, physiological arousal, and emotions/avoidance behaviors.

One thing that has been important for the client was the development of a greater awareness of and questioning of thoughts relating to anxiety. After thought monitoring, labeling of the cognitive distortions, examining the evidence and generating a balanced alternative, he was able to view his anxious predictions as hypotheses and not facts. This transition seemed especially significant in terms of lessening the thought intensity of "I will panic", "People will laugh at me" and "I will not be able to manage". The client was also more acquainted with underlying beliefs connected to weakness, inadequacy and failure, enabling the therapy to go beyond simply a symptom management to a deeper level of cognitive restructuring.

The client demonstrated behaviorally, an increased willingness to get in closer to situations that he avoided in the past. He had conducted graded exposure and behavior experiments, and he had seen that feared predictions would not necessarily lead to catastrophic outcomes; anxiety symptoms could increase, but stay tolerable and get better without catastrophic consequences. He also engaged in interoceptive exposure, which decreased his fear of his body sensations (e.g., a racing heart and sweating). These gains were facilitated with coping skills such as slow breathing, grounding, mindfulness, coping statements, activity scheduling and problem solving strategies.

The client reported that he is more confident controlling anxiety, and that his response is more in his control. He also demonstrated increased participation in daily activities and enhanced willingness to approach anxiety-inducing situations, and not just avoid them. But, the result needs to be considered carefully because it was only one clinical case and no standardized post-treatment assessment was available, and no long-term follow-up data were recorded.

To sum up, in this case, clinically useful application of CBT was done for a Pakistani male client with GAD, panic-like physiological symptoms and agoraphobic avoidance. The intervention proposes that a formulation-based CBT (cognitive-behavioral therapy) combining psychoeducation, cognitive restructuring, exposure, problem solving and relapse prevention can be useful to decrease avoidance, increase coping self-efficacy, and enhance functioning in similar clinical presentations.

DISCUSSION

In the present case report, the use of cognitive behavioural therapy with a 44-year-old male client suffering from Generalized Anxiety Disorder, panic-like physiological symptoms and agoraphobic avoidance was described. The client's primary problems were overthinking, apprehensiveness about going out in public, avoiding public transport, insomnia, lack of self-confidence, irritability and negative thinking around coping. The CBT formulation revealed that his symptoms being maintained through catastrophic interpretation of bodily sensations, avoidance, lack of confidence and repeated worry.

The outcome of therapy indicated that CBT was beneficial in helping the client to better understand and manage anxiety. Through psychoeducation, he learned that his physical symptoms of sweating, rapid heartbeat, and other physical symptoms were linked to his anxiety, and not necessarily indicative of serious physical illness. This was of importance since one of the key factors in his avoidance was fear of sensations in his body. This discovery is in line with the cognitive models of anxiety; that threaten interpretations and underestimation of coping can help maintain anxiety (Beck et al., 1985; Clark & Beck, 2010).

Through cognitive restructuring, the client was able to uncover automatic thoughts and look at them realistically. He was able to identify thoughts like "I am going to panic," "People will laugh at me," and "I can't handle this" as predictions, not facts. Using thought records, checking evidence and alternative thinking, he became more balanced in his thoughts

about feared situations, over time. This process seemed to diminish his catastrophic thinking and enhance his confidence in his coping of anxiety.

Behavioural techniques also played a role in this instance. The client's physiological arousal was addressed through relaxation, breathing, mindfulness, grounding, and sleep hygiene and activity scheduling, all of which helped the client to manage the physiological arousal and increase her functioning in daily life. Graded exposure and behavioral experiments proved to be very helpful, as avoidance was a large maintaining factor. Facing feared situations in a gradual manner allowed the client to challenge his predictions, and to learn that anxiety could diminish without escaping. This is consistent with exposure-based therapy, in which repeated exposure helps to diminish fear and avoidance (Craske et al., 2008).

The case also points towards the role of cultural and social context. However, the client's anxiety did not manifest itself only internally, it also involved family issues, job issues, financial issues and fear of others judging him negatively. In a South Asian/Pakistani context, these concerns can have a significant impact on the expression and experience of anxiety. Thus, when CBT was linked to the client's actual life tasks and significance, it was more beneficial. This aligns with other literature indicating that CBT can be effective across cultures when considering adaptations to the client's context (Naeem et al., 2019).

There are some limitations of this case report. It's a single client, so results cannot be generalized to all GAD and/or agoraphobic avoidance clients. No control condition and standardized post-treatment scores were not reported. Outcome was assessed through clinical observation and homework review and client self-report. Further, no long term follow up was documented and therefore the sustainability of the gains remains unknown.

In summary, a formulation based CBT may be beneficial for clients who are presenting with chronic worry, panic like symptoms and avoidance. This case illustrates the efficacy of integrating psychoeducation, cognitive restructuring, exposure, problem solving and relapse prevention in treating anxiety-related problems. Future case reports and clinical studies on this topic in Pakistan and other South Asian settings could provide further clues as to how CBT can be adapted and implemented in culturally relevant ways.

IMPLEMENTATION

The case is relevant for clinicians who work with clients having symptoms like chronic worry, panic-like symptoms and avoidance of public situations. The case demonstrates the effectiveness of the CBT when treatment is based on an individualized case formulation, not just symptoms. In clinical work, it can be helpful first to educate the client about the connection between thoughts, feelings, physical sensations, and avoidance. After the understanding of this essential step, cognitive restructuring and exposure can be added gradually according to the readiness of the client.

The case also illustrates the differences that could be made by adapting CBT to the client's social and cultural context. In this instance, anxiety was very associated with family responsibilities, financial worries, work pressure, and fear of unfavorable judgment. Thus, treatment was more significant when therapeutic objectives were related to the client's life. This should also incorporate Relapse Prevention to help clients sustain gains after treatment.

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ETHICAL CONSIDERATIONS AND INFORMED CONSENT

The client provided informed written consent for the publication of this case study. All identifying information has been removed or altered to protect confidentiality, including name, specific location details, university, and family member names. This case study adheres to ethical principles for clinical case reporting as outlined in the Declaration of Helsinki. Institutional ethical approval was obtained from the respective authorities, and the clinical work was conducted in accordance with professional standards for psychological practice in Pakistan.