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ARTICLE

Cognitive Therapy and Desensitization Based Exposure for Social Anxiety Disorder: The Case of "Ayesha"

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ABSTRACT

Social Anxiety Disorder (SAD) is a critical condition characterized by excessive fear and avoidance of social situations. Cognitive Therapy (CT) combined with Desensitization-Based Exposure (DBE) is a short-term, evidence-based intervention (8–20 sessions) for SAD involves techniques such as identifying and disputing negative automatic thoughts, reducing safety behaviors, reinforcing positive self-statements, and developing assertive communication skills. This study aims to provide a systematic account of a 12-session CT-DBE intervention for a 21-year-old female, referred to a pseudo name "Ayesha" to maintain confidentiality. Using a case study design, qualitative data were analyzed alongside standardized quantitative assessment measures, i.e., Mini-Mental Status Examination, Rorschach test for Personality profile, Liebowitz Social Anxiety Scale (LSAS-SR) for self-report measure of social anxiety as pre-test measures, and Subjective Unit of Distress Scale administered as pre-and post-treatment measure. The intervention followed a structured approach incorporating cognitive restructuring, graduated exposure, and behavioural modifications to address Ayesha's social anxiety symptoms comprehensively. The findings indicate a significant reduction in Ayesha's social anxiety symptoms, increased engagement in social interactions. Qualitative analysis in the Rorschach test further highlighted enhanced cognitive flexibility, reduced avoidance behaviours, and greater confidence in social contexts. These findings (based on pre-intervention assessment and pre-post SUDS-ratings) contribute to the growing evidence supporting CT-DBE as a reliable treatment specifically in the Pakistani context for individuals with SAD. Future research should explore long-term maintenance of treatment gains and adaptations for diverse populations globally.

Keywords: Cognitive-Therapy; Desensitization Based Exposure; Social Anxiety Disorder; Social Phobia; Brief-Report

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1. Introduction

1.1. Client's Case

Ms. Ayesha (pseudo name) is a 21-year-old South Asian Pakistani female who came to the clinical psychologist's (researcher's) clinic, referred by the psychiatrist of a hospital in a Pakistani city for the purpose of assessment and psychotherapy. From the analysis of her verbatim, she came to the clinic with (already diagnosed) Social Anxiety Disorder (SAD). She felt marked fear of anxiety about possible scrutiny. She complained that the social situation always provoked anxiety for her. Social situations were avoided by her with a fear of anxiety out of proportion to the actual threat. Ayesha came to the clinic for a psychological assessment. She reported that her onset of symptoms started 6 months ago. She started feeling anxiety in conversation, being negatively evaluated, being humiliated by others, and avoiding social gatherings due to fear of anxiety in social situations (e.g., in university, at home, at a friend's marriage or birthday, etc.). She was currently taking the anti-anxiety anxiolytic (Xanax) prescribed by her psychiatrist.

A recent study claimed that Social Anxiety harms social relationships[1]. As a clinical psychologist, I was providing psychotherapeutic a client, Ayesha (pseudonym), with this disorder, so I explored further literature. A review[2] highlighted common therapies like Beck's Cognitive Behavior Therapy (CBT) and Foa's systematic desensitization with relapse prevention. In Pakistan, a research[3] found that CBT with cognitive restructuring and Foa's desensitization techniques were widely used. However, the Rorschach assessment, which was applied to Ayesha, had only been used internationally[4] but not in Pakistan. Additionally, Wells and Clark's cognitive therapy and Mattick's desensitization-based exposure (DBE), which was employed in the present case, were practiced relatively less in Pakistan despite the global usage[5]. This study uniquely fills the gap by applying Wells and Clark's therapy and DBE[6] within the Pakistani context, using a mixed-method approach and introducing the Rorschach Indian Manual adaptation. The Rorschach's manual (Indian version) was chosen over Exner's[7] or R-Pass[8] manual because of the sub-continent (India and Pakistan) culture that is similar and here in Pakistan, a large number of people understand each other's culture with same languages, i.e., Urdu and Hindi (230 million), and the amount of people understanding both languages in India are 50.8 million[9]. The cultural values and social disorders such as Social Anxiety Disorder have similar manifestations in both countries[10]. The R-Pass or Exner's Manuals for Rorschach are already validated worldwide. There was a need to use a manual created by and used by Indian and Pakistani clinical psychologists, so it was one of the primary efforts to establish the validity or at least use the native manual in Pakistan. The intervention outcomes make this single-case study one of the few contributions to psychotherapy from Pakistani clinical psychologists.

The American Psychological Association (APA) and National Institute for Health and Care Excellence (NICE) both present a guideline for social anxiety disorder and they both recommend cognitive and behavioral therapies for the treatment of Social Anxiety Disorder in an accommodating environment and sessional monitoring. So, these guidelines were followed for the present study. As NICE-Guidelines prefer group therapy[11], the limitation in the present study was a single case study but APA-Guidelines encourage single-case therapies, so there was ethical support for using cognitive and behavioral therapies in the present case scenario for the client's psychotherapeutic intervention for her Social Anxiety Disorder.

1.2. Exposure Hierarchy for Pre-Intervention

The exposure hierarchy of symptoms of the client is presented in **Table 1**.

Table 1. Exposure hierarchy of symptoms of the client with SUDS rating.

S.No.	Complaints	Frequency	PRE-SUDS Rating	POST-SUDS Ratings	Follow-Up SUDS-Ratings
1	Marked fear of anxiety of being humiliated while talking to someone.	Nearly Everyday	7/10	4/10	NA
2	Marked fear of acting in a way that will be negatively evaluated (people will get offended).	Nearly Everyday	8/10	4/10	NA
3	Social situations always provoke anxiety while sitting among more than 3 people.	Nearly Everyday	8/10	4/10	NA

Table 1. *Cont.*

S.No.	Complaints	Frequency	PRE-SUDS Rating	POST-SUDS Ratings	Follow-Up SUDS-Ratings
4	Social situation avoided due to fear of anxiety and walking away from places where more than 3 people are present.	Nearly Everyday	8/10	3/10	NA
5	Fear of anxiety out of proportion to the actual threat several days ago (when I have to attend any marriage ceremony or anyone's birthday).	Nearly Everyday	8/10	5/10	NA

Note: SUDS = Subjective Unit of Distress Rating.

2. Materials and Methods

2.1. Interview Information as Informal Assessment

Ayesha came for psychological assessment to the clinic. She reported that her onset of the symptoms started 6 months ago. She started feeling anxiety in conversation, being negatively evaluated, being humiliated by others, avoiding social gatherings due to fear of anxiety in social situations (e.g., in university, at home, at anyone's marriage or birthday, etc.). Ayesha had a pleasant pre-morbid personality. She was currently taking the anxiolytics (Xanax) prescribed by her psychiatrist. She was in the clinic with the presenting complaints or problems.

2.2. Behavioural Observation as Informal Assessment

She seemed to be a young girl of short height with a reasonable and presentable physique. Her eyesight was good. Her facial expressions showed a specific worry. The mood was reflective subjectively and euthymic with congruency objectively. Her attention and concentration were intact. Her memory (short-term and long-term) was good[12].

2.3. Formal Assessment

- Mini-Mental State Examination[13]: a cognitive and neurological scale to check for cognitive impairment or dementia. The rationale for using this scale was to check whether the client would understand and respond to the therapeutic process reasonably and with a stable cognitive state of mind or not.
- Liebowitz Social Anxiety Scale or LSAS-SR[14] is a self-report measure for social anxiety with a cut-off score of 60 for social anxiety disorder.
- Rorschach Ink Blot Test: the personality test with an Indian Version Manual[15] is similar to Exner's Rorschach test[7] in scoring and interpretation.
- Subjective Ratings and Subjective Units of Distress Scale (SUDS)[16] as a pre-posttest assessment on a scale of 1–10 for severity.

2.4. Other Steps for Rigor

Audio sessions were recorded; initial notes were taken before, during and after the session, and the SUDS ratings were kept as the main criteria for pre-post intervention result differences.

2.5. Validity and Reliability Issues for a Single Case Study

The generalizability issue[17] was covered in the internal validity of the case studies, which is typically high since it is nearer to that of a qualitative study (A × B × A; single case research design). In the current study, repetitive treatment methods were used that make the generalizability issue less for the current case study. The reliability of a case study doesn't come from a robust research strategy. To keep up with the reliability and validity, the most common way of collecting, analyzing and interpreting the data of the client was done subjectively for the current case study known as Yin's reliability method[18]. DSM-5-TR criteria interviews and average SUDS rating (as pre-posttest measure) were used to establish reliability. To screen out social anxiety, LSAS-SR was used as only a pre-test scale. The post-test evaluation (for all scales, including Rorschach and LSAS-SR) was not done (can be acknowledged as a major limitation of the present report) on the recommendation of the therapist (researcher himself) on the basis of a risk of getting the results similar to pre-test Rorschach test for the post-test as the client's scores on pre-test only showed moderate levels of personality-functioning with a pleasant

personality profile. The sample size and number of settings are expanded for a single case study investigation to control the compromised external validity. The novel qualitative measure using Rorschach's Indian manual was an additional method of reliability and validity for this single case study. The behavioral techniques used in the study (cognitive therapy and exposure) also enhance the reliability and validity of the study, especially in the Pakistani context (cross-cultural validity). The detailed qualitative and quantitative scores and interpretation can be seen in **Table 2**.

Table 2. Rorschach's statistics for Ayesha's quantitative and qualitative scoring.

Variable	Symbol	Reference Value (Adult)	Rating	Interpretation
Total Number of Responses	TR	22%	36%	Productivity
Total Blot Area	W	20%	30%	Organizing and synthesizing capacity
Common Blot Area	D	77%	61%	Practical Approach
Uncommon Blot Area	Dd	3%	2.7%	Emphasis on Minute Details
White Blot Area	S	5%	11%	Opposition Tendencies
Shape appropriate	F	76%	72%	Reality Testing
Action	M	7%	11%	Imaginative Processes
Color & Color Form	C + CF	5%	5.5%	Impulsivity
Form-Color	FC	2%	2.7%	Matured Emotionality
Black & White	Y	1%	5%	Enhanced IQ
Tactile	T	0%	13%	Over Conscious
3-Dimension	V	2%	5%	Inferiority Feelings
Animal	A	53%	19%	Enhanced Empathy
Human	H	17%	19%	Capacity to form and maintain human relationships
Internal Organs	An	4%	5%	Somatic Concern
Most Common Responses	P	18%	13%	Conformity to Social Norms

Note: The scoring was done using Dr. Rakesh Kumar's Manual.

The limitations of Indian Rorschach's manual relied heavily on percentage frequencies for variables like Shading (Y, T, V) and Contents (A, H, An), whereas Exner and R-PAS systems use raw frequency counts and ratios to prevent statistical distortion caused by varying total response numbers (TR). Acknowledging the psychometric meaning of "Enhanced IQ" as the Intelligence quotient more than average (as the manual claims) and the meanings of the "Enhanced Empathy" in Indian or nearabout context (such as Pakistan) is used in negative sense because these people remain more sensitive to the social situations and develop a sense of fear to face these situations (as was the case with client). The meaning of "over conscious" was taken from the manual for the person who consciously adopts behaviors to avoid social situations where more than 3 people are present (as she said, she feels uncomfortable when people other than her parents gather around her). So, she started getting more conscious about herself and started to have social anxiety by avoiding the situation. Acknowledging the diverse socioeconomic, regional, and linguistic sub-populations, the scores were found according to the baselines provided in the manual. Her projective test (Rorschach) interpretation showed that superior intellectual functioning, low abstract thinking, practical approach, poor perceptual ability, strong ego, anxiety in imaginative activity, repressed feelings, poor emotional control, and narrow relations, cautious, feelings of inferiority, self-critical introspection, vague and free-floating anxiety and interpersonal biases.

Subjective Units of Distress Scale or SUDS[16] as a pre-post-test assessment on a scale of 1–10 for severity was used. Informal assessment contained behavioral observations, study notes, intake form, consent agreement form and audio-recorded sections for methodological rigor.

3. Case Conceptualization and Formation

From Craske and Barlow's book[19] and the case conceptualization method based on clinical and theoretical models of social phobia for social anxiety disorder, a deficient view of the self as the primary feared during a major life-phase transition (leaving college), the client activated a core self-discrepancy in the client. An immediate inward focus on attention. This self-focused attention led the client towards self-monitoring of her anxiety symptoms, from which she got a negative self-image that she would be a cause of embarrassment for others. Ultimately, the client's avoidant behavior of leaving social places as a safety behavior prevented her from having broader public exposure. By shifting

the focus from the "consequences" of social phobia (fear of rejection) to the "stimulus", i.e., the exposed, deficient self, this formulation aligns the client's therapeutic targets with empirically validated clinical and theoretical models.

From the DSM-5 Case conceptualization [20], Ayesha experiences social anxiety driven by fear of negative evaluation, economic pressure, and embarrassment. Her symptoms began after leaving college, leading to difficulty expressing herself and a distorted self-image. She fixates on perceived social expectations, reinforcing self-doubt and pessimism. Her anxiety distorts her self-assessment, making her overly critical of her abilities while minimizing her achievements. Based on this conceptualization, Ayesha exhibits symptoms consistent with social anxiety disorder.

From the DSM-5-TR criteria of the 5Ps case formulation, the prodromal manifestation of Ayesha was "leaving the college and taking admission in university". The predisposing factors were leaving the company of college friends and the environmental change. The precipitating factors were going to university and attending the company of university fellows. The perpetuating factors were cognitive biases of jumping to conclusions that no one is interested in talking to her. The protective factor was social support (parents).

4. 12-Session Structure, Therapeutic Goals and Management Plan

The initial sessions were 1 to 4. The goal of these sessions was to establish rapport building, conduct clinical interview and perform test administration. The middle phase was of 5 to 10 sessions for engaging the patient in a therapy with psycho-education and for the application of the main therapeutic intervention. Sessions 11–12 were conducted as the last phase for relapse prevention, client's feedback, evaluation and termination of sessions.

- **Sessions 1–2**

Rapport building and history taking with reflection, mirroring and empathy, etc. [21] was done with Ayesha in Session 1. She presented and filled out SUDS ratings for her complaints. The second was to apply the Mini-Mental Status and Liebowitz Social Anxiety Scale (LSAS-SR) to Ayesha.

- **Sessions 3–4**

The third session was conducted to apply Rorschach to Ayesha. In the 4th session, DSM-5-TR [20] Criteria Matching for social Anxiety for Ayesha, the hierarchy of social situations was identified by her. Ayesha understood the risk and prognostic factors for her disorder. She identified the social situation hierarchy where she had problems (university, home, relatives, birthdays, marriages and family functions).

- **Sessions 5–6**

Ayesha was introduced to imaginal exposure and asked to imagine a university scenario where she imagined her conversation problem with others due to keeping a focus on her anxiety and not on the conversation with others. She learned to respond positively to others with the use of this technique during the session. In the 6th session, in continuation of the safety behavior that Ayesha used during the social situations in the hierarchy was applied to the social situations where the safety behaviors she was using, and she had to leave these behaviors by focusing her attention on the conversation and the people present there. The same technique was done with the client on her next hierarchical social situation, i.e., birthdays.

- **Sessions 7–8**

In the 7th session, the two social situations (marriage and family functions) came into consideration for this session and exposure technique was applied to both these situations involving the client in these situations simultaneously. In Session 8, the desensitization-based exposure technique was applied to Ayesha in five steps: (i) Sit on a revolving chair and spin (30 s) and then stop for 30 s and do this exercise for 5 min. (ii) Shake head from left to right and backward (30 s) and then stop. (iii) Bring head to knee (30 s) and then take it back up side (30 s) and do this for 5 min. (iv) Breathe shallow for 30 s and then breathe normally for 30 s. Do this for 5 min. (v) Numbers 1 and 3 could not be tried by numbers 2 and 4 were done in the session. Ayesha was made aware of the main purpose of this technique (that was desensitization to anxiety by exposure to anxiety).

- **Sessions 9–10**

Session 9 was done with Ayesha because of her complaint that she found it hard to stay longer in a social situation to talk to people. She was told about the assertive communication (talking in a way that may keep a relationship out of danger of being broken; talking with respect and conveying the point such that people may not feel it as a disgusting or disrespectful communication). Assertive communication was

practiced with her in her social situations using a Socratic-questioning style. In the 10th session, from the domain of behavioral experiments, the technique of "producing a rational response to cognitive distortions by exposure" on a situation about being in university talking to other classmates was tried with her in Socratic style. The main question was, "is she really not being noticed by the other people or that's only her own thought?" She practiced this technique by thinking about a few other social situations she had on her social hierarchy.

- **Sessions 11–12**

In Session 11, Ayesha was given an overview of the therapy. She was made realized about her changed coping and new coping skills in conversation while controlling her anxiety symptoms in all her hierarchical social situations as relapse prevention. In session 12, the SUDS ratings for the sake of post-test were taken and all the ratings showed a significant subjective decrease in all her social anxiety symptoms she came with in the first session. She was given the blueprint of the therapy with an offer of the follow-up sessions in the next two consecutive months twice.

- **Psychotherapeutic Techniques in Sessions**

In Sessions 1–4, rapport building and assessment of proposed scales were done with Ayesha, with an interview based on DSM-5-TR [20] Criteria Matching for social Anxiety was done. The hierarchy of social situations was identified by her. In Sessions 5–8, major therapy techniques such as Imaginal Exposure for Ayesha's conversation problem with others, the drop of safety behaviors on her hierarchy of the social situations (marriage and family functions and birthdays) by focusing her attention on the conversation and people present there and de-focusing her anxiety symptoms with techniques of desensitization-based exposure techniques from the Mattick's Manual [22] were used in a Socratic Questioning style. In Sessions 9–10, the assertive communication, i.e., talking in a way that may keep a relationship out of danger of being broken, talking with respect, and conveying the point such that people may not feel it as a disgusting or disrespectful communication [23], was practiced with her in her social situations using the Socratic-questioning style. The technique of "producing a rational response to cognitive distortions by exposure" in a situation about being in university, talking to other classmates, was tried with her in Socratic questioning and role-play styles. In Sessions 11–12, Ayesha was given an overview of the therapy. She was made aware of her changed coping and new coping skills in conversation while managing her anxiety symptoms in all her hierarchical social situations as relapse prevention. The SUDS ratings for the sake of post-test were taken and these ratings showed a significant decrease in the symptoms (see **Table 1**). She was given the blueprint of the therapy with an offer of the follow-up sessions in the next two consecutive months (twice). The follow-up sessions (2) were conducted at the given time, and the therapeutic goal for the sessions was to find out the maintenance of the improvement of the client from the symptoms of social anxiety in real-world situations as the client told she had successfully attended 2 weddings after the therapeutic sessions and she faced fewer symptoms of social anxiety. She talked about her communication with her college fellows that improved much (according to her own words). The SUDS ratings in the follow-up sessions were not taken as pre-test and post-test ratings were already taken for particular 12 sessions. No specific interventions were used in follow-up sessions, and also, the subjective mood, memory of the client, and context-based proceedings of the follow-up sessions didn't allow the space for follow-up SUDS ratings, so they can also be taken as a major limitation of the present report [24]. The following **Table 3** shows an overall proceeding of the 12 sessions in terms of each session's goal, therapeutic technique, exposure target, behavioral experiment, and outcome of the sessions.

Table 3. Summary of the 12-session proceedings.

Session	Therapeutic Goal	Therapeutic Technique	Exposure Target	Behavioral Experiment	Outcome Indicator
1–2	Rapport & Assessment	Interview, Reflection, Mirroring	Pace-setting	SUDS baseline & diagnostic scales (MMSE, LSAS-SR)	Established rapport & baseline ratings
3–4	Diagnosis & Planning	Rorschach & DSM-5-TR Criteria-verification for SAD	Social hierarchy mapping	Identifying risk/prognostic factors	Defined social hierarchy list
5–6	Anxiety Management	Imaginal Exposure & Attention Training	University & birthday scenarios	Dropping safety behaviors; focus on conversation	Positive response during role-play

Table 3. *Cont.*

Session	Therapeutic Goal	Therapeutic Technique	Exposure Target	Behavioral Experiment	Outcome Indicator
7	Anxiety Management	Exposure (Simultaneous)	Marriage & family functions	Immersed interaction in social situations	Active engagement in targeted settings
8	Desensitization	Desensitization-based Exposure	Physiological anxiety symptoms	Physical exercises (head/breathing)	Understanding of anxiety-exposure link
9	Skill Building	Assertive Communication	General social situations	Socratic questioning for respectful dialogue	Ability to communicate assertively
10	Cognitive Restructuring	Rational Response/Exposure	University & classmate interaction	Socratic questioning of cognitive distortions	Disproving irrational thought patterns
11	Relapse Prevention	Therapy Overview	All hierarchical situations	Review of new coping skill application	Recognition of improved coping capacity
12	Evaluation & Termination	Post-test Assessment	All hierarchical situations	Final SUDS rating & Therapy blueprint	Significant decrease in symptoms

5. Discussion

The investigative case of the present study was that the Social Anxiety Disorder (SAD) symptoms may co-exist in a client under the influence of major life stressors (social conversation phobias for a student) can be treated with cognitive therapy, desensitization-based exposure, with cognitive restructuring and behavioral experiments in Cognitive and Behavior Therapies. Both notions are supported by the study of Clark et al.[25] and by Eya[26]. The grounding technique, from attention to self-focus and re-focusing on the social situation in the here and now, was suggested by previous literature[27] for the SAD, and it is an effective tool for social anxiety patients. In this case, Ayesha's SAD symptoms were relieved by using this evidence-based technique. The assertive communication used for the SAD is successful for clients[27] and the same techniques were used for the client in the present case study, and it turned out to be successful for the client. While every case of social anxiety in Pakistan is different on the basis of behavioral hierarchies, still, the manifestations of the common symptoms of social anxiety are similar in Pakistan and in other countries such as excessive and marked anxiety, fear of social situations and therefore, the therapeutic techniques of case management are similar worldwide. The only difference exists where the application of the interventions yields different results or similar results in Pakistan and other countries, which might be a matter of differences in clinical settings, skills of therapists and clinical judgments of the clinical psychologists[28]. The potential source of bias, as the researcher is also the therapist, is acknowledged and referred to the globally accepted limitations of case reports, as many psychologists around the world prefer to write their case reports by their own hands and get them published on their own as well and it is allowed by the Tri-Council Policy Statement or "TCP's"[29].

6. Conclusions

The SUDS ratings measure the pre- and post-test change on the scale of 1–10. Ratings were found to have an overall lower score (5) in the post-test after the completion of the sessions, compared to the overall pre-test score (8) in the very first session. On completion of all twelve sessions, Ayesha gave positive feedback that her symptoms were getting better. She accepted that she was no longer afraid of social phobia, and she was giving her full time to complete her studies.

Future studies should be done on the feasibility of similar cases worldwide with similar therapeutic strategies. Clinically observing, Ayesha had the courage to work for the reduction of symptoms and she did it with commitment and self-motivation. Further researchers should be done on the relationship of internal motivation of the client to reduce his/her symptoms of any disorder of anxiety (especially Social Anxiety Disorder). A therapist, a client, a teacher, a policy maker for education, a curriculum developer or a common person will read this article, will get awareness of social anxiety, its symptoms, the assessment and management plan for social anxiety or social phobia.

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Institutional Review Board Statement

The study was conducted in strict accordance with the Declaration of Helsinki. The protocol was formally reviewed

and approved by the Ethical Approval Committee (ERB) of the University of Sargodha (protocol reference number 104236-RC-25, approved on 9 December 2025). Ethics of confidentiality, anonymity and safety of the client were ensured in this study. In accordance with the American Psychological Association (APA) guidelines, all the reported data are anonymized, and all identifiable personal markers, institutional titles, or geographical locators have been omitted or modified to protect participant privacy.

Informed Consent Statement

Written informed consent was obtained from the client (over 21 years old) regarding the therapeutic sessions in the university clinic to conduct any assessment or therapeutic intervention.

Data Availability Statement

No data is attached to this report (except the figure of Rorschach's results and evaluation—data from other clinical measurements for case assessment). No other data can be shared upon request to fulfil the ethical consideration of data confidentiality. The reason behind not providing the data is the policy of the referral hospital and the referral psychiatrist. As per the rules of the University, the data can only be provided upon physical arrival at the University.

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Conflicts of Interest

There is no conflict of interest between the hospital psychiatrist (referral) and the clinical psychologist (author) regarding writing the report or claiming the authorship.

AI Use Statement

No generative AI tools were used for content generation or data analysis. AI was employed solely for language editing and proofreading support. The author subsequently reviewed and edited the content as necessary and takes full responsibility for the final content of the published article.

References

[1] Del Pozo, N.Q., Estévez, A.I., Jauregui, P., et al., 2025. Romantic Myths, Psychological Symptomatology, and Their Impact on Emotional Dependence in Ecuadorian University Students. Journal of Cultural Analysis and Social Change. 10(2), 2973–2983. DOI: https://doi.org/10.64753/jcasc.v10i2.2041

[2] Zhang, J., Bakhir, N.B.M., Han, H., et al., 2024. Quantitative and Qualitative Analysis of Social Anxiety Disorder Treatment Methods: A Bibliometric Approach from the Perspective of Cognitive Behavioral Theory. Educational Administration: Theory and Practice. 30(4), 190–202.

[3] Akram, B., Wazir, S., 2025. Cognitive Behavioral Therapy for Treating Aerophobia: A Case Study. Journal of Professional & Applied Psychology. 6(4), 660–667. DOI: https://doi.org/10.52053/jpap.v6i4.454

[4] Nelson, R.E., Emelianchik-Key, K., 2024. Clinical Assessments and Personality Testing. In: Gill, C.S., Emelianchik-Key, K., Torres, A. (Eds.). Appraisal, Assessment, and Evaluation for Counselors: A Practical Guide. Springer Publishing Company: New York, NY, USA. pp. 217–244. DOI: https://doi.org/10.1891/9780826189134.0010

[5] Tan, Y.L., Chang, V.Y.X., Ang, W.H., et al., 2025. Virtual reality exposure therapy for social anxiety disorders: A meta-analysis and meta-regression of randomized controlled trials. Anxiety, Stress, & Coping. 38(2), 141–160. DOI: https://doi.org/10.1080/10615806.2024.2392195

[6] Banakou, D., Johnston, T., Beacco, A., et al., 2024. Desensitizing anxiety through imperceptible change: Feasibility study on a paradigm for single-session exposure therapy for fear of public speaking. JMIR Formative Research. 8, e52212. DOI: https://doi.org/10.2196/52212

[7] Exner Jr., J.E., 2013. Issues and Methods in Rorschach Research. Routledge: London, UK.

[8] Meyer, G.J., Viglione, D.J., Mihura, J.L., 2016. Psychometric Foundations of the Rorschach Performance Assessment System® (R-PAS®). In: Erard, R.E., Evans, F.B. (Eds.). The Rorschach in Multimethod Forensic Assessment: Conceptual Foundations and Practical Applications. Routledge: New York, NY, USA. pp. 47–115.

[9] Ambreen, S., To, C.K., 2025. Review of the phonological system of contemporary Urdu spoken in Pakistan. International Journal of Speech-Language Pathology. 27(1), 101–112. DOI: https://doi.org/10.1080/17549507.2024.2324905

[10] Farooq, S.A., Muneeb, A., Ajmal, W., et al., 2017. Quality of life perceptions in school-going adolescents with social anxiety. Journal of Childhood & Developmental Disorders. 3(2), 8.

[11] Asakura, S., Yoshinaga, N., Yamada, H., et al., 2023. Japanese Society of Anxiety and Related Disorders/Japanese Society of Neuropsychopharmacology: Clinical practice guideline for social anxiety disorder (2021). Neuropsychopharmacology Reports. 43(3), 288–309. DOI: https://doi.org/10.1002/npr2.12365

[12] Bicego, L., 2025. The Experience of Making Behavioral Observations during Neuropsychological Assessment: A Conventional Content Analysis [PhD Thesis]. California Northstate University: Northridge, CA, USA. Available from: https://www.proquest.com/openview/69a18d9f313e065ebaff6d532547ed7d/1?pq-origsite=gscholar&cbl=18750&diss=y

[13] Cockrell, J.R., Folstein, M.F., 2002. Mini-mental state examination. In: Abou-Saleh, M.T., Katona, C.L.E., Anand, K.A. (Eds.). Principles and Practice of Geriatric Psychiatry. John Wiley & Sons: Chichester, UK. pp. 140–141. DOI: https://doi.org/10.1002/0470846410.ch27(ii)

[14] Baker, S.L., Heinrichs, N., Kim, H.J., et al., 2002. The Liebowitz social anxiety scale as a self-report instrument: A preliminary psychometric analysis. Behaviour Research and Therapy. 40(6), 701–715. DOI: https://doi.org/10.1016/S0005-7967(01)00060-2

[15] Kumar, R., 2023. Rorschach Inkblot Test: A Guide to Modified Scoring System. Prasad Psycho Corporation: New Delhi, India. Available from: https://www.researchgate.net/profile/Rakesh-Kumar-402/publication/373990454_RORSCHACH_INKBLOT_TEST_A_Guide_to_Modified_Scoring_System_Practical_Tips_Skills_for_Beginners/links/650758f0ca19e8355c9a78ed/RORSCHACH-INKBLOT-TEST-A-Guide-to-Modified-Scoring-System-Practical-Tips-Skills-for-Beginners.pdf

[16] Kiyimba, N., O'Reilly, M., 2020. The clinical use of Subjective Units of Distress scales (SUDs) in child mental health assessments: A thematic evaluation. Journal of Mental Health. 29(4), 418–423. DOI: https://doi.org/10.1080/09638237.2017.1340616

[17] Wikfeldt, E., 2016. Generalising from Case Studies. Available from: https://www.diva-portal.org/smash/record.jsf?pid=diva2%3A1051446&dswid=-3211 (cited 26 March 2026).

[18] Cole, R., 2024. Inter-rater reliability methods in qualitative case study research. Sociological Methods & Research. 53(4), 1944–1975. DOI: https://doi.org/10.1177/00491241231156971

[19] Craske, M.G., Barlow, D.H., 2022. Mastery of Your Anxiety and Panic: Therapist Guide. Oxford University Press: Oxford, UK.

[20] First, M.B., 2024. DSM-5-TR® Handbook of Differential Diagnosis. American Psychiatric Association Publishing: Washington, DC, USA. DOI: https://doi.org/10.1176/appi.books.9781615375363

[21] Lee, S.H., Yoo, H.J., 2024. Therapeutic communication using mirroring interventions in nursing education: A mixed methods study. Asian Nursing Research. 18(5), 435–442. DOI: https://doi.org/10.1016/j.anr.2024.09.012

[22] Mattick, R.P., Peters, L., Clarke, J.C., 1989. Exposure and cognitive restructuring for social phobia: A controlled study. Behavior Therapy. 20(1), 3–23. DOI: https://doi.org/10.1016/S0005-7894(89)80115-7

[23] Entwistle, V.A., Cribb, A., Mitchell, P., 2024. Tackling disrespect in health care: The relevance of sociorelational equality. Journal of Health Services Research & Policy. 29(1), 42–50. DOI: https://doi.org/10.1177/13558196231187961

[24] Conrod, P.J., Stewart, S.H., 2005. A Critical Look at Dual-Focused Cognitive-Behavioral Treatments for Comorbid Substance Use and Psychiatric Disorders: Strengths, Limitations, and Future Directions. Journal of Cognitive Psychotherapy. 19(3). DOI: https://doi.org/10.1891/jcop.2005.19.3.261

[25] Clark, D.M., Ehlers, A., Hackmann, A., et al., 2006. Cognitive therapy versus exposure and applied relaxation in social phobia: A randomized controlled trial. Journal of Consulting and Clinical Psychology. 74(3), 568–578. DOI: https://psycnet.apa.org/doi/10.1037/0022-006X.74.3.568

[26] Eya, N.M., Anumudu, J.I., Nweze, B.N., et al., 2024. Evaluating the efficacy of cognitive restructuring and exposure therapies on secondary school chemistry students' test anxiety: A randomized trial. Medicine. 103(32), e39253. DOI: https://doi.org/10.1097/MD.0000000000039253

[27] Boehme, S., Miltner, W.H., Straube, T., 2015. Neural correlates of self-focused attention in social anxiety. Social Cognitive and Affective Neuroscience. 10(6), 856–862. DOI: https://doi.org/10.1093/scan/nsu128

[28] Urbán, D.J., García-Fernández, J.M., Inglés, C.J., 2024. Risk profiles of social anxiety for interpersonal difficulties in a sample of Spanish adolescents. Revista de Psicodidáctica (English ed.). 29(1), 9–18. DOI: https://doi.org/10.1016/j.psicoe.2023.11.001

[29] Khan, T., Hussain, S., Faisal, S., et al., 2025. Nursing Students' Perception with the Objective Structured Clinical Examination (OSCE): A Quantitative Cross-Sectional Study in Private Colleges of Peshawar, Pakistan. National Journal of Life and Health Sciences. 4(2), 67–72. DOI: https://doi.org/10.62746/njlhs.v4n2.90