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E. Hougaard

Response to Commentaries on A Novel Group Therapeutic Format in Cognitive Behavioral Treatment for Clients with Social Phobia in a Training Setting: A Case Study of One Treatment Group with Nine Clients

Further Reflections on the Therapy Training Program in Aarhus, and the Role of Case Studies in Psychotherapy Research

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ABSTRACT

This paper responds to commentaries by Edwards (2008) and Huppert, Carmeli and Gilon (2008) on the case study of a special format of intensive, group cognitive-behavioral therapy for social phobia in an Anxiety Clinic run by the Department of Psychology of the University of Aarhus in Denmark (Hougaard et al., 2008). My response addresses the following topics: 1) case studies and evidence-based practice; 2) the evidence-basis of the Aarhus treatment program; 3) mechanisms of change in psychotherapy; 4) the Aarhus clients and their treatment in the program; 5) the Aarhus trainees and their learning; and 6) differences between the training program of Huppert et al. in Jerusalem and our Aarhus program.

Keywords: case studies; social phobia; cognitive-behavioral therapy; group therapy; training; evidence-based practice

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I would like to thank Edwards (2008) and Huppert, Carmeli and Gilon (2008) for their most relevant and interesting commentaries on our case study (Hougaard et al., 2008). As acknowledged in both commentaries, it is not possible to respond in a single response all of the issues they raise, so I have focused on six of their salient points: 1) case studies and evidence-based practice (EBP); 2) the evidence-basis of the treatment program at the University of Aarhus Anxiety Clinic; 3) mechanisms of change in psychotherapy; 4) the Aarhus clients and their treatment; 5) the Aarhus trainees and their learning; and 6) some differences between the training program of Huppert et al. in Jerusalem and ours in Aarhus. Although the commentaries overlap somewhat with regard to topics covered, the first three points mostly refer to the commentary by Edwards (2008), while the last three primarily refer to Huppert et al. (2008).

Both commentaries ask for more information on the educational part of the program, and Edwards (2008) raises the question of why it was not more formally evaluated in the case study, since the primary purpose of the treatment program is to train student therapists. I agree that this is a weakness of the study, and consequently I have initiated plans for a case study next year focusing on the students and their training in the social phobia part of our program.

CASE STUDIES AND EVIDENCE-BASED PRACTICE

Both commentaries deal with the place of case studies within evidence-based practice (EBP). In line with Edwards, Datillio, and Bromley (2004), Edwards (2008) argues for a more prominent place for case studies within EBP as a complement to randomized clinical trials and other group studies. Huppert et al. (2008) propose an intriguing idea on the relationship between individualized EBP (Sackett, Straus, Richardson, Rosenberg & Hayness, 2001; American Psychological Association, 2006) and case-based reasoning (Prentzas & Hatzilygerudis, 2007). Since EBP is defined as the "integration of the best research evidence with clinical expertise and patient values" (Sackett et al., 2001, p. 1), and since clinicians' expertise is embedded in case-based reasoning grounded in their own professional experiences (Schön, 1983), it appears that aggregated, systematic case studies could provide a more explicitly formulated and thus improved data base for idiographic clinical reasoning. According to a metaphor by Malan (1979), clinicians are programmed like computers by their day-to-day experiences, probably in the form of rules derived from intuitively grasped covariance between events, and cases in the form of implicit stories about their clients. However, in line with Paul Meehl's (1954) classic monograph on clinical versus statistical prediction, it should come as no surprise that practitioners are not highly efficient as "intuitive statisticians," since, for example, it has been difficult to prove that clinical experience is consistently related to improved clinical judgment (Garb, 1989), or to better therapeutic outcome (Christensen & Jacobson, 1994). If this line of reasoning is correct, systematically and rigorously documented case studies might improve the idiographic aspects of EBP, making a clinician's intuitively developed expertise explicitly and transparently formalized, conceptualized, articulated, and critically reflected upon. There are, of course, other rationales for the use of case studies in theory testing (e.g., Stiles, in press) and in the inductive generation of best practice guidelines from aggregated case studies of the same type (Edwards 2008; Fishman, 2005; Watson, Goldman, & Greenberg, 2007).

EVIDENCE-BASIS OF THE AARHUS PROGRAM

Both Edwards (2008) and Huppert et al. (2008) raise the question of whether our Aarhus Anxiety Clinic is based on the best available evidence. Specifically, studies with Clark's individual CBT (e.g., Stangier, Heidenreich, Peitz, Lauterbach, & Clark, 2003; Clark et al., 2006) have achieved larger effect sizes than those in our Aarhus case. Moreover, studies by Clark and his colleagues have found individual CBT to be more efficacious than a group version of the same therapy (Stangier et al., 2003), as well as a 41-hour intensive group treatment program (Mörtberg, Clark, Sundin, Wisted & Åberg, 2006). There are, however, also examples in the literature of group therapy outperforming individual therapy (e.g., Scholling & Emmelkamp, 1993). A meta-analysis by Federoff and Taylor (2001) concluded a tie between the two treatment formats based on cross-study analyses of effect sizes. Generally, there are very

few comparative studies, and results might vary with different forms of CBT and with how group processes are taken into account within a group CBT format (Taube-Schiff, Suvak, Antony, Bieling & McCabe, 2007; Yalom, 1975/1995).

Based on a proposal by Edwards (2008), we have illustratively benchmarked our results with the two, above-mentioned Clark studies (Stangier et al., 2003; Clark et al., 2006), reporting results on the Mattick and Clarke (1998) self-report scales—the Social Phobia Scale (SPS) and the Social Interaction Anxiety Scale (SIAS)—also included in our study. Results in each study are presented in Table 1 in terms of Cohen's "effect size" *d* statistic. Results from our Aarhus study are reported both for all clients, and for "clinical cases," leaving out the two cases (Laila and Cecilia) with very low social phobia pre-treatment scores, in accordance with a suggestion by Huppert et al. (2008). As can be seen in Table 1, the Clark et al. studies achieved larger effect sizes than for the two samples in our studies: for SPS, 1.47 and 1.41 in the Clark studies compared with .95 and 1.09 in our two samples; and for SIAS, 1.90 and 1.76 in the Clark studies, compared with .92 and 1.55 for our two samples. Many factors vary between studies, and this reduces the value of effect-size benchmarking, especially with small samples (e.g., see the rather large confidence intervals in Table 1). Furthermore, the effect sizes achieved by Clark and his associates are very large compared with general results from meta-analyses (Federoff & Taylor, 2001; Hofmann & Smits, 2008; Norton & Price, 2007). As acknowledged by Edwards (2008), it might be a little unfair to benchmark results achieved by inexperienced student therapists with, probably, the largest effect sizes reported in the literature.

According to our experience at Aarhus, essential components of the Clark program can rather easily be employed within an intensive group setting, although detailed individual case-formulations are more adequately provided in the individual sessions prior to the group therapy, and schema-focused therapy is also better delivered in an individual format. Since client and therapist factors account for a substantial degree of therapeutic outcome (Tallman & Bohart, 1999; Wampold & Brown, 2005), and therapists and clientele vary between settings, every implementation of a treatment program in a new setting could be considered a type of "experimental treatment" in need of its own empirical evaluation. This argument especially holds for treatments administered by inexperienced therapists in training. Since we took for granted the pedagogical value of the intensive group-week, the appropriateness of studying the clinical value of this type of treatment-program seemed rather obvious to us. Moreover, our intensive treatment program is quite different from previous ones by Lincoln, Rief, Hahlweg and Frank (2003) or by Mörtberg et al. (2007). Our assumptions about the educational value of the intensive group-week should be considered tentative, of course, until the program's pedagogical value has been formally evaluated.

Most likely, the treatment program offered at our Anxiety Clinic in Aarhus is not cost-effective when considering the therapist resources involved, since many clients do have rather extensive treatment. This is, however, a matter of less concern in a training clinic. The students will profit from rather extensive contacts with their clients, and most clients achieve fast symptomatic relief in the intensive group-program. .

MECHANISMS OF CHANGE

Although psychotherapeutic processes or change mechanisms were not the focus of our case study, the students' case-study reports deal with mechanisms of change in line with the conceptual model employed in this journal, *Pragmatic Case Studies in Psychotherapy* (Fishman, 2005), mostly based on qualitative information. I do agree with both the Edwards and Huppert et al. commentaries that studying such mechanisms should be given high priority in psychotherapy research, a view also emphasized by Hyman (2000). Answering the question is intrinsically difficult, and at present there is relatively little hard-core scientific evidence on change mechanisms in any form of psychotherapy, including CBT (Kazdin, 2007; Longmore & Worrell, 2007). At a conference with the title, "What works in psychotherapy," in the spring of 2008 in Lund, Sweden, Robert DeRubeis suggested several research strategies for studying change mechanisms. One is to study change mechanisms experimentally outside of psychotherapy (e.g.,Clark, 2004). Within psychotherapy, he advised researchers to study change points "early, intensively, [and] idiographically," especially in connection with "critical events" (Rice & Greenberg, 1984) or "sudden gains" (Tang & DeRubeis, 1999), i.e., episodes with maximum change in the mediator or in the outcome variable. Kazdin (2007), in his recent methodological paper on mediating variables in psychotherapy, recommends intensive measurements of mediators and outcome variables throughout therapy, preferably with more than one hypothesized mediator related to competing theories of change. He also leaves a door open for systematic qualitative studies as a method of investigating change mechanisms.

The pragmatic case study strategy could clearly play a role in solving the riddle of change processes in psychotherapy. However, some have argued that such change mechanisms are rather opaque because of the comprehensive meaning horizon of client expressions in psychotherapy, hidden from observers, and, to a large degree, also from the therapists and clients themselves, only allowing glimpses of what is going on through the "windows" of transparent, prototypical change events (Elliott & Shapiro, 1992). Even with such events it might not be an easy task to understand what really is going on from a molecular change mechanism perspective. An example of a remarkable change event followed by sudden symptomatic gain from one of our intensive group therapy sessions might help in clarifying the issues.

> The client, a woman in her mid thirties, suffered from social phobia with a comorbid obsessive-compulsive disorder (OCD), which was well treated with cognitive-behavior therapy and SSRI medication. Her reason for application was a life-long fear of blushing, which according to her had been even more distressful than her OCD. During the first two days in the intensive group-week she was rather demoralized, since she was the only client in the group with fear of blushing and she received information that it is not possible to learn to inhibit the blushing reflex, which was what she had hoped for. In a cognitive restructuring task at day two, she was told (a) that the best alternative thought for clients with blushing phobia ordinarily is that "It is OK to blush," and (b) that her attempts to control her reddening paradoxically would strengthen the reaction, since it is not possible to control involuntary autonomic reactions, and attempts to do so might heighten the experience of uncontrollability.

The third day she chose in her behavioral experiment to tell a story from her childhood in front of the whole group with no attempts to repress her reddening, but just to let it come and accept it and the accompanying negative affects. Her story was a highly moving one from her early teens when she suffered from life threatening anorexia. Her parents informed her that they had to have her sent to a hospital for treatment if she did not put on weight, with cancellation of her coming confirmation celebration as a consequence (a disastrous event from her point of view at that time). She told us that she gave up her anorectic eating habits for her confirmation celebration, but at the same time started controlling her thoughts, thus changing her disorder into OCD. Her storytelling was highly emotionally charged and very touching for the audience. After the presentation she was asked to compare her experience during the presentation with her expectations (written down beforehand on the whiteboard); she received comments from the other members of the group; and the video recording was replayed.

She was highly satisfied with this behavioral experiment. Although she strongly felt her reddening, especially in the beginning, and reacted with severe anxiety and sad feelings with tears in her eyes, she was surprised that she could just let her feelings come without totally loosing control, and that her negative emotions declined after a while—more quickly, she thought, than it would have happened if she had tried to combat her reactions. She was pleased by the positive reactions from the other members of the group, and highly surprised by the video-feedback, where she could see that she reddened and cried, but in no way showed an appearance resembling the grossly distorted view of herself with red and swollen face that she had imagined. She told us after the experiment that she was sure she could use the results in her future strategies to overcome her phobia, because she knew now, that she should just let the feelings come, and was convinced that she was not looking totally foolish, even though she reddened a lot. At the end of the day she announced that she this evening would tell her fellow members in her choir about her social phobia and fear of blushing. She did so, although not without hesitation (she had to ask the choir leader to inform the group about an announcement she would like to make). The next day, when she told the group about the event, she was praised for her courage by the group members.

Although she knew she had to practice her newly acquired insights and skills in her day-to-day living after the course, she told us at the end of the intensive week that she thought she would be able do this on her own, and that she did not need any further treatment for her social phobia (although she wanted help with a spider phobia, which was successfully treated in two extra individual sessions). At follow-up two months later she was doing well and not much bothered by her reddening tendency, although she still sometimes blushed and felt it unpleasant in social situations.

The sudden change in this client's longstanding blushing phobia makes it almost certain that the exposure exercise was the causal agent. Answering the question of which mechanisms were responsible for the change is, however, much more complicated. According to what she said, the video-feedback and insight into her dysfunctional emotion regulation strategies had played a major role. The Clark and Wells (1995) conception of receiving evidence that contradicts her view of self from an observer point of view fits the case well. She needed, however, to practice her suddenly acquired insights in her day-to-day life in the following period. Moreover, much of the exposure-related changes here might not have taken place on an explicit,

strategic cognitive level, but rather on a more primitive conditioning level as assumed by many emotion theorists (e.g., LeDoux, 1996).

Foa & Kozak's (1986) emotional processing theory, a highly influential conditioning theory, explains the mechanisms of exposure by a combination of, on the one hand, within- and between-session habituation (i.e., passive emotional decay), and, on the other, corrective information in the situation challenging the fear structure, including the information that the anxiety declines after a while instead of escalating uncontrollably. Although emotional processing theory might not be empirically well supported (Craske, Kircanski, Selikowsky, Mystkowski, Chowdhury & Baker, 2008), the information in this case example seems to be fully in accordance with the theory, i.e., the client's fear of blushing declined in and between sessions with the provision of information incompatible with her prior fear structure.

A newly formulated version of the conditioning theory of exposure by Craske et al. (2008) stresses inhibitory learning as opposed to unlearning, which was originally proposed by emotional processing theory. This inhibitory learning is supposed to be based on a mismatch between expectations and stimuli (mostly on an implicit, automatic representational level) and an increased tolerance of negative emotions.

Bandura (1977) explains the effects of exposure in terms of self-efficacy, and this theory has recently been applied to panic disorder in the form of panic-self-efficacy (Casey, Oei. & Newcombe, 2004). Panic-self-efficacy, the ability to master panic attacks, might also be relevant for some specific social phobias, including blushing phobia in the present case, since the client panicked when she reddened, and seemed to learn to master her panic attack in the behavioral experiment. Emotion regulation theory (Gross, 2007; Craske et al., 2008) underline tolerance of negative emotions as an important component in overcoming emotional disorders, which surely also might have played a role in the present case example. The emotional impacts of non-specific group therapy factors (Yalom, 1975/1995) could also likely have been involved.

Thus, although this case example seems rather transparent on a molar level concerning which components of treatment were responsible for change, it might not be easy from the available qualitative case information to choose between competing theories of change mechanisms on a molecular level. Perhaps further information from the client might help in clarifying the episode. The student therapist is presently writing her case-study report on this case, and the client has agreed to read and comment on her report. Client feedback and reflections might, however, not solve the puzzle, since judgments of internal mental processes are not necessarily highly reliable (Nisbett & Wilson, 1977). More systematic and rigorous qualitative research strategies are available (e.g., Elliott, 2008; Stiles, in press), but there are still few systematic, qualitative studies of therapeutic change mechanisms. More studies are needed within this challenging area before we can decide upon the respective values of different research strategies.

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THE AARHUS CLIENTS AND THEIR TREATMENT

The Aarhus clients were screened from their letters of application. Overall, about 20-25% of the applicants have been rejected based on information in the letter for a variety of reasons—because they had a high degree of psychiatric problems; because they did not seem to suffer from an anxiety disorder; because they stated that they had OCD for which there is a specialized clinic at the psychiatric hospital; or because they already were in psychotherapy elsewhere. Very few clients invited for an assessment interview have been denied treatment at the clinic, and we accept clients with comorbid mild-moderate depression, "cluster C" personality disorders (e.g., avoidant personality), and sometimes also mild Cluster B (e.g., borderline personality disorder). We also accept clients with sub-clinical problems, sometimes for very short, psychoeducational individual courses (3-5 sessions). Until now, Laila from our case study (Hougaard et al., 2008)has been the only client in the intensive social phobia group-treatment program with no formal diagnosis of social phobia. Ordinarily, a client like her would have been offered individual therapy. She was, however, judged to be able to profit from the group program, where there were empty places. Initially, she also had some positive changes after group treatment, although they were not durable. However, she remained highly satisfied with her treatment.

The high degree of personality disorder involvement in the problems of Mona from our case study (Hougaard et al., 2008) were not immediately obvious in the diagnostic assessment interview, where we generally decide on treatment. The clients are asked in the assessment interview to complete self-report scales at home and to deliver them at their second appointment, so that the SCID-II measure of personality disorder did not influence our decision. It is, however, not unusual for clients to score high on the SCID-II, and yet to profit from treatment. At present, we consider it premature to make a general rule of not accepting clients with a SCID-II self-report score above a certain limit.

Transparency of treatment conditions and informed consent, are, of course, important for all psychotherapy clients. We inform our clients about the treatment conditions, including the facts that most of the treatment is carried out by student therapists under supervision, and that there are other treatment facilities in the area. This information is stated on the website, in the letter informing the client that he or she is on the waiting list (with instructions on how they could be referred to the anxiety clinic at the psychiatric hospital), and in the assessment interview, where treatment possibilities are discussed with the client. The clients do not, however, sign a formal contract, which is only required in Denmark for research purposes that interfere with ordinary clinical practice.

It is the general impression of the supervisors that the clients in our Psychology Department's Anxiety Clinic at the university are "simpler cases" than in the anxiety clinic at the local psychiatric hospital, as they should be. However, as can be seen from the case vignettes of the 9 clients in our study (Hougaard et al., 2008), many of the clients were rather severely disturbed with longstanding problems. The ethical dilemma of offering severely disturbed clients treatment by inexperienced therapists should be considered in light of the fact that the alternative most often would be no treatment. Many clients with anxiety disorders resist treatment at a psychiatric institution, and, if they do accept, there is a rather long waiting list (presently about

one year for social phobia). Until recently, there has been no insurance coverage of psychological treatment for anxiety or depression in Denmark (except in cases where individuals have suffered specified traumatic events, in which instance the clients can have up to 12 sessions of "crisis intervention"). In 2008, it was decided that the national health insurance should cover 60% of the expenses of up to 12 sessions of psychological treatment in private practice for mild to moderately depressed clients. A similar arrangement for anxiety disorders has just now been agreed upon starting in 2010. Twenty million crowns (about 4 million dollars) a year have been budgeted for depression, and 25 million for anxiety—most certainly insufficient amounts. According to calculations by the London School of Economics (2006), transposed to a Danish context with about 5 million inhabitants, about 300-400 million crowns are necessary to meet the needs for CBT for depression and anxiety. Thus, the scarcity of psychological treatment facilities for anxiety-disordered clients in Denmark is expected to endure in the near future.

It is, of course, important to strengthen the morale of novice student therapists by letting them experience successes with their clients. Including only mildly disturbed clients would, however, give the students a misleading impression of psychotherapy, and probably also hinder learning of more advanced therapeutic skills. Since the students' first clients join the group program, the students share the responsibility for these clients' outcomes with the experienced psychologists—that is, the burden of therapeutic failure is not on their shoulders alone. Generally, we succeed in cultivating a cohesive and supportive culture in the supervision groups, with a high degree of shared responsibility for the clients and emotional support for each other in case of personal problems or doubts about therapeutic abilities. We try to arrange our assignments so that all students have at least one successfully treated case, an objective that is achieved in almost all instances, including all the students in the present case study. For example, in the present study, the student therapist of Mona, who showed little change and prematurely dropped out, was also the therapist of Niels, probably the most successfully treated client in the study. The student who treated Cecilia, who showed no change, also treated Vera, who was judged "very much improved." Such experiences with differential outcomes achieved by the same therapist help in convincing students that therapeutic results to a large degree depend on the clients—a lesson they repeatedly are told in preparation for and during the program.

We encourage students to take a special interest in the less successful cases, which we, in line with Huppert et al. (2008), consider more clinically and scientifically informative than standard cases responding to standard therapeutic strategies. Although students generally consider it a tough and challenging experience to work with non-responding clients, many have afterwards considered it an important lesson. Several of our students have chosen to write their case-study report about their less successful client, as did the student who treated Laila and found this experience most touching and fascinating. A more detailed study of treatment failures is planned in the future.

Effect sizes do, of course, profit from large and homogeneous pre-treatment scores, and excluding clients with low scores should thus enhance the results, to the benefit of both therapists and researchers. Cecilia in the present study (Hougaard et al., 2008), who is mentioned by Huppert et al (2008) as an example of a probably easy-to-treat client with low social phobia pre-treatment scores, was clearly distressed and disabled in her academic studies by her

circumscribed social phobia. Since she mentioned oral presentations as her main problem, she was judged a good candidate for group treatment where it is easy to arrange behavioral experiments with oral presentations. However, it turned out that she did not profit from her presentation tasks because of her high internal standards. Ordinarily, we would have recommended further individual therapy for Cecilia, but she had to stop treatment because of the upcoming delivery of her baby. Despite her low scores on the self-report scales, she was probably not an easy-to-treat client due to her high degree of perfectionism.

The question of how many sessions to conduct, or when to end treatment, is of course an important one. Generally, we strive to achieve high end-state functioning and attainment of initial goals for clients, ordinarily discussed with them in the 2nd or 3rd therapy session, within the time limits of the 2-semester program (for very few clients we have extended the treatment period beyond the end of the program). Ordinarily, we arrange treatment length in blocks of 5- or 10-sessions (10 sessions for most cases who start with individual therapy), with the possibility of extension (typically 5 sessions) if the client is in need of further therapy. We have experienced relatively few problems with ending treatment, maybe due to explicit time frames communicated to the clients in the assessment interview, and later in the event of treatment extension. Clients in more extended individual therapy know from the start that treatment has to stop when the training program stops with the end of the year. Students are advised to always explore possible problems with stopping, several sessions before treatment ends.

THE TRAINEES AND THEIR LEARNING CONTEXT

The students in our program are in the 8th semester (4th year) or later of their study. Before entering the program they have had theoretical courses in psychopathology, psychological assessment, and different forms of psychotherapy for different disorders, and a training course on counselling skills. Our Clinic does not specifically select students for the program by specific procedures. Rather, we leave it up to the psychology training program's administration to make the selection according to general rules of assignment to courses (there are many more applicants for our anxiety clinic than places). Although students differ in their therapeutic skills, we have until now had no decisive failures in therapeutic functioning among our trainees. All students enrolled in the course have completed it, except for one, who experienced a depressive episode prior to the client intake.

Very early in the first semester of the course we arrange two 2-day courses with a focus on role-play exercises involving assessment, case-formulation, and CBT techniques. In small groups of four students they in turn function as interviewer/therapist, client, and observer/supervisor with video-recordings of the interactions, which are, in some cases, played back before the whole group (an exposure exercise for the students!). The students' worries about their upcoming therapist role are employed as the target of cognitive restructuring in one of the exercises. Videotapes of this exercise are then supervised in the whole group—an excellent exercise according to the students' feedback. To educate the students about the process of CBT, they are introduced to Young and Beck's (1980) "Cognitive Therapy Rating Scale" in an exercise involving rating a videotaped psychotherapy session with the scale, along with a discussion of their ratings. The students are encouraged—and later reminded—to use the scale

on their own video-recordings of their therapy sessions. Rather early in the first semester we then start to include clients, and the intensive group-week takes place round the 1st of May (about 3 months after the semester starts), leaving time for both prior individual sessions and for the following 6 weekly group therapy sessions before the semester closes down for summer holiday on the 1st of July.

The supervision does, of course, focus on both technical matters and on relationship issues, and on possible obstacles to therapeutic progress (including the student-therapists' personal problems). Generally, supervision in the first semester mostly focuses on simple technical matters (what to do in the next session). In the second semester (where all students have at least one client in individual therapy, often with another disorder than their first client), the supervision deals more with students´ personal therapeutic styles, personal reactions to events in therapy, client and relationship-related obstacles and, for some clients, therapeutic strategies aimed at personality change, i.e., schema-focused therapy. In line with the Beck tradition (Beck, Rush, Shaw & Emery, 1979), schema-focused therapy is used as a later, optional phase of treatment after a symptom-focused first phase. Most students work with relatively simple CBT schema-focused strategies, e.g., helping clients to consider their problems in light of their personal history, cognitive restructuring of dysfunctional attitudes, and assertiveness training. Only in a few cases are more complex strategies included in the therapy, such as processing childhood traumas, working with images from the past and with dialogues, or helping clients to gain insight from alliance ruptures (Young, Klosko, & Weishaar, 2003). The program primarily aims at teaching students basic symptom-focused skills of CBT for anxiety disorders, not the much more complex skills needed for schema-therapy for personality disorders.

The 30 minutes of daily reflection at the end of each day in the intensive group-week is not a very fixed schedule, but the amount of time we have experienced as a useful average (originally, we had scheduled one whole hour). We also sometimes use lunch or coffee breaks for reflections, if needed. The therapy in the group is highly psychoeducational, explicitly explaining to clients the reasons for interventions, thus making the purpose of the procedures rather transparent for both clients and observing students.

The manual (Hougaard, 2006) we use for both therapists and clients generally focuses on therapeutic principles rather than step-by-step procedures for specific disorders, although a step-by-step program is suggested for both social phobia and panic disorder. In line with Barlow, Allen & Choate (2004), we consider it more useful for clinicians to learn to apply broader therapeutic principles, rather than to follow step-by-step manuals for specific disorders. Accordingly, we underline that treatment is generally best delivered from a "mix-and-match" perspective, using strategies from several manuals, based on the client's case-formulation (Persons, 2005). As Huppert et al. (2008) mention, the client often does not fit the manual, and in this situation we advise the students to "follow the client," unless the mismatch is due to obstacles that can be removed.

Although the students in our program generally do well, we do not consider them ready for independent therapeutic work after their training course, or once they graduate with a master's degree after 5 years of study. There are still rather few clinical psychologists in

Denmark with a Ph.D. degree, although the number of Ph.D. students is growing. In the Danish context, psychologists can achieve certification as a clinical psychologist after two years' of postgraduate, supervised work, and many thereafter specialize in psychotherapy (or in other fields of clinical psychology) in a further, 3-year educational and training course.

DIFFERENCES BETWEEN THE TRAINING PROGRAMS

It was interesting to learn about the educational CBT program at the Hebrew University of Jerusalem, and to consider both the similarities and differences in relation to our Aarhus program. The most impressive aspect of the Jerusalem program, from my point of view, is its focus on mechanisms of change based on specific research questions and stringent strategies of quantitative, single-case research. The Aarhus program primarily focuses on clinical training and experience with the aim that the students achieve basic therapeutic skills and a concrete, clinically and scientifically based understanding of anxiety disorders and their treatment. Research thus seems to be given higher priority in the Jerusalem program. The students in the Aarhus program may, on the other hand, have more varied clinical experiences with different clients, disorders, therapist styles, therapeutic tasks, and problems in therapy. It is reassuring to know that both programs achieve a high degree of satisfaction among their students.

Another major difference between the programs is the reliance on group versus individual formats in treatment as well as in supervision. As mentioned above, the relationship between group and individual therapy is not well researched for social phobia—or for any of the anxiety disorders. In our experience, the intensive group-week is, primarily, an excellent training tool with a highly compressed, *in vivo* demonstration of experienced therapists dealing with many different problems early in the program. It also seems to help in facilitating group cohesiveness among the students, and in their development into "real" therapists by gradually letting them take over responsibility for treatment. The students are at first rather anxious about administering the exercises in the intensive group-week, but in 3 of the 4 courses we have completed so far, the students have themselves (at their own suggestion) been in charge of the large group behavioral experiments at day 4 in the week, without the presence of the supervisors.

We are quite fond of group supervision, which, with a rather small amount of supervisor resources, allows students to learn from many different clients, and from their fellow students' functioning as therapists. With the high degree of group cohesion among the students in the program (and among them and the supervisors), it is possible for the students to accept (softly formulated) critical feedback on their performance in the group (it is always possible for students to have individual consultations). It is, of course, plausible that the much more intensive individual supervision with supervisors' prior viewing of videotaped sessions—as offered in the Jerusalem program—could result in a better grasp of the therapeutic strategies and techniques among the trainees. The faculty resources available in our anxiety clinic would not, however, allow for such time-consuming supervision.

Some differences between the two programs might be due to the fact that our present case study deals with social phobia, while the Jerusalem program deals with panic disorder, where there is generally less personality involvement. Most clients in the panic disorder section of our

program are not in need of further therapy after the intensive group-week, or they receive only a few individual sessions (2-5). In individual therapy most clients with uncomplicated panic disorder are successfully treated within 10 sessions.

Some minor changes in our program have narrowed the gap with the Jerusalem program. Thus, we now allow students in their second semester of the program to administer the Anxiety Disorder Interview Schedule for DSM-IV (ADIS-IV; Brown, DiNardo, & Barlow, 1994) on their own, with supervision based on their videotapes of the administration. Starting this year we have cancelled the 6 weekly group treatment sessions following the intensive group-week and replaced them with individual therapy for clients in need of further therapy (we have never used this part of the program for panic-disordered clients). The weekly group therapy was, in our experience, a valuable pedagogical means for students to learn therapeutic skills in close collaboration with their fellow students, and for building up team spirit. However, there were problems with client attendance, partly do to time-scheduling issues, and some clients did not need further therapy after the intensive group-week. Cancelling the weekly group therapy is an example of sacrificing educationally valuable components of the treatment program for the students in exchange for clinical benefits for the clients.

CONCLUDING COMMENTS

Like most of the students in our Aarhus program, I also found this experience of my first attempt to write a case study following the guidelines of *Pragmatic Case Studies in Psychotherapy* challenging and time-consuming, but at the same time absorbing and fascinating. The complexity of the project only gradually became clear to me during the process, and it is further clarified now after its completion by the keen commentaries by Edwards (2008) and Huppert et al. (2008)—as are the many implicit assumptions we had taken for granted in writing our case study. Thus my experience with writing the case study reflects some of the problems inherent in clinical reasoning, and therefore indirectly supports the value of one of the objectives of *Pragmatic Case Studies in Psychotherapy* (Fishman, 2005)—to develop a database of systematic, clearly articulated, and methodologically sound case studies as a resource for helping clinicians to use empirically informed and scientifically disciplined reasoning in their clinical practice.

REFERENCES

American Psychological Association (2006). American Psychological Association Presidential
        Task Force on Evidence-based Practice: Evidence-based practice in psychology.
        *American Psychologist, 61,*271-285.
Bandura, A. (1977). Self-efficacy: Towards a unifying theory of behavioral change.
        Psychological Review, 84, 191-215.
Barlow, D.H., Allen, L.B. & Choate, M.L. (2004). Toward a unified treatment for emotional
        disorders. *Behavior Therapy, 35*, 205-230.
Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive therapy of depression*. New
        York: Guilford Press.

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Brown, T.A., Di Nardo, P.A. & Barlow, D.A. (1994). *Anxiety Disorder Interview Schedule for DSM-IV: Adult version.* New York: Graywind Publication.

Casey, L.M., Oei, T.P.S. & Newcombe, P.A. (2004). An integrated model of panic disorder: The role of positive and negative cognitions. *Clinical Psychology Review, 24*, 529-555.

Christensen, A. & Jacobson, N.S. (1994). Who (or what) can do psychotherapy: The status and challenge of nonprofessional therapists. *Psychological Science, 5*, 8-14.

Clark, D.M. (2004). Developing new treatments: On the interplay between theories, experimental science and clinical innovation. *Behaviour Research and Therapy, 42*, 1089-1104.

Clark, D.M., Ehlers, A., Hackmann, A., McManus, R., Fennell, M., Grey, N., Waddington, L. & Wild, J. (2006). Cognitive therapy versus exposure and applied relaxation in social phobia: A randomized trial. *Journal of Consulting and Clinical Psychology, 74*, 568-578.

Clark, D.M. & Wells, A. (1995). A cognitive model of social phobia. In: R.G. Heimberg, M.R. Liebowitz, D.A. Hope & F.R. Scheier (eds.), *Social phobia: Diagnosis, assessment, and treatment*. New York: Guilford.

Craske, M.G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N. & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour Research and Therapy, 46*, 5-27.

Edwards, D. (2008). Handling multiple levels of data and multiple research questions in an embedded case study: Methodological challenges. *Pragmatic Case Studies in Psychotherapy*, [Online], *Vol. 4*(4), Article 2, 53-65. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Edwards, D.J.A., Dattillio, F.M. & Bromley, D.B. (2004). Developing evidence-based practice: The role of case-based research. *Professional Psychology: Research and Practice, 35*, 589-597.

Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research, 18,* 239-242.

Elliott, R. & Shapiro, D.A. (1992). Client and therapist as analysts of significant events. In: S. G. Toukmanian & D.L. Rennie (eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 163-187). London: Sage.

Fedoroff, I.C. & Taylor, S. (2001). Psychological and pharmacological treatments of social phobia: A meta-analysis. *Journal of Clinical Psychopharmacology, 21*, 311-324.

Fishman, D. B. (2005). Editor's introduction to PCSP - From single case to database: A new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy* [Online], *Vol. 1*(1), Article 2, 1-50. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal.

Foa, E.B. & Kozak, M.J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20-35.

Garb, H.N. (1989). Clinical judgment, clinical training, and professional experience. *Psychological Bulletin, 105*, 387-396.

Gross, J.J. (ed.) (2007). *Handbook of emotion regulation*. New York: Guilford..

Hofmann, S.G. & Smits, J.A.J. (2008). Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomized placebo-controlled trials. *Journal of Clinical Psychiatry, 69,* 621-632.

Hougaard, E. (2006). *Kognitiv behandling af panikangst og socialfobi: En vejledning for klienter og behandlere* (Cognitive behavioral treatment for panic disorder and social phobia: A guideline for clients and therapists). København: Dansk Psykologisk Forlag.

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Hougaard, E., Madsen, S.S., Hansen, L.M., Jensen, M., Katborg, G.S., Morsaa, L., Pedersen, M. Pedersen, S.M. & Piet, J. (2008). A Novel Group Therapeutic Format in Cognitive Behavioral Treatment for Clients with Social Phobia in a Training Setting: A Case Study of One Treatment Group with Nine Clients. *Pragmatic Case Studies in Psychotherapy* [Online], *Vol. 4*(4), Article 1, 1-52. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Huppert, J.D., Carmeli, G. & Gilon, D. (2008). When novice therapists meet heir first patients: Reflections and questions on training in CBT. *Pragmatic Case Studies in Psychotherapy*, [Online], *Vol. 4*(4), Article 3, 66-75. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Hyman, S.E. (2000). The millennium of mind, brain, and behavior. *Archives of General Psychiatry, 57*, 88-89.

Kazdin, A.E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annual Review of Clinical Psychology, 3*, 1-27.

LeDoux, J. E. (1996). *The emotional brain: The mysteriously underpinnings of emotional life.* New York: Simon & Schuster.

Lincoln, T.M., Rief, W., Hahlweg, K. & Frank, M. (2003). Effectiveness of an empirically supported treatment for social phobia in the field. *Behaviour Research and Therapy, 41*, 1251-1269.

London School of Economics. (2006). *The depression report: A new deal for depression and anxiety disorders.* London: the Centre for Economic Performance's Mental Health Policy Group.

Longmore, R.J. & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behaviour therapy? *Clinical Psychology Review, 27*, 173-187.

Malan, D.H. (1979). *Individual psychotherapy and the science of psychodynamics.* London: Butterworths.

Mattick, R.P. & Clarke, J.C. (1998). Development and validation of measures of social phobia, scrutiny fear and social interaction anxiety. *Behavior Research and Therapy, 36*, 455-470.

Meehl, P.E. (1954). *Clinical versus statistical prediction.* Minneapolis: University of Minnesota Press.

Moncrieff, J. (1998). Reseach synthesis: Systematic reviews and meta-analysis. *International Review of Psychiatry, 10,* 304-311.

Mörtberg, E, Clark, D.M., Sundin, Ö., Wisted, A. & Åberg, A. (2006). Intensive group cognitive treatment and individual cognitive therapy vs. treatment as usual in social phobia: A randomized controlled study. *Acta Psychiatrica Scandinavica, 115*, 142-154.

Nisbett, R. & Wilson, T.D. (1977). Telling more than we can know: Verbal reports on mental processes. *Psychological Review, 84*, 231-259.

Norton, P. J., & Price, E. C. (2007). A meta-analytic review of adult cognitive-behavioral treatment outcome across the anxiety disorders. *Journal of Nervous and Mental Disease, 195*(6), 521-531.

Persons, J.B. (2005). Empiricism, mechanism, and the practice of cognitive-behavior therapy. *Behavior Therapy, 37*, 107-118.

Prentzas, J. & Hatzilygeroudis, I. (2007). Categorizing approaches combining rule-based and case-based reasoning. *Expert Systems, 24*, 97-121,

Rice, L.N. & Greenberg, L.S. (eds.) (1984). *Patterns of change: Intensive analysis of psychotherapy process*. New York: Guilford Press.

Sackett, D.L., Straus, S.E., Richardson, W.S., Rosenberg, W. & Hayness, R.B. (2001). *Evidence-based medicine: How to practice and teach EBM*. London: Churchill Livingstone.

Scholling, A. & Emmelkamp, P.M.G. (1993). Exposure with and without cognitive therapy for generalized social phobia: Effects of individual and group treatment. *Behaviour Research and Therapy, 41*, 991-1007.

Schön, D.A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.

Stangier, U., Heidenreich, T., Peitz, M., Lauterbach, W. & Clark, D.M. (2003). Cognitive therapy for social phobia: Individual versus group treatment. *Behavior Research and Therapy, 41*, 991-1007.

Stiles, W.B. (in press). Logical operations in theory-building case studies. *Pragmatic Case Studies in Psychotherapy* [Online], xx

Talman, K. & Bohart, A.C. (1999). The client as a common factor: Clients as self-healers. In: M.A. Hubble, S.D. Miller & B.L. Duncan (eds.), *The heart and soul of change: What works in therapy* (pp. 91-131). New York: American Psychological Association.

Tang, T.Z. & DeRubeis, R.J. (1999). Sudden gains and critical sessions in cognitive-behavioral therapy for depression. *Journal of Consulting and Clinical Psychology, 67*, 894-904.

Taube-Schiff, M., Suvak, M.K., Antony, M.M., Bieling, P.J. & McCabe, R.E. (2007). Group cohesion in cognitive-behavioral group therapy for social phobia. *Behaviour Research and Therapy, 45*, 687-698.

Wampold, B.E. & Brown, G.S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73*, 914-923.

Watson, J.C., Goldman, R.N., & Greenberg, L.S. (2007). *Case studies in emotion-focused treatment of depression: A comparison of good and poor outcome.* Washington, DC, US: American Psychological Association.

Yalom, I.D. (1975/1995). *The theory and practice og group psychotherapy* (5th ed. 1995). New York: Basic Books.

Young, J. & Beck, A.T. (1980). *Cognitive Therapy Rating Scale (Revised draft).* University of Pennsylvania (www.academyofct.org).

Young, J.E., Klosko, J.S. & Weishaar, M.E. (2003). *Schema therapy: A practitioner's guide.* New York, NY: Guilford.

Table 1. Benchmarking with individual CBT in studies by Clark et al. (2003; 2006)

Assessment	Stangier et al. (2003) ($n = 20$) Mean (Standard Deviation)	Clark et al. (2006) ($n = 21$) Mean (Standard Deviation)	Hougaard et al. (2008) – all clients ($n = 8$) Mean (Standard Deviation)	Hougaard et al. (2008) – "clinical cases" ($n = 6$) Mean (Standard Deviation)
SPS				
Pretreatment	30.2 (14.8)	29.9 (13,5)	39.0 (16.8)	44.2 (15.1)
Posttreatment	10.9 (11.3)	9.0 (6.0)	24.5 (14.5)	27.0 (16.4)
Difference	19.3	20.9	14.5	16.8
ES (95% CL)	1.47 (.86 – 2.08)*	1.41 (.76 – 2.06)*	.95 (.40 - 1.50)	1.09 (.42 – 1.76)
SIAS				
Pretreatment	48.3 (12.3)	43.6 (17.8)	40.9 (18.5)	48.8 (12.5)
Posttreatment	24.5 (13.8)	18.2 (10.0)	26.0 (13.4)	28.0 (14.4)
Difference	23.8	25.4	14.9	20.8
ES (95% CL)	1.90 (1.39 - 2.51)*	1.76 (1.11 - 2.41)*	.92 (.28 – 1.55)	1.55 (1.05 – 2.05)

SPS: Social Phobia Scale
SIAS: Social Interaction Anxiety Scale
ES: Effect Size (Cohen's *d)*
CL: confidence limits
* estimated from the formula: 95% CL = SD +/- 1.96 x $[(n_1 + n_2) / (n_1 \times n_{2)})]^{1/2}$ (Moncrieff, 1998).