Collaborative Partnership and Reflective Practice: An Intern Counselling Psychologist and Client Share Their Therapeutic Journey

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Counselling psychology is an emerging scope of practice in New Zealand. This article outlines the core values of counselling psychology and illustrates how they can be applied to a case study. The case study involves a client with panic disorder and the use of a cognitive behavioural intervention. It is written from the perspective of an intern counselling psychologist and includes the reflection of both therapist and client. The aim is to provide some insight into both viewpoints of the therapeutic relationship and the course of the intervention, as well as outlining how the principles of counselling psychology can be applied to such a case.

Keywords: counselling psychology, panic disorder, reflective practice, intern psychologist, and case study.

Counselling psychology is a fairly new scope of psychological practice for Aotearoa/New Zealand with the only training institution gaining full accreditation in 2012. As counselling psychologists we are often asked for clarification around what makes it different to other psychological scopes of practice. This is a question that can be difficult to answer because it is an emerging field and counselling psychology is still establishing its identity as practiced in this country.

The existing literature describes the core values of counselling psychology as including an adherence to the scientist-practitioner model and a move away from the medical model and towards collaboration between client and therapist. Counselling psychology also places a focus on the promotion of wellbeing, an emphasis on the therapeutic relationship, takes an integrative and holistic approach, and places value and respect on individual differences and contexts (Howard, 1992; Strawbridge & Woolfe, 2010). These aspects characterise the counselling psychology approach in working with individuals, groups, or communities in Aotearoa/New Zealand. They are also analogous to the Principles of the Treaty of Waitangi (1840) that guide healthcare practice in this country; partnership (working together collaboratively), participation (active involvement by all parties) and protection (ensuring safety and enhancement of client well-being) (Herbert & Morrison, 2007).

Counselling psychology also encourages its practitioners to engage in reflective practice (Strawbridge & Woolfe, 2010). Reflective practice allows an opportunity for the different aspects of therapy to be examined such as; the application of the chosen approach, further development of the formulation, emotional or cognitive responses that arise, or client-therapist interactions (Bennett-Levy, 2003; Lavender, 2003). Reflection can be done in a number of ways, including through supervision, by watching a tape of the session, or in simply thinking or writing about therapeutic encounters.

Based on Schon's (1987) model of reflective practice, Lavender (2003) suggests that reflective practice involves four main processes. *Reflection in action* is when reflection occurs during the process, and you are able to think about what has just been said, and what could be said next. *Reflection on action* happens after the experience has occurred, and can be completed either as thinking about the event alone or explored in supervision. *Reflection about impact on others* can involve eliciting feedback from others, to determine their feelings about the event. And lastly, *reflection about the self* can help therapists to examine themselves and any issues based on personal experiences and how this may impact their work with clients. These reflection processes enable the therapist to develop awareness and further strengthen themselves as an individual and as a therapist. Engaging in reflective practice, whether structured or spontaneous, enables practitioners to develop effective professional knowledge and skill relating to themselves, their clients, and their practice.

The following case study describes a cognitive behavioural therapy (CBT) intervention with a client experiencing panic disorder symptoms. The article uses a co-authoring approach from narrative therapy (Morgan, 2000) in which both the therapist's and the client's perspective are examined in order to provide a deeper level of description of the therapeutic process. It is written in the first person by the first author (AK), in consultation with her internship supervisor (JF). This article also aims to outline how a counselling psychology framework was applied to this case.

**pseudonym,* the name has been changed to protect the identity of the client. Miranda has been fully involved in the preparation of this manuscript and has approved the material from her therapy which is included here.

On completion of this manuscript, AK still had approximately 4 months to go of her 1500-hour internship. At this stage, AK and the client had completed the CBT intervention described throughout this article and were continuing to work together on remaining issues with a third wave CBT approach.

Case Study

Miranda* is a woman of European descent in her 40's. She was referred to the counselling psychology clinic after waking up in the middle of the night with difficulty breathing and heart palpitations on two occasions. These sensations were so distressing for Miranda that she was hospitalized. Miranda was told by medical staff that she may have a heart condition (supraventricular tachycardia) and was placed on medication (beta blockers). Miranda received follow up treatment with a heart specialist but they were unable to successfully record information about her heartbeat that confirmed a medical diagnosis.

After the initial hospitalisations Miranda continued to experience the physical symptoms, which she found very unsettling. Although they lessened in time and intensity she continued to experience them at least once per week. They often occurred during the night and Miranda became very anxious in the evening leading up to bedtime. Miranda had follow up contact with her GP and she was placed on further medication (Citalopram) to manage the anxiety she was feeling around these events.

Miranda is married with three children aged between 9 and 16 years. She described her relationship with her husband as good; he is an optimist and the spontaneous one whereas she is a bit more of a realist and cautious and so they balance each other out well. Miranda has a good relationship with her children but can find family life demanding at times as she has some very busy days during the week when she is busy with her children's school and sport activities.

Miranda has two sisters who both live in Auckland, as does her mother. She sees her mother often and has regular contact with her sisters. She has a small social circle and a few close friends. Miranda's father passed away a few years ago and she reported this was a very difficult and stressful time for the family due to the associated medical complications.

Miranda maintains a healthy diet and weight and she used to run several times a week. However, she stopped running for 5 months after the initial sensations occurred as she was nervous that something was going to happen while running. At the time this intervention began she had just started running again but was somewhat tentative about engaging in this activity.

Prior to this course of therapy Miranda had engaged in a breathing clinic and several therapy sessions with another intern counselling psychologist who was at the end of their training so had left the clinic. Previously, she had also engaged in six sessions of CBT, referred to by her family doctor. Miranda found these interventions helpful but she was still experiencing some symptoms and was finding these distressing. Furthermore, Miranda's family were planning to travel overseas in a few months and she was not sure she felt she could go on this 3 week trip. She was keen to have further support that may enable her to manage the sensations and anxiety she was experiencing.

Initial assessment

In the initial sessions a psychological assessment was completed and Miranda was screened for psychological disorders. Miranda was under the care of her doctor and had some follow up appointments with a heart specialist to rule out possible medical conditions. She reported her main issues to be the experiencing of physical symptoms, including tingly limbs and digits, racing heart, shallow breathing, tightness of chest, and a tense abdomen. Miranda was also experiencing fear and anxiety around the symptoms occurring at any moment, without any known trigger. As well as poor sleep due to anxiety about experiencing the sensations again, Miranda had also begun to avoid staying overnight in places other than her home. This meant she was missing out on school trips with her children and family holidays.

My supervisor and I looked into possible alternative diagnoses or reasons for her symptoms. We came to the conclusion that Miranda's presentation was best described by panic disorder after ruling out other possible conditions with similar presenting symptoms, such as other anxiety disorders. Miranda also reported low mood, although she did not meet the criteria for a major depressive episode at this stage. It was possible she had met criteria in the weeks after she experienced the initial sensations.

Miranda and I discussed her goals for therapy which were initially to reduce her symptoms so she was able to go on the overseas trip with her family. In consultation with my supervisor, I decided to base my intervention on the panic disorder CBT invention protocol described by Craske and Barlow (2008). This is an evidence based treatment that research has found to be more effective than other placebo type treatments.

After Miranda's medical tests were completed she was encouraged to continue her running schedule. This was because Miranda had previously found this an effective method for managing stress and it was an important release for her as well as being a key element in maintaining her wellbeing and improving her mood.

My reflection. I felt that basing my intervention on a manualised treatment would be helpful as it would give me a good structure to start with, as well as being evidence based. A manualised intervention also helped somewhat with the terror I felt as an inexperienced intern and not having worked with this type of issue, as it gave me a stable base to follow. Miranda was very open into trying this intervention even though at this stage Miranda felt her symptoms were based on a medical issue rather than a psychological issue. Because of this Miranda and I coined a term for her experiences that she felt comfortable with ('the sensations') rather than using the term panic disorder.

Miranda was really distressed about her experiences so I tried to instil hope for her around what she was experiencing. As well as building rapport and validating her experiences as being very distressing for her, we also discussed the range of options for evidence-based interventions that had been found to reduce the symptoms that she was experiencing.

Miranda's reflection. At this stage, I had many unanswered questions about what I was experiencing. I was still feeling very fragile and vulnerable and almost desperate to find something that would make me 'normal' again. When it was suggested I have some sessions with a counselling psychology intern I took this as a chance to hopefully gain some more insight or clarity into my experiences.

As I had engaged in a previous CBT intervention, I was a bit worried when the therapist suggested a CBT based treatment as the previous one had been very structured and left me with little chance to talk about myself or my experiences. I felt this would have been very helpful in terms of relieving some of the anxiety about what I was experiencing. However, I was willing to give a CBT intervention another chance from a different perspective.

I also found it very beneficial being able to learn the CBT techniques alongside being able to talk with the therapist about how I was feeling. It felt so reassuring to know that she cared and that she was not just there as a teacher of techniques.

Psychoeducation

The intervention began with psychoeducation and this involved a discussion about hyperventilation and how this can affect the body. Miranda was encouraged to induce hyperventilation in our session by breathing in a quick and shallow manner for one minute. This was so she could experience the effects of breathing style as well as learning how deep breathing could stop these effects.

In supervision we discussed how I could approach Miranda's understanding of her problem in therapy and the models that I could use to explain this, such as the cognitive model of panic (Clark, 1986). It was helpful going through this model in supervision as I was able to practice how I could explain it to Miranda in the sessions to help her understanding.

Miranda and I discussed this model together and looked at how we could target the different areas of the cycle, including her thought patterns as well as the physical sensations.

My reflection. Miranda was very receptive to having reading material as homework and she particularly requested literature about other peoples' experiences with these symptoms. I found this really helpful to me as a therapist as Miranda had such an enthusiasm for gaining an understanding to her problem. After undertaking a literature search I found minimal information available in this style, as it was either difficult for a layperson to comprehend or was from unreliable sources on the internet. This was frustrating as I felt that if Miranda was able to read about others' similar experiences then this may have helped her to validate and normalise her experience. It was this experience that contributed to the development of this article.

Miranda's reflection. I was able to make some connection between this material and what I was experiencing as I had learnt about this in prior interventions. Although the readings were helpful in gaining understanding, I was hoping to read something that really described what I was going through from another person's perspective as this would have given me more understanding and possibly acceptance that this was what I was going through. As I was still undergoing specialist follow up, it was hard for me to accept that there was a psychological aspect to what I was experiencing. For me, it was easier to accept a medical cause for my symptoms, especially as there did not appear to be a trigger to my experiences and it all seemed to be so random.

Breathing/relaxation training

Miranda had previously participated in a breathing clinic so she had some awareness of effective breathing techniques. To follow the structure of the intervention we also practiced diaphragmatic breathing in these initial sessions to ensure she was engaging in the correct technique. Miranda was set homework of practicing diaphragmatic breathing a minimum of twice per day. We practiced some relaxation exercises, including mindfulness and progressive muscle relaxation. Stress was identified as a possible trigger for Miranda's sensations so we looked at some problem solving strategies around reducing stress in her life and regular relaxation practice was recommended.

My reflection. I noticed that Miranda was not engaging in the relaxation and mindfulness exercises in her own time. While she engaged in them during the sessions she often did not complete them on her own accord, despite being frequently reminded about these in sessions. In my naiveté, I found this quite frustrating and hard to understand; as "surely if I ask Miranda to complete these activities to help her get better, then she will do them"? I developed a number of hypotheses around why she was not completing them, including either Miranda did not think they would be helpful or she felt unable to prioritise any extra time toward promotion of her own wellbeing.

Miranda and I ended up working out that Miranda's reluctance was because she did not like being 'prescribed' relaxation exercises, as she was still in the stages of accepting that there was a psychological element to what she was experiencing. We reframed the exercises to be considered part of her wellbeing, similar to her physical exercise, and Miranda then felt more able to complete the activities on a regular basis. This made me realise I needed to be careful in how I pose 'homework' tasks to clients, as if presented in an unconsidered way they may not be completed.

Miranda's reflection. Although I knew the relaxation exercises would probably be helpful, it was hard for me to start engaging in this regularly. This was partly because it was hard for me to prioritise taking time for myself and also because in the back of my mind I did not feel comfortable with the idea of being 'prescribed' relaxation as I did not think this would be beneficial. However, I found the mindfulness exercises helpful in getting me back on track when my thinking became negative and they enabled me to break the negative thinking cycle at times.

Monitoring symptoms

Over the course of the intervention Miranda monitored her symptoms using a mood record. This record included a daily recording of Miranda's average anxiety, average depression, and average fear about panic. Miranda would give a rating from zero (none) to 10 (most extreme) for each category. This record was modified from the one by described by Craske and Barlow (2008). This

allowed us to track her symptoms throughout her treatment.

Miranda initially used a recording sheet to record her panic attacks. However, as her symptoms reduced over time, this was discontinued after approximately three sessions into the intervention. Miranda continued to note the days and times that she was experiencing some sensations on her mood record and this allowed us to track back and find a pattern around when the sensations occurred. I compiled Miranda's scores into a graph every few weeks and Miranda and I would review this so we were both aware of her scores over time.

As there were some days where Miranda's mood was quite low, we discussed behavioural activation (Dimidjian, Martell, Addis, & Herman-Dunn, 2008) and how this may work in improving Miranda's mood. Miranda created a list of brief and achievable pleasurable activities which she could do when feeling low.

My reflection. Although Miranda's depression, anxiety, and fear of panic gradually declined over time, there were times were these scores peaked. I felt that Miranda found these peaks disheartening as I wondered if it felt to her that she was not making enough progress but I explained they gave us an opportunity to look for patterns in her scores. By involving Miranda in the monitoring of her symptoms over time I hoped this gave her a sense of collaboration in the therapy process. To be honest, I also found these peaks disheartening. In supervision, I was reminded of the importance of these peaks, as they helped to illustrate that increasing scores did not mean the end of the world, and that they actually helped strengthen Miranda's resilience as she learnt to manage them more effectively.

Miranda's reflection. I found logging my moods and sensations helpful as it enabled me to reflect on my moods and what I was doing each day. Having to log on a daily basis helped me realise it was important to do this for myself and to make it a priority as I could see my progress. I was aware I had been having some changes in my scores throughout the course of therapy. However, my therapist advised that I was doing well and that some increases in my scores were to be expected and was part of the process and that was reassuring.

Cognitive restructuring

In the next sessions Miranda and I looked at the cognitive side to her experiences, particularly the thoughts that were accompanying the sensations that she was experiencing. We examined this using the panic model by Clark (1986) which assumes a catastrophic inference is made alongside the experienced physical sensations. At this stage of the therapy, while Miranda was having a lot of negative thoughts, she was no longer having catastrophic thoughts. I raised this in supervision and we discussed tracking back to her cognitions to when she had initially experienced the sensations so we could get an understanding of her thought processes when she perceived most threat to herself: Miranda's misappraisals to the sensations she experienced would end with the most catastrophic cognition of "I'm going to die". It was apparent that the link between her sensations and her fear was not yet resolved, even though logically she had now accepted that she was not going to die.

In session, we looked at the cognitions that were maintaining Miranda's anxiety around experiencing more of the sensations. Although Miranda had reduced the catastrophic element to these cognitions, the thoughts she was still having were negatively impacting her mood. Miranda used a thought diary to record her thoughts and moods. We then reviewed these thoughts in the therapy session and she was presented with the idea that a thought was only an idea or perception, not a fact. Miranda was given information about the different types of cognitive distortions that can occur. Miranda was encouraged to examine which cognitive distortions she may be using, such as catastrophisation or overestimation. Then Miranda and I worked together to dispute her negative thoughts, by looking for evidence for and against the thought, as well as seeing if there were any alternative explanations for her thoughts.

We applied this technique to the thoughts Miranda was having about going on the overseas trip with her family to examine why she was feeling unable to go. We did some problem solving around how Miranda and her family could make the trip less daunting and generated some ideas, such as breaking up the plane journey into smaller trips.

My reflection. While Miranda was receptive to cognitive restructuring in the sessions, I was aware that she was having some bad days and during these times it was difficult to find the energy to look for evidence against her thoughts. I noticed that when Miranda felt discouraged that after the session I also felt some distress. On reflection I realised that again, this was making me feel as though I was failing as Miranda's therapist. Is this a common theme for new interns? In discussing this in supervision, I was reminded that therapy was a process and there is rarely a 'quick fix'. This was helpful in reminding me that I cannot save the world single handedly, as much as I wish I could. Also, I could see how hard Miranda was working to get through this and greatly admired her courage to keep going even though she had some difficult moments.

Miranda's reflection. Being able to learn how to look for evidence to dispute my negative thoughts was helpful. However, there were some times I was unable to get rid of the sense of doubt that would creep into my thoughts. As I was still having good and bad days, when I was feeling good I was able to dispute my thoughts well, but on days where my mood was low, it was harder for me to look for evidence and believe it.

Exposure

The next part of the intervention involved exposure techniques. In terms of in vivo exposure, Miranda chose to go on a short trip out of the city which she achieved. She reported she was anxious about this but was glad she had pushed herself to go through with it. Miranda then kept postponing making the decision to go on the 3 week overseas trip. As I felt it was important for Miranda to decide so we could work together with her decision, I encouraged her to set a deadline for her to do this. When the deadline came, Miranda chose

not to go on the 3 week trip with her family as she did not feel that she would manage the long period of travelling. We discussed the possibility of Miranda working towards travelling overseas at some stage so she does not continue to avoid overseas travel. Miranda then made a decision to take a shorter overseas trip in the near future when it is suitable for her and her family to do so. Once this is planned, Miranda and I will work through any possible anxiety that arises around this trip, if needed.

Miranda was then introduced to interoceptive exposure and its purpose of eliciting the sensations that Miranda feared so she could use the strategies she had learnt in the previous sessions including relaxation, deep breathing, and cognitive restructuring, to reduce the sensations and the associated anxiety. Miranda was advised that she may experience some discomfort when doing the exercises, but we would finish each exercise by completing some deep breathing until she felt better.

Miranda completed a range of exposure exercises in the therapy sessions and on completion of each exercise Miranda would give a score out of 10 around the intensity of the sensations, similarity to the sensations she has experienced, and how distressing it was. Miranda completed a couple of exercises in each session and nine exercises were completed in total, ranging from Miranda holding her breath for 30 seconds to spinning around on the spot for 60 seconds. Miranda would also report the physical sensations she noticed in herself and her thoughts about the exercise. After Miranda had completed all the exercises in sessions we then chose the three exercises with the highest intensity and similarity scores. These were: hyperventilating for 60 seconds (4.5/10 similarity and 4/10 intensity), spinning on the spot for 60 seconds (3/10 for both similarity and intensity), and maintaining muscle tension for 60 seconds (4 for similarity and 3.5 for intensity). Miranda's task was to practice one exercise each week, every day for 7 days and then we reviewed this in the next session.

My reflection. I had attempted some of the exposure exercises prior to completing them with Miranda, so I was able to talk to Miranda with honesty about what she may experience. I recall after Miranda did the spinning exercise, she just about dropped to the floor, and she looked rather unwell afterwards. I noticed I felt quite uncomfortable about being the one that inflicted deliberate discomfort on my client. I remembered reading that exposure techniques can be underutilised in CBT treatment and I did wonder if this was the very reason. I discussed my feelings around this in supervision and my supervisor reminded me that I was using an evidence based approach which helped to soothe some of my discomfort around this.

I noticed I felt like I had failed as a therapist, as Miranda chose not to go on the overseas trip. Whilst I know this was her decision and she did not feel ready, it somehow felt as though I had not enabled this in our work together and I felt disappointed with this. This emotional reaction made me begin to wonder whose goal it was to go on the trip, Miranda's or mine? I brought this issue to supervision and we discussed how it is important to be aware of goals and to ensure that when working with a goal focus, that it is actually the client's goal rather than what you wish for the client, even if you are wishing the best for them.

Miranda's reflection. Going on the short trip with my family was difficult but I was really happy that I pushed through the difficulties around this. I was very worried about being away from home and sleeping in a different place, but I felt that if I could achieve this, then maybe I could achieve the overseas trip. As it happened, even though I achieved this short trip when the time came to decide on the bigger trip, I just did not feel ready to commit to this due to the long period of travel. My therapist encouraged me to set a date for making a decision about the trip and to tell my husband. Although I really hated this at the time it was what I needed as I just kept avoiding the decision making. Although I was disappointed I could not go after I made this decision I felt a lot less pressure and could now focus towards getting well.

The exposure exercises were uncomfortable but it felt good to be doing these, like I was really achieving something to address the sensations. Although the sensations from these exercises were not identical they were similar and I felt like I learnt I was able to gain a sense of control over them.

Relapse prevention

After Miranda had completed the exposure exercises, the sensations and fear of sensations reduced. However, she was still experiencing some residual symptoms in these areas. In looking at Miranda's logs of symptoms we noticed a pattern around the sensations often occurring on a weekend night, and hypothesised that this may be due to stress that Miranda experienced during the weekend days. We did some problem solving around how Miranda could reduce stress and decided on some strategies for Miranda to implement in her daily life.

As Miranda's family were off for their 3 week trip during this time, Miranda was worried about how she was going to manage this time alone. We worked together to ensure she had some structured activities planned in this time to reduce her time to worry about the sensations. We also ensured that she had some pleasurable activities planned to boost her mood. As Miranda had this time to herself she was able to incorporate lots of relaxation practice and she developed a list of short relaxation activities that she could engage in regularly.

During this time, after several weeks without any sensations, Miranda woke up in the middle of the night feeling spacy, dizzy, and with hot flushes. Although she was distressed by these feelings she was able to use the tools she had learnt through the course of therapy until the sensations faded and then was able to get back to sleep. In the next session Miranda reported she was disappointed that this had occurred but we discussed the positive side, which was she had been able to successfully manage the experience which reduced some of her fear around further sensations.

When Miranda's family arrived back from their trip her husband surprised Miranda by giving her a letter from his cousin. This letter outlined the struggle he had had with a very similar experience and how he had overcome this difficulty. Miranda brought this letter into therapy to show me and

was amazed to hear that someone else that she knew had gone through this experience.

My reflection. By this stage it appeared that Miranda had come so far in terms of accepting what she was experiencing and it seemed having the time to reflect as well as receiving the letter had both greatly contributed to this. I felt that this attitude shift was even more important for Miranda than not experiencing any more sensations as some of her fear of the panic sensations had lifted, which had been causing her much distress. This letter had great meaning for Miranda and it was exactly what we had been previously trying to find in the literature. I was very touched that Miranda brought it into the session to show me because it was so meaningful and helpful for Miranda. It also suggested to me that Miranda had also really valued my part (as her therapist) throughout her journey.

Miranda's reflection. It was a big challenge for me to be without my family for 3 weeks. I was in two minds during this time, on one part I was excited to have this challenge presented to me but on the other part I was terrified about not being able to manage. However, this time enabled me lots of opportunity to reflect on my experiences and also lots of 'me' time, which helped me come to terms with my experiences.

Receiving the letter from my husband's cousin was an invaluable revelation. It was that personal experience and hope that I had been desperately wanting to read about. It was like an acceptance of what I have been going through and has made my mind so much more receptive to all of therapy we have been through.

Final Reflection

My reflection. I found it very interesting reflecting on the therapeutic process with Miranda and tracking back to the start of our therapy as I felt I really had grown as a therapist. As cliché as that sounds, I remember at the beginning of the process when I first met Miranda I was so anxious due to my inexperience and knowing that Miranda really needed support, which led me to feeling some kind of desperation as I was not sure I really would be able to help her. Reading Miranda's reflection about being so anxious and desperate to get help at the beginning of therapy I wondered if this was a form of counter-transference (O'Brien, 2010). Now that Miranda has learnt to accept her distressing thoughts and experiences I feel I am also now able to accept my inexperience and flaws as a therapist and not be so hard on myself as I gain experience and skills as a counselling psychologist. In supervision we discussed another aspect that may have been at play here as well: the fact I had prioritised my own needs by practicing new skills and self-reflecting, may have helped me to help Miranda to do the same.

In terms of reflective practice, I feel that this process really helped me think more deeply about this case, and allowed me create a individualised formulation for Miranda's experience beyond the standard CBT formulation for panic disorder. I think that by being open to reflections that occur beyond the confines of the 'working day' can also allow for further insight to be gained, which then can enhance the detail of the individualised formulation. For example, the most insightful reflections would often come at an unexpected time, such as walking to the car at the end of the work day. This would result in a scramble to note them down in some way, so as not to lose important thoughts and ideas around a formulation or other therapeutic aspect. However, I am aware with reflective practice that clear boundaries need to be set, so you are not holding your clients in mind all the time. When I notice that my 'reflections' are creeping too much into my personal and family life, I will engage in practices, such as mindfulness techniques. These techniques enable me to return to the present moment, which works to ensure I am able to have my own space that is separate from my work and the lives of my clients.

Miranda's reflection. Over the past 6 months I really do feel like I have been on a roller coaster of a journey. Not on my own, but with my therapist. From being a very frightened woman who was consumed by daily distressing physical symptoms and fearful thoughts, I am now able to face these sensations and accept them (most of the time). I still experience setbacks but now have the knowledge to understand that this ongoing exposure is a very important part of the recovery process. Having this opportunity to express my reflections in a written form about this ongoing journey of therapy and support has been a very positive experience for me and I am pleased to be able to share it with others who have a common interest.

Summary and Conclusion

This case study has outlined the practice of a CBT based intervention as applied to panic disorder. The core principles of counselling psychology were demonstrated throughout this process. For example, a focus on the therapeutic relationship was paramount and the relationship was built by keeping the client informed in each step of the process and by validating her concerns as they arose. Throughout therapy there were times when Miranda's mood was low and anxious and, in addition to safety screening, counselling micro-skills were used including empathy and warmth, which allowed her to validate and normalise the way she was feeling. These aspects illustrate the importance of the therapeutic alliance in the therapy setting.

A scientist-practitioner model (Jones & Mehr, 2007) was used in deciding what intervention would work for this client. Once the assessment had been completed and a formulation and diagnostic impression was made, research was undertaken to find an intervention that was evidence based. The protocol offered by Craske and Barlow (2008) reports good results on treating panic disorder symptoms, therefore it was chosen as the base for the intervention.

Although a structured CBT intervention was used, it was adapted to allow for contextual aspects to be considered. For example, Miranda's context was taken into consideration in determining the triggers to her stress. Although Miranda felt there was no clear trigger to the sensations, we looked closely at the meaning that Miranda attributed to certain events in her life and how these impacted on her situation. This enabled us to make a plan for how she could reduce stress in the different areas of her life, such as placing prompts around her home that reminded her to

be mindful.

As a European New Zealander, to be able to have the chance to travel overseas had a lot of meaning for Miranda and her family as they had planned to connect with extended family they had not seen for some time. When Miranda decided she was unable to travel we tried to create meaning for Miranda in a different way, to help overcome her disappointment around this. This was done by scheduling in meaningful activities for Miranda to do while her family were away as well as enabling her to reflect in this time about her experiences. Miranda reported this time to herself as challenging but invaluable and we also noticed that her strength and confidence in herself grew over this period. This experience highlighted the fact that Miranda really appreciated having time to herself which had previous been limited because of her very full family life.

Reflective practice is a core element of counselling psychology (Strawbridge & Woolfe, 2010). Reflecting on the whole therapy process has enabled me (AK) to review what went well and what I could have changed, as well as my reactions to the therapy process and to Miranda. I feel this reflective process has enhanced the therapeutic relationship as it has given me a phenomenological understanding of what was really meaningful and helpful for Miranda in comparison to my own thoughts and processes. I feel it has also been incredibly valuable for Miranda, as revisiting the various stages of the therapy enabled her to see the changes she has made over the 16 sessions.

At the time this article went to review, Miranda and I were still working together. Although the frequency and intensity of Miranda's sensations had reduced, as well as her anxiety about further sensations, Miranda was still experiencing some residual symptoms in these areas. We have started to work with an evolution of the formulation; that the sensations may function as message to her to prioritise her own needs. As the CBT based programme has been completed, we plan to address this by using an acceptance and values based perspective from acceptance and commitment therapy (Harris, 2009). This fits with the counselling psychology notion of taking an integrative approach with clients in order to adapt interventions to best suit the client (O'Brien, 2010).

This article has outlined my perspective as an intern counselling psychologist (AK) and the client's perspective (M) as we journeyed together through a treatment programme for panic disorder with the support of my supervisor (JF). We hope it will be helpful and insightful for others to read as it has been for each of us to reflect upon.

References

Bennett-Levy, J. (2003). Reflection: a blind spot in psychology? *Clinical Psychology, 27*, 16-9. Retrieved from http://www.cbttraining.com.au/uploads/images/documents/.

Clark, D. M. (1986). A Cognitive approach to panic. *Behavior Research and Therapy, 24*(4), 461-470. http://dx.doi.org/10.1016/0005-7967(86)90011-2

Craske, M. G., & Barlow, D. H. (2008). Panic disorder and agoraphobia. In D. H. Barlow (Ed.) *Clinical handbook of psychological disorders: a step-by-step approach* (4th Ed., pp 1-64). New York, NY: Guilford Press.

Dimidjian, S., Martell, C. R. Addis, M. E., & Herman-Dunn, R. (2008). Behavioral activation for depression. In D. H. Barlow (Ed.) *Clinical handbook of psychological disorders: a step-by-step approach* (4th Ed., pp 306-328). New York, NY: Guilford Press.

Harris, R. (2009). *ACT made simple.* Oakland, CA: New Harbinger Publications.

Herbert, A. M. L., & Morrison, L. E. (2007). Practice of psychology in Aotearoa New Zealand: A Māori perspective. In I. M. Evans, J. J. Rucklidge, & O'Driscoll (Eds.) *Professional Practice of Psychology in Aotearoa New Zealand* (pp 35-47). Wellington, New Zealand: The New Zealand Psychological Society Inc.

Howard, G. S. (1992). Behold our creation! What counselling psychology has become and might yet become. *Journal of Counseling Psychology, 39*(4), 419-442. http://dx.doi.org/10.1037/0022-0167.39.4.419

Jones, J. L., & Mehr, S. L. (2007). Foundations and assumptions of the Scientist-Practitioner Model. *American Behavioral Scientist, 50*(6), 766-771. http://dx.doi.org/10.1177/0002764206296454

Lavender, T. (2003). Redressing the balance: the place, history and future of reflective practice in clinical training. *Clinical Psychology, 27*, 11-15. Retrieved from http://www.psychminded.co.uk/news/news2003/july03/clinicalpsychlogy.pdf

Morgan, A. (2000). *What is narrative therapy?* Adelaide, Australia: Dulwich Centre Publications.

O'Brien, M. (2010). Towards integration. In R. Woolfe, S Strawbridge, B. Douglas, & W. Dryden (Eds.) *Handbook of counselling psychology* (3rd Ed., pp.173-192). London, England: Sage Publications Ltd.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S Strawbridge, B. Douglas, & W. Dryden (Eds.) *Handbook of counselling psychology* (pp. 3-22). London, England: Sage Publications Ltd.

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