AMERICAN UNIVERSITY OF BEIRUT

THE INFLUENCE OF PARENTIFICATION, CHRONIC ABUSE, AND ALIENATION ON IDENTITY AND DEPRESSION: A CASE STUDY USING EXISTENTIAL ANALYSIS

by
JENNIFER ANTOINE ALHAROUNY

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JENNIFER ANTOINE ALHAROUNY

Approved by:

___

Dr. Sarine Agopian, Assistant Professor — Advisor
Department of Psychology

___

Dr. Tania Bosqui, Assistant Professor — Member of Committee
Department of Psychology

___

Dr. Mona Ayoub, Assistant Professor — Member of Committee
Department of Psychology

___

Dr. Jennifer Fisher, Lecturer — Member of Committee
Department of Psychology

Date of thesis defense: October 24, 2025

ABSTRACT
OF THE THESIS OF

Jennifer Antoine Alharouny for Master of Arts
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Title: The Influence of Parentification, Chronic Abuse, and Alienation on Identity and Depression: A Case Study Using Existential Analysis

This thesis explores the psychological influences of parentification, chronic abuse, and alienation in a case study of one adult participant living with depression and identity struggles. The research addresses a gap in understanding how individuals experience depression in the context of parentification, chronic abuse, and alienation through an existential framework. This case study thus aimed to explore the lived experience of one participant with depression and identity, uncovering subjective meanings and informing clinical practice through an existential lens.

Using a qualitative case study approach, data was collected from session transcripts, clinical session notes, and reflective journals throughout my work with this participant as a clinical psychologist in training at an approved training site over the course of 5 months. The data was analyzed using MAXQDA 2024 and Merriam and Tisdell's 5 step approach to qualitative analysis.

Findings showed main themes of lack of security, identity disruption and reconnection, interpersonal needs and ruptures, and therapeutic processes and change.

As such, the participant's experience of parentification, chronic abuse, and alienation have led to her lived experience of depression according to the major themes of identity disruption and relational needs and ruptures.

Keywords: parentification, chronic abuse, alienation, identity, depression, existential analysis, fundamental motivations, security, authenticity

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CHAPTER 1

INTRODUCTION

Parentification has been noted as a significant contributor to long-term distress, including challenges in identity formation and mental health struggles (Shamsaee et al., 2024). Individuals who grow up parentified often face challenges forming their own sense of self given that they had to fit into a specific role in their family system, thus depriving them of the freedom to discover their true selves (Hajjar, 2018). Later in life, such conflicts with identity may become more salient through psychological difficulties, including depression, feelings of emptiness, and challenges in interpersonal relationship dynamics (Cho & Lee, 2018). The case study at hand will explore the influence of parentification on identity formation and presentation of depression in adulthood, as well as how existential analysis may address the different layers of this presentation and its history.

There exists a plethora of research targeting the relationship between parentification and mental health difficulties; however, not as many studies exist that tackle the influence of parentification on identity formation – the process whereby an individual forms an independent and solid sense of self apart from the roles they occupy in a group or family system (Bogaerts et al., 2018). Moreover, alienation from family, culture, or society may also aggravate struggles with identity and depression, thus thwarting one's capacity to connect with their innermost self (Chen et al., 2022). As such, various existential anxieties and concerns may result from such early experiences occupying a parent-like role (Chirico et al., 2023) and may benefit from an existential analysis perspective. The case at hand presents an individual who was parentified during

childhood, experienced chronic abuse for most of her life, and currently suffers from depression and loss of meaning in life. Thus, this case study aims to understand such difficulties through the application of an existential conceptualization and treatment, as will be elaborated in later sections.

This study is noteworthy as it offers a distinctive understanding of the intersection between how early and maintained parentification in adulthood as well as chronic abuse and alienation contribute to struggles with identity and depression. The following review of the existing literature tackles this intersection and explores the existing gaps that the case study aims to address.

CHAPTER 2

LITERATURE REVIEW

2.1 Conceptualizing Parentification

Parentification is a process whereby children or younger individuals take on the role of adults, mainly parents, including their caretaking responsibilities (Dariotis et al., 2023). In the literature, classical models of parentification often classify the phenomenon into emotional and instrumental types; emotional parentification requires the child to manage the emotional needs of the family, including possibly being a peacemaker or containing distress for one or more member (Dariotis et al., 2023). Instrumental parentification, on the other hand, requires the child to take on more practical tasks to maintain the household, such as managing finances or completing chores (Dariotis et al., 2023). As such, the child may assume either or both types of parentification. Additionally, the literature may also differentiate between different role-based parentification, whereby the child takes on the role of the parent to either care for their parent or siblings or to become a spouse for one of their parents (Dariotis et al., 2023). Usually, parentification results from a conscious or unconscious neglect of parental responsibilities, resulting from a variety of factors that may include parental physical or mental illness, parental loss, external crises, or generally dysfunctional family dynamics (Dariotis et al., 2023).

Various family systems theories, including that of Minuchin (1967), stipulate that the family typically involves a hierarchy with clear and defined roles that match each member's capacities and responsibilities. The absence of that may disrupt the family dynamics and bring more distress into the family. As such, parentification alters the typical family structure, diffuses boundaries, and leads children to take on roles and

responsibilities that do not meet their developmental, mental, and emotional capacities (Dariotis et al., 2023). Hooper et al. (2012) found that parentified children experience higher levels of distress than non-parentified counterparts. More specifically, such parentified children will likely face emotional exhaustion and heightened rates of depression, anxiety, and stress. More often than not, these children are also not met with the support needed to manage the distress that results from parentification, thus exacerbating their distress. Aside from the psychological distress they may face, parentified children have also been found to be more likely to experience difficulties in future interpersonal relationships (Burton et al., 2000). However, several studies have also reported that parentification may increase empathy and resilience (Van der Mijl, 2017), augment competence and self-efficacy (Borchet et al., 2021; Dariotis et al., 2023), and foster independence (Dariotis et al., 2023). As such, the literature affirms that the findings on the effects of parentification on the child's psyche and well-being are not conclusive and are instead largely affected by the extent of their responsibilities, the presence of a supportive system, and other factors such as child temperament, cultural factors, and family dynamics. Taken together, these considerations may affect the child's experience of parentification differently.

As for in existential theories and existential analysis, the concept of "parentification" is not as explicitly addressed or elaborated on. However, the experiential underpinnings and consequences of parentification that have been noted in other theories (systemic family therapy, trauma-informed therapy) link very closely to Alfried Langle's four fundamental motivations for existence (Längle, 2003; 2005) which will further be elaborated on throughout this study. Existential analysis addresses the client's lived experience of having roles reversed in the family, losing a sense of safety, experiencing

conditional self-value, and resulting struggles with finding authentic meaning in life as they have occupied a role outside of their true self (Längle, 2012).

2.2 Parentification and Identity Struggles

Family dynamics have long been an interesting area of research when studying human traits, behavior, beliefs, and more, leading to an abundance of literature that explores how families can leave an impact on its members in more ways than one. In a correlational self-report study, Zhou et al. (2023) particularly note that psychological capital in the family largely and positively influences adolescents' identity formation; factors such as hierarchical structure, levels of warmth, and intimacy may empower and support the young, strengthening their sense of self. Additionally, maladaptive family dynamics including hostility, lack of coherence between parents during upbringing, and non-directive parenting may create an environment where the child or adolescent is unable to truly express themselves and create an identity of their own (Yablonska, 2013). In cases where childhood trauma is a factor, children are more likely to be enmeshed with either of their parents, thus feeling indispensable from them and fusing their own emotions with that of their parents and blurring the boundaries between the two parties, as shown in a mediation model applied on self-reports from university students (Baroncelli et al., 2025). Consequently, enmeshed children may find it much more difficult to differentiate themselves from their parents and discover who they are away from them and the role they play in such a dynamic (Baroncelli et al., 2025). More specifically, parentification also contributes to a disrupted identity formation and development. This was suggested in a qualitative study assessing the well-being of parentified girls in single-parent households, despite findings that suggested a positive

impact of parentification on emotional maturity (Shamsaee et al., 2024). Implications of parentification on attachment styles have also been identified (Engelhardt, 2012), with insecure attachment styles being more likely to struggle with their identity in the future.

Parentification can have effects that persist into a person's adulthood and mid-life. Individuals who have experienced parentification in their youth may not only face difficulty in establishing their self-concept and identity, but also in maintaining their self-esteem well into adulthood (Dariotis et al., 2023). Consequently, parentified children are more likely than their non-parentified counterparts to develop depression later in life (Schier et al., 2014). Studies also denote that adults with a history of parentification may struggle with autonomy and competence, especially in romantic relationships in adulthood (Tolmacz et al., 2024). Relevant to this case study is also a finding that draws strong links between parental depression, parentification, and role or identity confusion; children with depressed parents have been found to be confused about the role they play in the family dynamics, thus influencing their view and understanding of their identity and affecting various areas across their life (DiMarzio et al., 2021).

From an existential perspective, identity is viewed as an emerging phenomenon over the course of an individual's life (Längle, 2012), affected by various concepts such as freedom, authenticity, and more. According to existential analysis, the emerging identity is rather rooted in Langle's four fundamental motivations; the ability to have space and protection, to engage with life and feel, to find self-value, and to have meaning and direction (Längle, 2012). Once such motivations are met, one's personhood can truly be grounded (Längle, 2012). Therefore, a parentified individual may naturally face some struggles finding their true, grounded, sense of self as parentification violates at least one of the aforementioned fundamental motivations. A parentified child, as mentioned in

prior sections, may learn to overshadow their authentic self to occupy this role they have been given, thus stunting the process of their own identity emergence. Therefore, and although explicit links between parentification and identity formation are not made in existential analysis, such conclusions may be hypothesized based on the grounds of the 4 FMs and the way this theory views identity as a continual process.

2.3 The Role of Alienation and Disrupted Belongingness in Identity Development

A sense of belonging and connection to social groups is considered a primary human need that predicts various outcomes of mental and physical health (Allen et al., 2021). It is first important to recognize that alienation can occur in a variety of settings and groups, and although the existing literature defines alienation differently according to different theoretical backgrounds and contexts, it mainly is an umbrella term that denotes a form of detachment or disrupted belongingness from a group (Safipour et al., 2011). In light of the aforementioned phenomenon of parentification, children who grow up with a parent-like role have been found to feel more isolated from others in their surroundings; they often disavow their own needs and shift their focus to this role they are taking, thus hindering their ability to connect with those around them, even within their own household (Chojnacka, 2020). As such, alienation and parentification can often happen simultaneously due to the practical and emotional tolls this role takes on the child.

As will be elaborated throughout the study, the client struggles with connection and authenticity, partially due to her bicultural identity, feeling like she does not belong in either culture and experiencing both a physical and interpersonal distance from the people in her life. Individuals with a bicultural identity may experience alienation, too, as they might struggle with conflicting cultural norms, feeling “othered”, as well as

confusion about their identity and belongingness (Schwartz & Unger, 2010). Schwartz et al. (2019) also note that bicultural identity integration (BII) may fluctuate according to perceived cultural conflict; when such conflict takes place, individuals are more prone to feelings of alienation and decreased self-esteem. Language has also been identified as one of the factors that may trigger this conflict between the different cultural frameworks, thus leading to changes in self-perception for individuals who may try to resolve their two identities but still feel alienated (Purpuri et al., 2024).

Profound psychological effects may result from this feeling of alienation or thwarted belongingness, regardless of context; constant social exclusion may lead to serious feelings of loneliness and social isolation which, in turn, yield different cognitive and effective repercussions (Lee et al., 2024). Even among older adults in midlife, both objective social isolation as well as perceived loneliness are heavily linked to cognitive decline and an increased occurrence of depression symptoms (Necka et al., 2020). A tangible example of this sequence was observed during the COVID-19 pandemic, during which individuals were socially isolated from one another; the lack of social connection, support, and belongingness during that period of time left many feeling detached, numb, anxious, and depressed (Robb et al., 2020). Allen et al. (2021) note in their narrative review that the sense of self develops within the social, cultural, even environmental and geographical frameworks of existence, and that such frameworks can either defy or support one's sense of belonging. When belonging is threatened, self-concept concerns may arise, which eventually lead to identity issues in adulthood (Allen et al., 2021).

Existential analysis also defines alienation as a form of estrangement; estrangement from the self, from the other, or even from the world (Längle, 2003; 2011), and that is the definition that will be adopted throughout this study. Längle stipulates that

this sense of estrangement or alienation is a result of one or more unmet existential needs such as vitality, safety, self-value, and meaning. Therefore, if a person is physically away from their safe space, unable to live life authentically, struggle with acknowledging their self-worth, and find life meaningless for a variety of reasons, they are likely to feel estranged from their authentic self, from the people around them, and from life itself (Längle, 2011). In the context of parentification, as previously mentioned, this alienation may manifest due to the child's disrupted experience of safety in the household, the absence of their authentic self, the conditional appreciation and love they may receive, and the lack of access to genuine and supportive relationships. Consequently, the child becomes foreign to themselves, others, and the world around them, as what they do comes from the role they have adopted to feel accepted rather than their own free choice to simply be.

2.4 The Wide Influence of Chronic Abuse

Chronic abuse signifies recurrent and sustained incidents of any form of maltreatment, be it physical, emotional, verbal, or sexual (Fuller-Thomson et al., 2016; Lagdon et al., 2022). It is different from singular instances of abuse in that they are continuous and prolonged, leading to various negative mental health detriments such as depression symptoms, suicidal ideation, and poor emotional regulation and self-esteem (Ashraf et al., 2023). Chronic abuse and parentification often occur simultaneously in various households, whereby the child takes on responsibilities that the parents are either unable or unwilling to carry out, as seen in a two-factor model tested by Hooper et al. (2012). Such a household dynamic is not only burdensome for the child in its own right but may also expose them to neglect and maltreatment by the parents, thus potentially

increasing the risk for psychological difficulties including depression (Hooper et al., 2012). Although parentification may be categorized as a form of chronic abuse in some research and literature, the case at hand fits more in both categories distinctively, as will be elaborated on in following sections of this case study.

Penner et al. (2019) have found, through self-reports, that the experience of chronic abuse significantly affects one's ability to form a stable sense of self; particularly, individuals who experience prolonged abuse are at risk of identity diffusion, which is associated with lower self-esteem, meaning in life, and general functioning. Additionally, further self-reports have found that what may stem from the experience of parentification and chronic abuse is inherent feelings of shame as well as role confusion, both of which disrupt the formation of healthy boundaries between the parentified child and those surrounding them and negatively impact emotional well-being (Vulliez-Coady et al., 2013). Hayashi et al. (2015) have particularly found that individuals who have experienced prolonged abuse tend to internalize negative views of themselves and adopt a sense of helplessness, both of which make them more susceptible to developing depression symptoms. Such individuals are also often unfamiliar with adaptive coping mechanisms that may shield them from further psychological consequences and have difficulty regulating their emotions, thus also increasing likelihood for depression (Hayashi et al., 2015).

An interesting aspect of chronic abuse has also been studied, particularly about the dual role of family estrangement in either improving or worsening of survivors' well-being. Estrangement from family members who have instigated such abuse can therefore either form a protective factor, as the individual's distancing provides them with diversion from harm, or a source of distress, as the distance may magnify feelings of disconnection,

isolation, and loneliness (Hank, 2024). This therefore introduces a nuanced view of how individuals may choose to navigate and regulate their well-being after having been abused.

2.5 EA for Parentified Adults with Depression

Existential psychotherapy, including existential analysis (EA), is one of many other forms of psychotherapy that place a greater focus on experiential work with individuals in the clinic; particularly, it focuses on relational aspects of therapy as a healing component, emphasizes the individual's lived experience and encourages to deeply explore their emotions, and adopts a meaning-centered approach to the therapeutic framework by helping individuals find meaning and purpose (Hoffman et al., 2014). A meta-analysis conducted by Vos et al. (2014) on the effect of existential therapies reviewed 15 different RCTs which showed moderate improvements on various presentations of psychopathology, including depression. Other forms of meaning therapies such as existential dynamic therapy, or VITA, proved to be significantly impactful for psychological improvements in adults with treatment-resistant depression and cluster C traits (Stålsett et al., 2012). Even short-term existential therapy in group settings for cancer patients was found to contribute positively to the patients' quality of life and decrease their existential distress (Nakamura & Kawase, 2021). In light of such promising outcomes, researchers have been attempting to make existential therapy accessible and research-friendly, integrating it with the extended evolutionary meta-model (EEMM) for a process-based focus (Menzies & Menzies, 2024), and developing meaning-centered psychotherapy (MCP) to help individuals discover their meaning and purpose (Breitbart et al., 2018). Existential concerns, including thoughts about lost time,

are more common than assumed in the therapeutic context, and they are no less important to address and explore more deeply (Schnipke & MacKay, 2023). Taghizadeh (2023) notes that existential therapy significantly reduces feelings of helplessness and failure, aging and emptiness, and confusion and conflict in teachers who have reached retirement. Carl Jung himself even experienced a period of distress, tension, and uncertainty that was somehow resolved after he found meaning in his lived experience (Diamond, 2018). Existential psychotherapy therefore relieves a certain existential tension about lost time and other concerns that may emerge in midlife that may have never been relevant prior (Cook, 2023).

2.6 Gaps in Knowledge

The existing literature addresses how individuals experience depression in the context of parentification; however, the added factors of chronic abuse and/or alienation are not usually considered. Additionally, research on depression in relation to parentification and chronic abuse has been predominantly based on self-report surveys, which allows for drawing general inferences about the mediating role of parentification. This however misses some of the nuances that can be shown in each case. Individuals with such presentations may face a variety of concerns that transcend the typical presentation for depression and touch upon existential themes such as meaning-making, identity, and authenticity. As such, and despite pre-existing research on depression, little is known about how individuals experience depression in the context of parentification, chronic abuse, and alienation. This case study therefore aims to address the following research questions:

RQ: What is the participant's lived experience of depression in the context of parentification, chronic abuse, and alienation?

CHAPTER 3

METHODS

3.1 Research Design

This study uses a qualitative case study approach within a constructionist-interventionist paradigm, grounded in an interpretive-constructive epistemology; this assumes that reality is constructed through human interpretation, meaning that multiple realities may exist according to individual experiences, and that people do not derive meaning in vacuum, but rather within a specific context (Merriam & Tisdell, 2016). As such, both the participant and I have co-constructed meaning as two individuals from different backgrounds, assumptions, attitudes, and values, working together and influencing one another in a circular way on the path to understand her lived experience. The study's analysis is also informed by phenomenological and hermeneutic principles to describe the participant's lived experience on one hand and to interpret the meaning it carries within the framework of existential analysis on the other. This allows for an in-depth analysis and a holistic assessment of the client's experiences and their relation to the study's main research questions encompassing constructs such as parentification and identity formation, alienation, chronic abuse, and depression, particularly through an existential analysis (EA) lens.

3.2 Participant and Context

The case at hand in this study is one participant; she is a 45-year-old woman diagnosed with depression, and whose experiences of parentification, chronic abuse, and alienation are examined within a mental health context in Lebanon. The boundaries of the case are thus defined by her psychotherapeutic journey over the course of 5 months

at the clinical training site and the data collected by me during her therapy sessions. Other contextual factors such as culture and religion pertaining to the participant will be taken into consideration without overpowering the case and while also maintaining the focus on the participant and her experience of such factors. As such, the primary focus of the case will be on the participant's experience of depression and the factors that influence it.

The participant for this study was sampled conveniently as she was already assigned to me for treatment as part of my clinical training program. She was then selected according to inclusion criteria stipulating that the participant must be 1) an adult aged 18 or older, who is 2) accessing mental health treatment from myself, a clinical psychologist in training (CPT), in an approved site, and 3) gives full informed consent for their data to be used as part of this research study. No restrictions were made on the type of mental health difficulty (e.g. depression, anxiety, etc.), nationality, or any other characteristic, and there was no upper cut-off on age. The participant would have been excluded only if she does not provide informed consent or if the level of risk to self or others is deemed high by myself, the CPT, and my clinical supervisor. For this study, the participant had initially consented to having her sessions recorded as part of the clinical training program requirements at the clinical training site; this is initially done in order to monitor the performance of the clinical psychologists in training. Subsequently, the participant was asked for consent to be part of this case study. She gave her oral and written informed consent, acknowledging that she may withdraw her data at any time point if she changes her mind. Essentially, nothing else was done procedurally other than what would already be required by the clinical training program at the clinical site, and treatment was also administered as it would have had the participant not been a part of this case study.

Despite the participant being sampled conveniently for practical reasons, the case unfolded as one that is theoretically informative due to the participant's chief complaint of loss of meaning as well as her varied and overlapping experiences that influenced her symptomatology and current mental health journey. The existential relevance of her narrative made it especially suitable for phenomenological exploration. As such, the case offers an opportunity to delve into the lived dynamics of various contextual factors — parentification, chronic abuse, and alienation — and the participant's selfhood and well-being, aligned with the common aim of existential and phenomenological research to understand and uncover meaning within results and findings.

3.3 Data Sources and Collection

For this case study, several sources of data were utilized for as much of a comprehensive understanding of the case at hand as possible. Primarily, two semi-structured interviews comprising of one recorded assessment session and one recorded treatment session (found under Appendix B and D respectively) were transcribed and anonymized. The interviews were approached with openness to the participant's lived experience while also encouraging further exploration of the topics at hand. Some questions that were used to elicit further reflection and uncover more detail include "When you were upset as a child, how was that dealt with in the family?", and "What does it mean to you to be lonely?". As such, the participant and I worked towards a clearer, co-constructed understanding of her experience. Additionally, artifacts such as clinical session notes were written as part of usual clinical practice and used to document progress throughout treatment (found under Appendix E). A reflective diary (found under Appendix G) with entries following each session with the client also supported this study

by noting my experience as a CPT throughout the course of therapy, thus informing the reflective reports found under Appendix K. In this study, data saturation was considered complete when the recurrent themes of existential analysis such as responsibility, isolation, and authenticity arose consistently across the different data sources and when no new meanings, themes, or interpretations emerged upon revision of the data.

3.4 Data Analysis

This study employed a thematic analysis to analyze the different data sources according to Merriam and Tisdell's (2016) five step approach to qualitative data analysis. The unit of analysis in this study consisted of *meaning units* that represent segments of texts (mainly phrases and full sentences) that communicated any form of experiential significance to the participant's lived experience of her depression, identity, and the contextual factors that surround them. The steps of Merriam and Tisdell's (2016) qualitative analysis include the following: compilation, disassembly, reassembly, interpretation, and verification.

In the first step, compilation, two sessions (one assessment session and one treatment session) were transcribed and organized alongside the session notes and reflexive diaries using MAXQDA 2024. As this was being done, I familiarized myself with the varied data sources and read through them multiple times with no coding.

In the next phase, disassembly, initial codes were assigned openly and inductively, grounded in the phenomenological method of existential analysis and allowing whatever is there to emerge (Längle & Klaassen, 2019). The different data sources generated codes that naturally grasped notable components surrounding this study's research questions (e.g. "parentification", "identity confusion", etc.) as well as

other concepts that may later be relevant to the study and the work in general (e.g. “insecurity”, “guilt”, etc.).

Following the initial coding stage, that of reassembly then comprised of the second iteration of the coding process; clusters were generated, merging some codes that referred to the same concepts and eliminating others that were not robust enough to fit the study’s areas of exploration. For example, codes such as “lack of support”, “dismissal”, and “fear of judgement” were merged under a pre-existing code titled “loss of trust”. Other codes such as “identity confusion”, “loss of freedom”, and “use of we” were also merged under a pre-existing code titled “loss of self”. Additionally, codes such as “attunement”, “frustration”, and “understanding of anxiety” were eliminated among a few other codes that, upon review, were much less frequent and also less relevant to the study’s highlighted focus. The reassembly phase also included the deductive generation of themes and sub-themes from the finalized list of codes. These themes were theory-driven from existential analysis (e.g. “disconnection from oneself”, “absence of security”) and also generated based on the phenomenological method within this existential theoretical framework, considering the therapist’s role in receiving the client’s experience openly with no assumptions (e.g. “therapist’s subjective experience”) (Längle & Klaassen, 2019). The themes and sub-themes were reviewed repeatedly and refined meticulously to ensure clarity, avoid overlapping concepts, and deepen understanding of the participant’s narrative within an existential-phenomenological context. Below is a code theme hierarchy that represents the aforementioned process. The complete code system can be found under Appendix H.

Table 1. Example of Code-Theme Hierarchy

Initial codes	Clustered code	Subtheme	Theme
value of self	fluctuating self-worth	disconnection from oneself	Identity Disruption and Reconnection
self-blame			
view of self			
need to prove oneself			
insecurity			
need for validation			
positive self-view			
avoidance			
negative self-view			

After the generation of themes and subthemes, the interpretation stage included the categorization of such themes in alignment with the existing literature as well as this study's theoretical framework, the 4 FMs, and aforementioned research question.

To secure the last phase, verification, analytic quality was facilitated and supported by peer debriefings, supervisor feedback, and the consultation of a fellow researcher who coded the transcribed treatment session.

3.5 Establishing Trustworthiness

Additional procedures were taken to ensure the study's credibility and rigor. Firstly, the presence of multiple data sources (transcripts, session notes, journal) enables methodological triangulation which further deepens the analysis and supports the development of consistent themes. The two transcribed sessions were respectively proofread and checked for accuracy by my clinical supervisor as well as a colleague of mine at the same clinical training site. Prolonged immersion in the data as well as supervisor debriefs in the coding phase also reduces researcher bias, especially given my dual role as a clinician and researcher. The case was elaborated with thick and context-

rich descriptions that can also help with the potential transferability of findings, although quite limited. The confirmability of the findings was also supported through my reflexive journaling in this process as it allowed me to further examine my expectations and assumptions and share my personal biases that may hinder the analytic process. The independent audit of 20% of the coded data by a second peer coder was also done to further enable a transparent and credible analytic process. Both the peer coder and I separately reviewed and coded one transcript. Discussions after comparing the resulting codes took place to help us resolve any discrepancies, reach a shared understanding of meaning in the data, and confirm conceptual alignment. This dialogical process revealed no notable discrepancies, suggesting minimized individual biases and a solid basis of understanding of the participant's lived experience within an existential-phenomenological context. Although member checking was absent in this study due to clinical confidentiality, the credibility of the analysis was supported by consistent peer debriefings and supervisor feedback. These compensatory strategies provide room for continuous critical reflection and analytic validation in the absence of the participant's personal verification.

3.6 Dual Roles and Reflexivity

Given my dual role as the CPT and the primary researcher of the study, extensive efforts to maintain analytical distance were made to ensure both ethical and methodological concerns. While my engagement with the client in a therapeutic sense enriched the data collection by providing a layer of depth and richness in the quality of information that was being shared, it may have also allowed for some bias in interpretation. Several reflexive practices were consolidated as part of this study to

manage this dual role, including the bracketing of therapeutic assumptions during coding and analysis, thus shifting away from clinical interpretations to allow for a focus on the participant's lived experience. Moreover, the aforementioned reflective journal was a great outlet for my personal impressions, reactions, and theoretical/clinical shifts throughout this journey. Routine supervision sessions with both my academic and clinical supervisors also offered various opportunities to consider alternative interpretations for the case at hand from both ends of my dual role, allowing space for critical thinking and reflection via feedback loops. Taken together, such strategies were implemented to maintain the phenomenological integrity of the study while also minimizing personal bias.

Keeping in mind the importance of the aforementioned reflexivity is important, the researcher's positionality is also an essential component of meaning making in this study, especially within the constructivist-interventionist paradigm. My position as an existentially informed therapist in training is established on the basis that therapy is an interactive process whereby a shared understanding is built through dialogical exchange and an authentic presence. Through this personal view of the therapeutic process as well as my interest in existential themes and analysis, I was able to approach the participant's narrative with attunement towards various existential themes and an inherent strive towards meaning making, be it on my part or the participant's. With this stance in mind, my role as a therapist and a researcher was not observational or objective; on the contrary, I was involved in co-constructing meaning with the participant and including myself as an active member in the therapeutic and research processes.

As such, it was even more important that I maintained a strong and continuous awareness of my existence as someone with personal values which include but are not

limited to authenticity, autonomy, emotional honesty, and relational depth. Such values and attitudes may have therefore influenced my perception and interpretations across the therapeutic process, making supervision and reflexive journaling not merely procedural but rather an opportunity to observe how meaning was co-created between myself and the participant. This epistemic reflexivity is therefore also consistent with the study's existential-phenomenological inquiry and commitment to self-awareness.

3.7 Measures and Materials

As part of the clinical site's procedures, and with approval from the Institutional Review Board (IRB), psychometric tools were administered to the participant and were used in to further study the case from an academic perspective. It is important to note that the following psychometric tools had no interpretative or inferential value and were only used as descriptive tools to better understand the case at hand.

As such, the GAD-7, PHQ-9 and WHO-5 were administered at the pre-, midpoint, and post- treatment time points. These psychometric measurement tools were selected based on their brevity, psychometric properties, and clinical relevance to the client's presentation.

The PHQ-9 was administered given that the participant's main presenting problem is her feelings of sadness and emptiness. Secondary to such feelings are her anxiety symptoms, which were explored through the administration of the GAD-7, and her overall wellbeing, explored through the WHO-5.

3.7.1 PHQ-9

The PHQ-9 is a brief 9-item self-report questionnaire for screening depression and measuring its severity (Kroenke & Spitzer, 2002). The PHQ-9 requires the respondents to rate how often they have been bothered by depression-related symptoms during the past two weeks, with responses following a Likert scale ranging from 0 = not at all, to 3 = nearly every day (Kroenke & Spitzer, 2002). Adding up all the item responses provides the total score for the scale, which can vary between 0 to 27 (Kroenke & Spitzer, 2002). A score of 0–4 represents minimal depression, a score of 5–9 mild depression, a score of 10–14 moderate depression, a score of 15–19 moderately severe depression, and a score of 20–27 severe depression (Kroenke & Spitzer, 2002).

The PHQ-9's development study with primary care established high internal consistency (Cronbach's α between .86 and .89), as well as a sensitivity of 88% and a specificity of 88% with the cutoff score of 10 for major depression (Kroenke et al., 2001). In a sample of Lebanese adult psychiatric outpatients at AUBMC, the Arabic PHQ-9 also had high internal consistency (Cronbach's α = .88) (Sawaya et al., 2016).

3.7.2 GAD-7

The GAD-7 (Spitzer et al., 2006) is a psychological self-report screening tool that aims to measure the severity of generalized anxiety symptoms based on the DSM-IV over a timespan of the past two weeks before administration. It asks individuals to rate the frequency of the distress caused by 7 different "problems" that are each scored on a 4-point Likert scale of 0 (= not at all) to 3 (= nearly every day) (Spitzer et al., 2006). Thus, the total score thus ranges from 0 to 21, with cutoff scores of 5 for mild, 10 for moderate, and 15 for severe anxiety (Spitzer et. al, 2006). The GAD-7 also includes a final question

that does not contribute to scoring but helps assess the rate of these problems' interference with work and personal matters (Spitzer et al., 2006). This question is also answered using a 4-point Likert scale ranging from "Not at all" to "Extremely difficult".

The development study of the GAD-7 presented satisfactory internal consistency (Cronbach's α = .92) and test-retest reliability (intraclass correlation coefficient = 0.83) (Spitzer et al., 2006). Spitzer et al. (2006) also identified the optimal cutoff score to be 10, as this allowed sensitivity and specificity to both be above .80.

3.7.3 WHO-5

The WHO-5 is a short 5-item self-report measure that assesses overall well-being (World Health Organization [WHO], 2024). This measure asks individuals to rate the feelings they have experienced in the last two weeks on a 6-point Likert scale from 0 = at no time, to 5 = all the time (WHO, 2024). The raw total score is obtained by adding up the answers to all items and can range from 0 to 25; the percentage is computed by multiplying the raw score by four (WHO, 2024). The cutoff point is either a raw score of 13 or a percentage of 50, and a score below this cutoff suggests the possible presence of a mental health condition and implies the need for supplementary assessment (WHO, 2024).

A systematic review of the literature on the WHO-5 which included 213 articles established good construct validity as well as a weighted sensitivity of .86 and specificity of .81 for cutoff scores below 50% in screening for depression (Topp et al., 2015). Most of the studies included in the literature review were primarily focused on clients with mental health disorders and medical conditions from Western countries (Topp et al., 2015).

3.8 Procedure

The study was reviewed by and received approval from the Institutional Review Board (IRB) at the American University of Beirut (AUB) (SBS-2024-0512). During the first session with the client, informed consent was covered for the services at the clinical training site. Once consent was given, oral consent for taking part of the thesis case study was also obtained. Written consent to be a part of the case study has also been obtained from the client in session. For the next 3 sessions, intake information was gathered based on an intake sheet template given to us by the clinical training site, and the aforementioned psychometric tools were administered. After each session with the client, I would take note of my personal impressions, experiences, and thoughts in a reflective diary. Records of the session are also written after each session and saved on the clinical training site's electronic system in the SOAP (subjective, objective, assessment, plan) format.

CHAPTER 4

FORMULATION

4.1 Background and Presenting Problem

The client is a woman in her 40s, currently living with her husband and the youngest of her three children. She was undergoing psychotherapy for 3 weeks at a different organization but complained of a mismatch between herself and the therapist, thus self-referring herself to the mental health services at the clinical training site. Upon intake, the client reported struggling from depression. As of recent, she has been finding it difficult to find meaning in her life, and while the client is able to function, it requires much effort, even when it comes to contacting those close to her. Current stressors include her dissatisfaction with her weight loss journey as well as feeling alienated from her daughter who is abroad to study as well as her close friends and family who are based abroad. It is also important to note that the client was born and raised in the USA and moved back to Lebanon at the age of 35. After her move, feelings of alienation have been central to her life, both those caused by the physical distance from her loved ones as well as that related to her cultural identity whereby the client also feels too American for Lebanon and too Lebanese for the USA. Taken together, the client feels alone and unable to maintain connections with those far away or form new ones with people around her in Lebanon.

4.2 Client History

The client is the youngest of four siblings. Growing up, the household was chaotic due to her mother's mental health decline, her father’s death, and her brother's “reckless”

lifestyle. There would be bursts of good times with the family, but the environment was generally unstable and sporadic. Discrepancies exist regarding the nature of the client's parents' relationship; however, the client recalls and emphasizes her father's "very bad temper", as noted in the assessment session transcript under Appendix B; he would often beat her and her siblings, although the client notes that he loved them. After her father's death and at the age of 6, the client felt burdened with the responsibility of looking after her mother both practically and emotionally. She took on this role out of fear due to the mother's recurrent threats of suicide, as well as out of obligation since no one else was taking care of her. While bearing practical and emotional responsibilities around the house, such as managing chores and supporting the mother emotionally, the client was also abused by her mother; the mother was dismissive towards the client and her emotions, often ridiculing them, and was physically abusive towards her to a large extent. Subsequently, the client did not feel supported by her and would therefore seek her older sister instead. The client's siblings were not as involved with their mother's situation as she was and were not as negatively affected by the family's circumstances. For this reason, and despite her love for them, the client holds a sense of resentment towards her siblings. Aside from that, the client notes that she presently gets along well with her siblings and especially feels protected by her brothers.

The client reported being shy but extroverted as a child. She described herself as reserved until she entered elementary school, where she recalled being much more outgoing with many friends. When she turned 13, however, the client felt a shift as she became more insecure and self-conscious, experiencing symptoms of anxiety that included heart palpitations, feelings of fear, and choking sensations, particularly in social contexts, At the time, the client was housing a friend with similar struggles by whom she

felt greatly unsupported. Her symptoms waxed and waned and were reportedly manageable, seeking no professional support. When the client was 16, she announced her engagement to her now-husband. Her family was very apprehensive of this due to her young age and would push her to rethink her decision, which made the client feel very alone and doubtful of herself. After getting married at 18, the client experienced a variety of depression symptoms and endured her pre-existing anxiety symptoms more intensely. The depression symptoms that the client relayed included feeling a loss of joy and energy, crying constantly, and feeling worthless. Her anxiety would also become more distressing as she noted being surrounded by and introduced to many new people at the time.

Since the worsening of her symptoms after marriage, the client had sought various psychiatric and psychological services to cope. While initially resistant to treatment when she was younger, she is currently on three different medications to manage her depression and anxiety symptoms. The client also smokes half a pack of cigarettes daily as she claims it helps her cope. There is no note of any other alcohol or substance use.

4.3 Current Family Dynamics

The client describes her relationship with her husband as a supportive one, although this support is quite newfound; up until the recent years, the client had been verbally and physically abused by her husband. The relationship between her and her older daughter is distant; her daughter is quite resentful towards the abuse that she witnessed between her parents growing up, and the client feels as though her efforts to stay for her children has gone unappreciated. As a result, they often clash, and the daughter finds difficulty trusting the client. As for her younger daughter, the client describes her as her friend and protector. They have a very good relationship and would

side with each other no matter what. The client's relationship with her son is unremarkable, although she admits to "baby-ing him" since he is the youngest and the only boy (as noted in the assessment session transcript under Appendix B). He tends to be playful towards her too, within the set boundaries.

As for the husband, he tends to favor the older daughter and sees her as the "golden child" (as noted in the assessment session transcript under Appendix B), whereas there would be a lot of conflict and clashing between him and his younger daughter. The client reports that he would always push her to do well and feel the need to "tell her what to do" (as noted in the assessment session transcript under Appendix B); this would sometimes lead to physical and emotional clashes which the client would need to protect the daughter from. As for the husband's relationship with the son, the client notes that it is unremarkable although quite distant.

The siblings also hold a variety of relationships among each other; the older daughter gets along very well with her brother but has a tumultuous relationship with her sister. As for the younger sister and brother, they generally get along well but also clash at times.

4.4 Risk and Protective Factors

The client did not present any active suicidal ideation, although it is usually present without intent during her depressive episodes. Passive suicidal ideation was present, however, and such passive thoughts would resurface every few weeks, lasting for a few hours on end. The client claims to have control over these thoughts. She has never attempted suicide and has never harmed herself without the intent of suicide.

The client noted being physically and emotionally abused by her parents during her upbringing on one hand, and by her husband during most of their relationship on the other hand. After the husband's brother's passing during the COVID-19 pandemic, he changed for the better, as noted by the client and her family members, and the abuse ended abruptly. She currently describes their relationship as supportive.

Nevertheless, the client's reported symptoms of active and passive suicidal ideation, her history of abuse, her mother's psychological struggles, and her parentified role as a child all pose a risk on the client's mental and physical well-being. Her recent diagnosis of fibromyalgia may also form another stressor for her and exacerbate her psychological difficulties. However, the client holds multiple protective factors such as her close relationship to both her daughter and her siblings that may provide her with the support she needs. Additionally, she displays an appropriate level of insight regarding the role her past has played in her mental health journey, which may equip her with the necessary awareness to cope with current and future difficulties.

4.5 Symptomatology and Diagnostic Impressions

As previously mentioned, the client reported struggling with feelings of sadness, emptiness, and hopelessness. During her depressive episodes, she is usually unable to eat, get out of bed, socialize, or complete any basic tasks. As of recent, she has been feeling like her "best years are behind her" the older she grows. In terms of her functionality and well-being, the client reported being able to complete daily tasks but claims them to be "forceful". She feels like she has no energy for daily tasks and is experiencing a sense of apathy towards others, decreasing her motivation to reach out to them.

As for the administered psychometric measures, the client first scored a total of 17 points on the GAD-7. With the cutoff being at 15 for severe anxiety, her score is well above the threshold. Generally, the client's score suggests the presence of significant generalized anxiety symptoms which can give more insight for the treatment plan to be set, especially since she had not mentioned anxiety concerns upon intake. This score also suggests recurrent and intense symptoms such as persistent worry, high irritability, and constant anticipation of negative future events. It is also consistent with clinically significant anxiety and may warrant a diagnosis of generalized anxiety disorder, especially given the symptoms' effects on her daily functioning as per the measure's additional question. Nevertheless, it is important to support this assessment measure with a more comprehensive tool to confirm this diagnosis. After all, the GAD-7, while being a quick and effective assessment tool, is still a short screening measure that warrants further investigation.

Moreover, the client scored a total of 5 points out of 25 on the WHO-5; this indicates 20% total well-being. Usually, a score under 13 indicates poor well-being and warrants testing for clinical depression. As such, the client scored a total of 18 on the PHQ-9, which falls in the moderately severe score range. This score suggests the presence of significant depression symptoms including persistent low mood and energy, loss of interest and/or pleasure, sleep and appetite disturbances, feelings of guilt and worthlessness, and more. This is in line with the client's subjective reporting of her chief complaint and symptomatology as well as the clinical observations that were recorded during the initial assessment sessions. She seems to be mainly struggling with low mood, motivation, and feelings of despair, which are in line with DSM-V criteria for clinical depression.

Based on the gathered information, the client seems to meet most DSM-V criteria for major depressive disorder. While the scores on the GAD-7 seem to reflect severe anxiety, the client had never spoken of current anxiety related concerns, thus necessitating further assessment to confirm an anxiety diagnosis, if applicable.

Screening for PTSD following the DSM interview guide (Zimmerman, 2013) was also done; however, no criteria of note was apparent. A possible differential diagnosis is that of complex PTSD given the client's history of parentification and chronic abuse from both her parents' and her husband's ends.

4.6 Theoretical Approach

This case study will be explored through an existential analysis framework based on Alfried Längle's four fundamental existential motivations, each representing a layer of human life (Längle, 2003; 2005). Building on Viktor Frankl's logotherapy (Längle, 2015a), Längle's approach comprised of suffering and distress as results of disruptions in one or more of the four fundamental existential motivations or conditions of existence (Längle, 2015b). These fundamental motivations (FMs) are not clear diagnostic categories but rather categories through which the individuals' experience of and relation to themselves, others, and life can be more profoundly understood (Längle, 2011). FM1 encompasses the notion and question of existence, including both the physical and emotional aspects of safety and occupying a space in the world; thus, when unmet, the individual may experience a sense of insecurity and anxiety (Längle, 2011). FM2 stipulates one's capacity to connect with life and experience it affectively, thus leading to feelings of numbness and disengagement if unmet (Längle, 2011). FM3 revolves around the self and the ability to experience oneself as authentic, independent, and autonomous; as such, when unmet, an individual may feel repressed and controlled by any person or

entity outside of themselves (Längle, 2011). Finally, FM4 questions the meaning of life as well as its purpose, thus leading to feelings of emptiness and confusion (Längle, 2011). The integration of EA, particularly through the 4 FMs, will allow for a more profound understanding of the client's concerns surrounding relevant existential constructs, which may bring her closer to a grounded being, an authentic sense of self, and meaning in life.

4.6.1 FM1 – Safety, Security, and a Place in the World

The client's history of instability in life influenced her ability to form a stable basis for her existence. Growing up with a mother who struggled psychologically, the client had to take on the role of the parent while also being exposed to constant abuse from both of her parents. This had likely left the client in a vulnerable state where she lacks the physical safety and emotional security she would need in life; even when distressed, the client would often struggle seeking out her mother due to the dismissal she would face and would instead seek out her sister for support. She was denied the opportunity to simply exist as she is and be protected by those around her. Instead of experiencing life in a safe environment, the client was responsible for the household's basic and emotional well-being, leaving her with a heavy role and unmet personal needs (Van Parys et al., 2014). This experience may have led the client to develop insecurities about the world she lives in, about safety or lack thereof, and about her role in life (Infurna et al., 2015). The client has personally relayed that her self-worth became heavily linked to her ability to care for others as well as others' approval of her (Van Parys et al., 2014), and although this notion best falls under FM3, it can be seen as largely informed and influenced by the deficits in FM1 for her. In the client's present life, she feels alienated from those around her unless she is caring for them in one way or another; despite living

with other loved ones around her, the client feels emotionally alone (Breitbart, 2017). Now that the majority of her friends and family are abroad, it is likely that her initial insecurities surrounding her place in the world are triggered; if she is not around them to care for them, she feels placeless, but when she does that, she feels overshadowed. Especially, the client had shared that her daughter made her feel heard and protected (as indicated in the assessment session transcript under Appendix B), thus indicating a potential feeling of loss of safety with her being abroad, too.

4.6.2 FM2 – Connection, Emotion, and Vitality

The client has reported feelings of emptiness and sadness. She experiences her life as a routine of sorts, lacking excitement, energy, and motivation. Instead, life to her is a burden, whereby she feels exhausted at the mere fact that she is fighting to persevere. Joy is therefore largely absent, leaving her with little vitality in everyday life. The client's depressive symptoms encompassing low mood and energy encompass more than just a mood disorder; they reflect the client's inability to find pleasure in being. Although she possesses the desire to craft a life of her own, societal norms surrounding what it means to be a mother and wife as well as what she considers a familiar lifestyle of caring for others have both left the client with underlying feelings that she is not allowed to exist outside the roles she occupies. Considering her history, the client has had little room for enjoyment which, in turn, may make it feel more out of reach, selfish, and meaningless. The client's world lacks this sense of emotion, joy, and vitality not by choice, but rather by fatigue due to her long-lasting experience of hardship. Even her perception of life as she knows it is experienced through a lens of perseverance, survival, and effort, rather than energy, vigor, and liveliness. With her daughter being abroad, the client has also lost

her "friend" (as noted in the assessment transcript under Appendix B), the person who has been providing her with the little joys of life amid her struggles, leaving her with more profound feelings of loss of connection and happiness. This feeling of alienation and disrupted from her loved ones may have also brought about several existential anxieties, resurfaced identity conflicts, and exacerbated her feelings of loneliness (Winston, 2016; Breitbart, 2017).

4.6.3 FM3 – Authenticity, Identity, and Existence as the Self

Identity is also a central concept in existential analysis, and frankly, in every person's life. The client has not had the chance to truly connect with herself and develop an independent identity over the course of her life. Instead, her identity revolved around the roles which she occupies (daughter, caretaker, parent), thus shifting the focus from her own sense of self and personal needs to those of others around her. Currently, she expresses feeling like she does not know who she is outside of being a mother, leaving her with feelings of frustration, sadness, and emptiness. It may also be possible that she is also re-experiencing a loss of identity after having closely identified with her younger daughter for many years; as the client noted in our assessment session, "there's a chemistry between us, a strong chemistry, … understanding", "even if I feel like I'm wrong, […] She will back me up no matter what" (as noted in the assessment session transcript under Appendix B). As such, the client may be facing confusion as to who she is without her daughter, her safe person and her "protector" (as noted in the assessment session transcript under Appendix B). She is now confronted with a sense of freedom from the caretaking role which she has occupied for the majority of her life, and she may not know what to do away from it. The client's symptoms of depression may reflect not

only negative feelings surrounding her life experiences and current circumstances, but also about her own self and being. She notably and repeatedly mentions “My best years are behind me”, indicating her feelings of grief and suggesting that those years were never really hers to begin with. Over the course of her life, not much was a result of decisions that she fully made; she was always concerned about others’ needs and well-being, and even when she made the decision to marry her now partner, the client confesses that it was largely a means to escape her chaotic and abusive family environment. After she had left her family house and married, she was subject to more abuse; as such, the client was faced with a sense of hopelessness and barely had an opportunity to focus on herself, her needs, and her existence as her own person in the world.

4.6.4 FM4 – Meaning, Purpose, and Contribution to Life

The client has explicitly reported that she is struggling to find meaning in life. The weakening nature of her relational ties to her loved ones also leaves her with an existential emptiness of sorts. And while it is true that she was met with a lot of suffering due to several factors that include her mother, the client still longs for a connection with her mother; the growing distance between them leaves the client conflicted, frustrated, and sad as she feels further and further away from those in her life, even if they have caused her harm. She feels invisible, forgotten, and not needed; she feels as though she lacks purpose. Nevertheless, the client expresses a subtle desire for things to mean something to her again. She is putting her best foot forward in therapy, practicing self-care when she can, and reflecting deeply, with adequate insight, to understand her struggles (“The Wiley World Handbook of Existential Therapy,” 2019). However, due to the tiredness she is

facing as a result of the many years of endurance and pain, she sometimes feels hopeless that treatment will be effective and exhibits a longing for a quick magical fix.

CHAPTER 5

TREATMENT PLAN

5.1 Treatment Goals

The client reported wanting to 1) strengthen her coping skills, 2) increase her compassion for herself, 3) increase her motivation, and 4) develop a more positive prospect towards life. This is in line with the formulation as it is stemming from her depressed mood, decreased energy, and hopelessness towards her psychological state as well as her life in general. However, based on the theoretical framework employed and referring to the four fundamental motivations, the following goals can also be addressed:

- FM1: rebuilding a sense of safety in the client’s life,
- FM2: reconnecting to emotions and increasing vitality,
- FM3: finding and strengthening her personal sense of self and worthiness, and
- FM4: discovering personal sources of meaning in life.

5.2 Treatment Plan

In order to address FM1 and the client’s goals surrounding coping and self-compassion from an existential interventional aspect, it would be helpful to further explore the early roles she took on, mainly the parentification. The purpose of this exploration is to come closer to the client’s understanding of her experience and bridge the anticipated gap between it and the reality of this parentification as a means to survive, not as a mistake or flaw. Additionally, the safe space created in the clinic would help give the client a safe environment to just *be* (Längle, 2003); no judgment, expectations, or

roles to fit into. Perhaps grounding exercises may also prove helpful to allow the client an opportunity to connect with her sense of being in the world (Engelhard et al., 2021).

FM2, alongside the client's goals related to coping and motivation, would underscore work revolving around tracking and reflecting on times of day where she may feel more alive and connected to her emotions. Emotionality, as well as acquiring the openness for emotions and their experience, are central to FM2; further exploring the details of the client's experience in that regard may provide insight for moving past obstacles and better integrating whatever makes the process easier for her (Längle, 2007). Exploring the client's feelings of guilt surrounding this area of her life as well as what is expected of her may also better inform this. During the sessions, it would be help for both the client and me to allow space for sitting with the emotions that come up and turning towards them rather than away from them.

To tackle FM3 and related goals surrounding self-compassion and motivation, existential interventions tackling the deconstruction of the client's internalized obligations may prove fruitful, regardless of the primary source of these obligations or expectations (Solobutina & Miyassarova, 2019). As the concept of authentic selfhood is important in EA, a phenomenological exploration of what it means to live authentically can also be employed (Binder, 2022). The thought record may also help with increasing self-compassion; however, to further do so, journaling under this theme can be encouraged to help the client approach herself kindlier (Stutts, 2022), and progress can be tracked collaboratively based on what the client is willing to share. It is important to really address the client's true self and invite her to think of her boundaries of self while working on FM3.

Finally, to address the goals related to FM4, meaning making, and shifting perspective towards life, it is important to first address and explore the client's sense of meaninglessness; this can be done through the understanding of the client's personal values, her idea of meaning, and the gap that exists in them and her reality (Vanhooren, 2019). Moreover, encouraging authentic choices and decision making with a future-oriented perspective is particularly relevant to FM4 and has proven helpful, according to Kwee and Längle (2013); thinking about future aspirations and ways to come closer to them can help the client come closer to living life more meaningfully and authentically. Additionally, existential theory and existential analysis imply that FM4 will be much easier to reach and fulfill when the work on previous FMs has been done. As such, all steps taken in this therapeutic journey are important and contribute to pursuit of meaning within FM4.

This treatment plan abides by the primary existential framework used to formulate the case. While it contains a lot of depth and room for exploration, it may also be helpful to reflect on other possible tools developed in other theoretical approaches to further support EA, especially given the limited time frame set by the clinical training program. As such, this may help the client come closer to the goals she has set during the assessment phase while keeping the focus on existential work. For example, cognitive aspects are often incorporated as part of EA and FM3 work, offering a space for reflectiveness, understanding, and the search for personal reasons and positioning, all of which help the client build practical scaffolding to the existential exploration she is already taking part in. Thought records may help the client grow more aware of negative automatic thoughts such as "my best years are behind me" or "I am only a caretaker" that hinder her from a meaningful existence, and Socratic questioning may allow for deeper

reflections to take place during sessions. Humanistic techniques such as reflections, summarizations, and empathetic attunement may both help the client feel seen and understood while also nurturing therapeutic alliance, an element often central to supporting clients living with existential difficulties. Moreover, interpersonal therapy components such as limited therapist disclosure may enrich alliance while also supporting the client in the relational aspect of her existential concerns; it may model authenticity and allow for a deeper and more human connection in therapy. Attachment informed work may also prove helpful to add context to the client's current struggles and help her understand how her past relationships may have influenced her current identity alongside her existential isolation. Such tools and techniques may enrich the existential work already taking place especially when the client feels powerless and stuck in her existential struggles.

CHAPTER 6

TREATMENT

Initially, the client and I had agreed on adopting a cognitive-behavioral mode of therapy. The research I have always read about CBT being the first-line therapy for depression was one of the main factors I considered, especially given her presenting problem: depressive episodes, negative self-view, decreased activity and motivation, etc. However, from the perspective of a clinical psychologist in training, it also felt right and most ethical given that CBT is the type of therapy I was most familiar throughout my studies. As such, the client and I agreed on the treatment plan that would include cognitive restructuring to target her maladaptive thoughts and beliefs and behavioral activation where needed to gain more momentum.

Various sessions were spent with that framework and plan in mind, and I had introduced and administered the thought record to target the client's negative beliefs and the emotions that come up for her. We filled one out in session, and it had revealed valuable information related to her frustrations surrounding her caretaker role. At this point, her identity struggles began forming more clearly for me. The next session, she came with a filled thought record based on our agreement; however, the next sessions revealed some resistance towards filling the thought record out. When I decided to probe further, the client also came forth with a concern on her own: she disclosed being well aware of her maladaptive thoughts and sensing that cognitive work is not exactly the type of therapy material she wants to engage in.

While I could have focused more on this form of resistance and proceeded with the initial treatment plan, I took an opportunity to cater to the client's interests. Her

existential concerns were very closely tied to her depressive symptoms, and I had long been interested in existential therapy, so I gave her my point of view: the cognitive work we were doing was valuable and would have been very helpful, but it appears that there is something experiential in nature that you would like to address. As such, we can proceed with an existential framework that targets your concerns surrounding identity, purpose, and connection. There and then, things started to clear up. Even though existential analysis is a form of therapy that is also evidence based, it was still a less familiar mode of work that induced some anxiety for me as a beginner therapist. However, I trusted that with proper supervision and self-monitoring, I could manage. As such, my clinical supervisor was also aware of the changes being made and was following up on the progression of sessions with the client, offering a safe space to reflect and seek professional support.

Thus, treatment was administered with phenomenological openness in mind and without pre-supposed knowledge of the client's lived experience, Although our work was also limited by the short time-frame set by the placement site, I tried my best to maintain this phenomenological approach within existential analysis, promoting genuine presence and allowing for the emergence of what the client believes is important to address during the session. Over time, it was apparent that the two main recurrent themes in our work were those of identity and connection; I approached both with as much compassion as I could, providing the client with what I hoped was a space in which she felt truly safe and understood, as opposed to the environment she grew up in. By simply providing said space, we were already doing FM1 work; establishing safety and security is a cornerstone of human existence that was missing from the client's life for a long time, and she seemed to truly find it in our space every week.

Working with this client phenomenologically heavily contributed to the most important themes in EA as well as the most prominent sources of distress in the client's life. A big portion of our work together, especially at the beginning, revolved around some indirect grief work and loss experiences; from losing her father and a sense of stability to losing her community and daughters due to travel, the client has experienced various losses in her life and had not yet fully processed them. As the client grew more open to sharing her experiences, guidance from my end was given to really sit with the emerging emotions, to turn towards them rather than away from them, thus allowing the client space to reconnect with her emotionality, be it positive or negative. While this was a result of clinical attunement, it was also directly contributing to FM2 by highlighting the client's emotions and uncovering what she values about herself and the life she is living.

Sessions with this client also consisted of work on her identity, to really explore who she is, her likes and dislikes, her aspirations, and her own view of herself away from any roles she occupies. While this relates to FM2 work by helping her turn towards things of value and promoting her connection to life, it also helps her reflect on her identity and set boundaries for who she is as a person which, in turn, connects to FM3 work. Within this type of work, both the client and I gained more clarity on the obstacles that hinder her from feeling fulfilled as well as what she could be doing to come closer to the life she would enjoy leading. Authenticity and genuine human support and connection were vital for her, and she grew more confident in what she seeks from herself, from others, and from life as a whole over time.

CHAPTER 7

RESULTS

The process of thematic analysis targeting the participant's personal experience of depression as well as the contextual factors that affect said experience generated an initial total of 111 codes, 8 of which, such as "differential diagnosis" and "understanding of anxiety", were omitted after the first review for various reasons that may overlap; (1) some codes had very low frequency, (2) the low frequency codes could not be merged with other codes, and (3) I did not find them to be either relevant to the research question and its components or impactful enough to contribute to the experiential work we were engaged in beyond the conceptualization of the case. As mentioned under the methods section, the remaining 103 codes were then reviewed and merged accordingly based on similarity (e.g.: "Lack of belonging" merged with "aloneness"). Once the codes were reviewed once more, ensuring singularity and rigor, they were then clustered into groups, or subthemes. The thematic analysis generated a total of 9 subthemes under 4 main themes that capture the participant's lived experience of depression: (1) Identity Disruption and Reconnection, (2) Absence of Security, (3) Interpersonal Needs and Ruptures, and (4) Therapeutic Processes and Change. The resulting subthemes will be elaborated below.

7.1 Theme 1: Identity Disruption and Reconnection

7.1.1 Internalized Roles

This subtheme included a total of 89 instances and included codes such as "responsibility", "prioritization of others", and "parentification". The participant expressed her experience of being parentified growing up, and this is shown presently as

she carries a large sense of responsibility towards others rather than her own self. The participant noted the following, as found in the assessment session transcript:

> *"I always had to be understanding and supportive and I felt like I needed to be that."*

The participant also would experience guilt often when she is not showing up for others or harbors some negative feelings towards them, sharing the following, as found in the treatment session transcript:

> *"Yeah! And then I'm like, I always feel bad. I, honestly, I could never, like, not talk to her. I know that about myself."*

The participant therefore upholds a standard that she is a giver and a caretaker before anything else, based on her past experiences of taking of responsibility as a child.

7.1.2 Disconnection from Oneself

This subtheme included 100 segments of data and codes such as "confusion and self-doubt" and "repression of emotions". Throughout the therapeutic journey, the participant relied on others for guidance, reassurance, and support, particularly when it came to areas surrounding her own sense of self. To exemplify this, the participant once asked the following, as found in the treatment session transcript:

> *"Do you think it would be safe, at some point, like, it would be okay to tell her "I don't feel like I'm being heard"? "I don't feel like I'm being seen the way I see you"? Or…"*

Impacted by her early sense of fear and responsibility, the client would let go of her own needs in order to ensure that others around her were well. She shared the following statement, also found in the assessment session transcript:

> *"Yeah I used to- honestly? Like- I feel like I would have killed myself to make sure that she was okay."*

The participant eventually became used to glossing over her own needs and emotions, and I noted the following in one of my SOAP notes after a session with her:

> *"She does not tend to share her concerns on a casual basis but rather prefers to confide in someone only when things become too heavy."*

As such, her disconnection from her *self*, her needs, and her being became more apparent.

7.1.3 Reclaiming Identity

The subtheme included a total of 13 segments and included the codes "connection to self" and "need for authenticity". It signified the participant's own personal needs when it comes to both herself and those around her. Despite the aforementioned fragments in her identity, several instances captured the participant's own perception of herself:

> *"She wants the space to be fully herself."*

from one of my SOAP notes after a session with her. The participant also displayed more confidence in her own judgement:

> *"No! I don't think I'm being too sensitive."*

during the treatment session, and I noted some personal reflections while writing my diaries:

> *"I could see how much lighter the client felt when noticing all other parts of her that exist outside of that role."*
>
> *"The client seems to be moving closer towards her genuine self, noting core issues that prevent her from being fully fulfilled in Lebanon."*

7.2 Theme 2: Absence of Security

7.2.1 Deficit of Protection

A total of 54 segments under codes such as "loss of parental figure" and "constant fear and lack of safety" were included in this subtheme. The subtheme essentially encompassed the participant's past and current circumstances that may have contributed to the absence of a safety net in her life. This includes her experience of being parentified as a child, losing parental figures, as well as other external influences further maintaining a sense of difficulty, loss and lack of safety or even alleviating them. To illustrate this notion are the following excerpts I noted from SOAP notes I had written after different sessions with her:

> *"I could only imagine how her fibromyalgia was adding on to her mental health difficulties"*
>
> *"The client reported being verbally and physically abused by her husband in the past."*

As such, the participant has experienced a variety of situations that have made her feel unsafe. This, in turn, relates to a notion that was repeatedly noted by the

participant, underscoring her different fears (death, abandonment, control, etc.), particularly surrounding loss. This also extended to her attitude towards her depression, as denoted below from one of the SOAP noted after a session with her:

> *"She is afraid of her feeling good as she does not know how long it will last and is worried about another depressive episode taking place."*

7.2.2 Intolerance of Uncertainty

This subtheme includes 9 segments from the data sources and encompasses the participant's attitude towards uncertainty, mainly manifested as impatience and a perpetual need for control. From the beginning of our journey together, the participant was eager to improve her mood and lifestyle, even despite her reservations regarding progress and the aforementioned fear of loss. She shared the following in the transcribed treatment session, illustrating one of many instances where she would emphasize her need for fast acting treatment.:

> *"I'm kind of impatient, like waiting for things to unfold with the summer coming, and the travel maybe going back… and I want those things to happen and I need a change, you know?"*

Moreover, her intolerance for distress and uncertainty was also indirectly represented through her need for control, which I mainly reflected on as I would process our sessions together, linking her past experiences to her current attitudes and behaviors, as found in the excerpt below from one of my reflexive diary entries, later confirmed by the participant herself in one of our sessions:

> *"She may have a need for control so as to compensate for her perceived weaknesses and to prove herself as still reliable and valuable to others."*

As such, the notions of control and uncertainty were much apparent in our work together.

7.3 Theme 3: Interpersonal Needs and Ruptures

7.3.1 Relational Ruptures

This subtheme is one of the most dense and prevalent in the participant's life. Containing a total of 91 segments across codes such as "aloneness" and "resentment", this subtheme represents the participant's negative interpersonal experiences with those in her life. Relevant to aforementioned subthemes, the participant had long experienced a sense of lack of safety and large amounts of responsibility to bear by herself, leading her to disclose her interpersonal struggles that were lived in parallel to and as a result of them. The most prevalent struggle was that of being alone; the participant not only described a persistent physical distance from her loved ones (living in Lebanon while they are in the US), but also a sense of loss of connection with those around her, even when she is surrounded by others. The participant noted the following, as seen in the transcribed treatment session:

> *"So, it's hard to connect, and that's another thing — so, with that, I don't feel at a full, I don't feel a full connectedness, and it doesn't really make — it doesn't make the loneliness, or the isolated feeling feel better. You know? It doesn't. Yeah."*

Additional to the sense of loneliness and isolation is the participant's loss of trust and resentment towards others in her life, mainly her family. She spoke of incidents of

dismissal by her mother, her siblings' mockery towards her distress, as well as her husband's negative comments, leaving her with a sense of weakened interpersonal trust and support. The participant particularly highlighted the following, as noted in one of my SOAP notes after a session with her:

> *"However, she has recently realized that she generally feels inferior and not respected around almost everyone, but especially around her family."*

7.3.2 Foundations for Connection

Despite the ruptures that resulted from the participant's negative interpersonal experiences, she has also found what foundations are most important for her to build meaningful relationships in her life. Under this subtheme exist 20 segments that relate to codes such as "meaning of friendship" and "need for support", exemplifying instances where the participant highlighted what she wants her interpersonal connections to look like and entail. The basis of this foundation exists within the participant's relationship with her daughters, particularly the younger one. She describes their connection as "endearing, supportive, and compassionate" (extracted and paraphrased from the assessment session transcript) and emphasizes the following in the transcribed assessment session:

> *"Even if- even if I feel like I'm wrong I'm a red line for her. So, she will back me up no matter what."*

Developing from this basis is the participant's need for support, which manifested both through her own speech as well as her actions. She relayed her disappointment at others' lack of initiative towards her, while also initiating her pursuit of support in her

own way. This was reflected in the following excerpt from one of my SOAP notes after a session with her:

> *"She reported almost canceling due to how she was feeling but came to the session because it is her "safe space"."*

As such, it is apparent that she needs an experience of true connection and unconditional support from those around her.

7.4 Theme 4: Therapeutic Processes and Change

7.4.1 Strength and Coping

Throughout our work together, the participant exhibited various points of strength as well as various coping strategies. This subtheme therefore encompasses such elements that were spoken about and displayed by the participant, through thought, speech and action. A total of 65 segments is related to codes such as "insight" and "protective factors". Although the participant spoke of some negative coping strategies such as her past use of prescription medication for emotional relief and smoking cigarettes for the same purpose, she still expressed various healthy coping strategies that she used to employ and still actively engages in, such as consistent exercise, meditation practices, listening to music, and even her active pursuit of spaces that could help her cope better. For instance, she has suggested starting a group therapy space for individuals with similar struggles as hers, noting the following in the transcribed treatment session:

> *"It will help me and so many other people, I think, to feel less isolated, and uhm, to cope better! Yeah."*

Moreover, the participant displayed a very good level of insight, even suggesting more experiential work as she noted being well aware of her maladaptive thoughts. Throughout the process, and despite her negative views of herself, the participant held a strong belief that she is worthy of a good life, that she is a good person, and that there is more she would like to do and achieve in the future. I noted the following from two of my SOAP notes after sessions with the participant:

> *"What keeps her going despite the difficulties is the belief that she is a good person who is deserving, loved, resilient, and a fighter."*
>
> *"She also acknowledges her awareness, her love for psychology, and her openness to discussion and learning that have likely aided her on this journey."*

As such, the client spoke of and applied several positive aspects of her life and herself to play an active role in closing the gap between the life she is living and the life she would like to enjoy.

7.4.2 Therapist's Experience

My contribution to this participant's therapeutic journey as a therapist-in-training was also apparent after the coding process, in more ways than one. The different data sources generated 54 segments that were relevant to this role and to different codes such as "therapist doubt about competence" and "therapist motivation". My ability to empathize with the participant's difficulties was highlighted in my reflexive diaries, but I also noticed several entries that relate to my problem-solving tendencies, as seen in the following excerpt from one of my reflexive diary's entries:

“With the client’s increased distress, I found myself almost rushing to “save” her.”

This was one component of the countertransference faced by me throughout my work with this participant, possibly impacting both my work and her gains during our sessions. Furthermore, multiple segments under this subtheme captured the essence of my doubts as a beginner therapist, as seen in another entry from my reflexive diaries:

“With her feeling better by the end of the session, I felt a sense of relief. This may have been attributed to my wanting for her to feel better, but also to my personal fear of not doing well on the job and not being as helpful to her. I notice that I still worry about that, even if I know that therapy is a journey that is everything but linear.”

I had written down doubts about my own skills, the timeframe and its impact on our work, as well as my possible unconscious behaviors that could hinder this process. However, with the progression of sessions, I had grown more aware of the biases and obstacles for my motivation during the work; it was bolstered by the participant’s active engagement, my ability to empathize and connect emotionally, as well as my slow but steady increase in confidence over time. Some reflections in regard to this were extracted from two different entries in my reflexive diaries as follows:

“I can’t exactly place why I felt less helpless. Maybe it’s because of her active input? Her readiness to work with a mode of therapy that better resembles myself as a clinician and my interests?”

“As someone who ultimately values structure and order, it is in my role as a clinician that I have found myself most comfortable letting go of them.”

It is now more apparent that the therapist's role and subjective experience is just as meaningful to the work as that of the client's, with multiple factors interacting to produce an authentic presence and contribute to a human connection in the therapeutic process.

CHAPTER 8

DISCUSSION AND CONCLUSION

This study aimed to understand the participant's lived experience of depression and the contextual factors that influence or shape this experience, including her history of parentification and abuse, her feelings of alienation, and her identity struggles. The thematic analysis conducted highlighted four overarching themes, as follows: "Absence of Security", "Identity Disruption and Reconnection", "Interpersonal Needs and Ruptures", and "Therapeutic Processes and Change". These themes construct a deeper understanding of how the participant experienced her depression during her life and throughout our therapeutic journey, while also considering my role as a therapist in understanding said experience and guiding treatment accordingly.

8.1 Theme 1: Identity Disruption and Reconnection

This theme was possibly one of the largest in terms of content and connection to the participant's main presenting problem. It may even be seen as the aftermath of all she has been through, as her past experiences have left her occupying a particular role that was assigned to her and that did not fully allow her the space to be herself. As such, she had internalized her role as the caretaker and finds her own value mainly through her ability to help others. While the participant acknowledges that this may stem from her experience of being parentified, she also attributes it to her genuine desire to care for others, even speaking of her dream to become a caretaker/psychologist at a nursing home. Nevertheless, the course of therapy had revealed to both the participant as well as me that her identity seems to be lost, underdeveloped, and confused with said role. This phenomenon in itself ties very closely to FM3 in EA as it is the ground of the self (Längle,

2011). The participant does not seem to have access to her *self* as the ground for her identity, and this, in turn, affects her ability to feel fulfilled in her life. As a result of this deficit in FM3, one may specifically notice her low self-esteem, conditional self-worth, and her confusion surrounding her own tendencies and choices. While this theme mainly encompasses the gaps in identity for the participant, it also highlights her attempts at reconnecting with her true self or even finding it from scratch. The participant, over time, came to realize her values, her needs, and ultimately the kind of person she is and wants to be more of. Without sensing it, she was already trying to reclaim her identity and bridge the gap that existed within her FM3.

8.2 Theme 2: Lack of Security

A persistent theme surrounding the participant's past is that of lack of security, which essentially stems from the absence of both of her parents, both physically and in terms of their role. This very closely ties into FM1 in EA as the participant once lost a sense of safety in environment (Längle, 2011). With her father having passed away when she was 6 and her mother being mentally unwell and needing constant care, the participant was parentified, having had to deal with large bouts of responsibility and presently reporting that she had no solid basis to lean back on to, both of which are key concepts that align with the existing literature (Dariotis et al., 2023; Hooper et al., 2012). Another layer of this theme is revealed through the constant emotional and physical abuse that the participant sustained, leaving her with a constant feeling of fear and being belittled, which eventually also arose in her marriage through her husband's abuse. The effects of this chronic abuse on the development of a sense of self were highlighted by Ashraf et al. (2023) and can be seen in this participant's case. As such, one may start to notice the

potential patterns that unfold: the participant had long experienced a deficit in FM1 as she had no acceptance or protection to just be. Ultimately, a weak ground in terms of safety will leave her with weaker ground for her *self*, tying into the aforementioned FM3. The ruptures in each FM therefore relate to each other to a certain extent, establishing a hierarchy.

8.3 Theme 3: Interpersonal Needs and Ruptures

This theme may be the most relevant to FM3 as it represents the core existential question of "Can I be myself around others?" (Längle, 2011). Ever since the participant was young, and given the circumstances that affected her aforementioned feelings of safety (or lack thereof) and insignificance, she has experienced a tendency to "people-please" and cater to those around her, a common reaction that was noted in studies such as that by Penner et al. (2019). Related to her disrupted identity, she has felt like she had to fulfill a particular role to be worthy. However, working with her has brought us both to the revelation that authenticity and connection is something vital for her, and that her depression, although mostly an FM2 problem, seems to be essentially tied to her FM3. She has thus grown to focus on her need for authenticity as a means to bring herself closer to the people she cares about and wants in her life. Nevertheless, despite her growing insight and efforts to be honest in her interactions, the participant may not always find it easy to bask in this authenticity she seeks due to the various interpersonal ruptures she has experienced over the course of her life. Be it her mother's invalidation, her husband's abuse, or even the tumultuous relationships she has experienced with her closest friends, the participant has been largely affected and experiences a lack of trust which does not allow her the most comfortable space to express herself authentically (Chojnacka, 2020).

This, in turn, makes her feel even more alienated from the people in her life, regardless of whether they are abroad or not. A relationship between all those factors can therefore be inferred; relational ruptures (including lack of trust) discourage the participant from being authentic with others which, in turn, makes her feel more distant from them, thus reinforcing her feelings of isolation and reported symptoms of depression.

8.4 Theme 4: Therapeutic Processes and Change

While this theme was not an initial focus for the case study at hand, it was prevalent through the various data sources that were gathered and analyzed. I would assume that this may come from the fact that I occupied a dual-role and had to reflect on my input as a therapist throughout this experience. This was also strengthened by the fact that I was a beginner therapist as well, as the theme entailed various personal aspects that influenced the work in one way or another; the self-doubt, the tendency to rush towards problem solving, the indirect compensatory behaviors for my lack of experience, and many more. Such seemingly negative experiences may have not only discouraged me in sessions but also may have enabled some patterns for the participant, such as needing external validation and guidance in lieu of her trusting herself and her inner voice. However, I also came to notice that my existence as a human being in the room with personal preferences and tendencies may also affect the therapeutic experience positively; it was only when I was authentic and in touch with my preference in therapeutic orientation that I was truly enjoying the process and not preoccupied with my next steps. I was able to exist authentically, which is a core concept relevant to the participant's narrative; being met with someone who was modeling this authenticity and engaging in honest communication has possibly brought her closer to understanding her interpersonal

needs, reconnecting with herself, and feeling safe to engage in the same manner, all of which are cornerstones to existential analysis and the four fundamental motivations.

These four themes do not stand alone but rather interact and establish a dynamic process as seen below in Figure 1, especially when analyzing and understanding them within the context of existential analysis and Längle's four fundamental motivations.

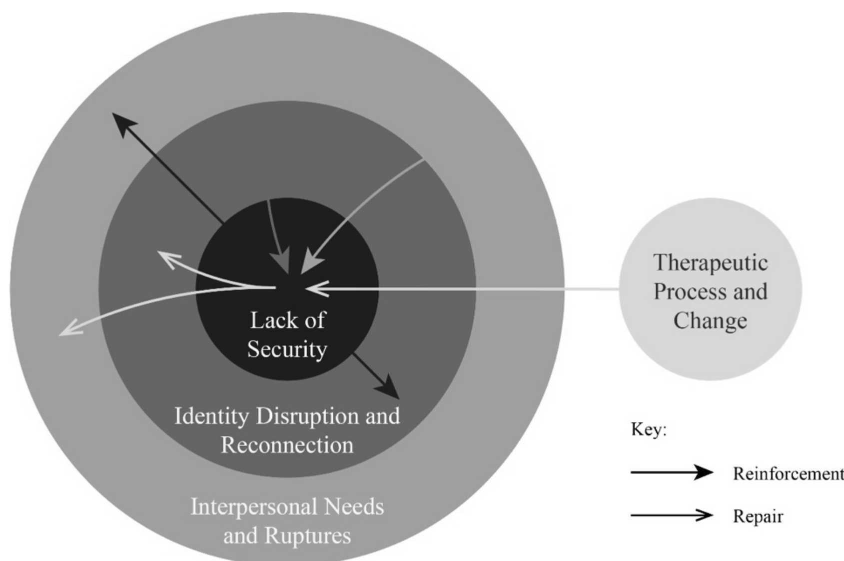

Figure 1. Thematic Map Showing the Fractal Interaction Between Themes

The lack of security that the participant experienced during the early stages of her life may have created the ground conditions for the forthcoming themes. She reported feeling destabilized in terms of safety, security, and self-worth, which ultimately facilitates the occurrence of various interpersonal ruptures as well as trouble meeting her needs relationally. As such, the lack of security in both the participant's environment, herself, and those around her makes her interpersonal needs such as trust, authenticity, and connection more important but also much more fragile. This was seen in the context of various relationships between the participant and others in her life, whereby attempts to form this connection only led to more rupture, resentment, and further lack of security,

thus reinforcing the established cycle. Nevertheless, such interpersonal ruptures, which have been present in both the participant's past as well as her current life, also directly impact her identity and sense of self. Ultimately, relationships resemble a space whereby identity can be mirrored, validated, and further developed. In the participant's case, we can clearly see that her sense of self is weakened due to the learned association between her role as a caretaker and her success in interpersonal connections. Despite such observations and understandings, the participant's unwavering search for authentic connection with both herself and those around her is a step towards reformation. While identity may be fragmented and disrupted amid insecurities and fears, its reconstruction can begin within the context of therapy, the gains of which extend to the participant's everyday life. The therapeutic space thus becomes, in itself, a corrective experience for the participant, whereby security is slowly re-established, on both personal and interpersonal levels. By modeling authenticity and providing unconditional support to the participant, the root ground is tackled, allowing for the transformation of its consequences and encouraging growth.

It can therefore be concluded that the participant experiences depression through a significant disruption of safety, belonging, and identity. In the participant's case, depression is not merely a clinical diagnosis and condition, but rather a living expression of various interpersonal wounds that resulted from her past experiences of being parentified, abused on various levels, and alienated from her culture, friends, and family. She still carries burdens and responsibilities that reflect her expectations for both herself and those around her, limiting her ability to live authentically and in a fulfilled manner. As such, the participant experiences a sense of loss on multiple levels: a loss of safety, belonging, worthiness, and meaning. Moreover, her depression can be understood as not

only a result of a disruption of her relational foundations, but also as a signal of her inner need to re-establish selfhood alongside personal and interpersonal security. Therefore, the participant's experience of parentification, chronic abuse, and alienation have led to her lived experience of depression according to the major themes of identity disruption and relational needs and ruptures.

8.5 Limitations

Despite the study's interesting findings, it carries various limitations that must be addressed. First and foremost, the fact that this is a case study ultimately limits generalizability as it only focuses on one participant's subjective experience. While dense and rich with information, it is very specific to her life rather than that of a broad population, even if similarities exist. The methodology is also important to address as a thematic analysis is rather subjective in nature. Due to my readings on existential analysis, I may have naturally emphasized some themes that either strongly or loosely relate to the core theory and overlooked other relevant aspects of the case. As such, the results may be influenced by my personal perspective, background, and subjective interpretation which, nevertheless, may still fall into this study's constructionist-interventionist paradigm as an assumption rather than a bias. Another bias can result from my dual role as a clinical psychologist and a researcher at once; although I was practicing reflexivity and trying to separate my roles depending on the context I was in, human nature is neither exact nor perfect, thus never guaranteeing a full distinction between the two roles. Moreover, the time limitation that I was bound with at the clinical training site can also be considered a limitation given the theoretical background of this study as well as the treatment for the participant. EA work is typically lengthier in practice, and I only had

less than 6 months to work with the client, thus leading to a relatively “incomplete” therapeutic process and a premature termination.

8.6 Implications

Although this study holds various limitations, it is important to address the insights and implications that may be derived from it in terms of theory, practice, and future research. The case study at hand presents rich findings that directly relate existential analysis by showcasing how lack of security, interpersonal ruptures, and identity disruption connect to form a narrative/process. Moreover, it underscores the role of the therapeutic space as a safe and correctional one, thus facilitating repair and identity reconstruction. In terms of therapeutic practice, I believe professionals should be mindful of the occurrence of ruptures in therapeutic alliance, as it may prove reflective of the client’s personal life as well as an excellent opportunity to repair and allow for growth to take place. This study also represents the importance of finding security in the therapeutic space and how it may be a core factor for a client’s personal journey. Adopting a phenomenological standpoint as a therapist not only facilitates unconditional regard for the client, but it also refreshes a therapist’s thought process and reminds them that a very important part of therapy is their complete presence without assumptions. However, the conclusions of this study may further encourage clinicians to consider their clients’ role in the family as well as their possible history of abuse when they present with a type of depression that is rooted in identity and interpersonal connections. With this in mind, emotional deficits tied to clients’ personhood and connection may also be explored as they may also imply a sense of neglect, absence, and loss. In terms of research, this case study may be further supported by longitudinal studies that may explore how identity

reconstruction may occur over time and outside the context of therapy. Other comparative case studies may also explore whether the thematic process, from lack of security to a disrupted identity and depression with a personal and interpersonal emphasis, is common for other individuals who have had similar backgrounds as well. What was helpful about this research study at hand was the presence of multiple data sources that confirmed similar concepts and brought several perspectives to light; I would encourage being even more extensive about gathering data in future research, transcribing more than two sessions, and even getting the participant's thoughts on findings and results. That is, after all, what represents the quality and nuance of qualitative research.

8.7 Ethical considerations

On a general note, it is essential to ensure the client's privacy and confidentiality by protecting sensitive and identifiable information. As such, everything in this case study was anonymized and nothing that the client prefers excluding was included. Informed consent was discussed with the client in session together, iterating that participation is completely voluntary and that she may withdraw at any point if a change of mind takes place. Consent was also treated as an ongoing process, given the dual roles that both the participant and I were involved in, both clinically and as part of research. As such, consent was revisited at multiple points in the timeframe during which we were working together to ensure her comfort and agreement with the use of our clinical material for research. More specifically, and given the client's presenting problem and background, difficult topics have been discussed in session, giving way to negative emotions. It was important to ensure that the client holds the mental and emotional capacities to delve into topics that may be more sensitive. Subsequently, it was important to mitigate the pacing of the

sessions, to provide the client with the necessary coping skills, and to offer additional referrals or support if necessary. As a clinical psychologist in training, it was also a responsibility of mine to be aware of the limits of my competence, to seek supervision on a regular basis, and to self-reflect on possible barriers to treatment that may arise on my part, especially given the challenging nature of working with depression, alienation, chronic abuse and intergenerational difficulties. Additionally, being mindful of the language I was using to describe the participant's narrative was of key importance to ensure that her lived experience was not being pathologized or sensationalized.

8.8 Diversity considerations

It is important to note that although the client is of Lebanese origin, she was born and raised in the United States and only came back to Lebanon around 10 years ago. This is especially relevant considering that all individuals hold multiple identities ranging from their race, gender, and so on. As such, her bicultural background may have impacted her worldviews, values, attitudes, expression, and more. Furthermore, the client comes from a Muslim background which is different from my own; thus, despite our shared nationality, cultural differences may have surfaced and affected the course of treatment. With that being said, an environment that promotes transparency and communication was essential to ensure that both the client and I are on the same page during our sessions, holding a clear understanding and acceptance of both our backgrounds wherever relevant. Additionally, given the client's life both in and out of Lebanon, her experience of various traumatic experiences that occurred nationally may have been different; especially in the context of this case study, it may have been interesting to navigate her experiences from a mindful, trauma-informed approach. One must have also considered the client's socio-

economic status as it may have contributed to the feelings of isolation, hopelessness, and distress.

APPENDICES

Appendix 1

Client's Intake Form
(Format obtained from clinical training site)

Socio-Demographic Information

Name: […]
Age: 45

Source of referral

It was either her or her daughter who found out about [**clinical training site**], which led her to call and book an appointment.

Reason for referral

The client was undergoing psychotherapy for 3 weeks at [**organization**] but did not have a good experience with them. After getting an appointment at [**clinical training site**], she terminated with [**organization**].

Living situation

The client is living with her husband and son. Her two older daughters are abroad for studies.

Occupation

Stay at home mom.

Educational background

The client graduated high school and completed only 1 year of junior college, majoring in psychology. Her husband was not supportive of her education, so she stopped.

Description of Presenting Problem

Presenting complaint/problem

The client reported struggling from depression. During her episodes, she is unable to eat, get out of bed, socialize, or complete any basic tasks.

History of presenting complaint

Her onset of symptoms was at the age of 14. At the time, the client was housing her best friend who comes from a "broken" family. Both she and the friend were struggling with their anxieties, but the client received no support from the friend. She would instead feel constantly attacked by her, which made her feel bad. At 16, the client was engaged to marry her now-husband. Her family was very apprehensive of this and would push her to rethink her

decision, telling her that she is very young. This made her doubtful of herself and exacerbated her depression and anxiety symptoms.

Pertinent factors (e.g., medication, social, medical issues, unknown/other)

The client is on 5 different medications: Gabrica, Lipinor, Venlax, Dioxin (?), and Xalipro. Gabrica is taken for her fibromyalgia (which she was diagnosed with around 1.5 years ago), Lipinor for her cholesterol, and the last 3 for her depression and anxiety.

Additional relevant information (e.g., substance use, medication)

She smokes half a pack of cigarettes per day. She only drinks socially, and when she does, it is in moderation. No other substance use reported.

Diagnostic Information

Past diagnoses

Major Depressive Disorder

Family mental health history

The client's mother has also struggled with depression and anxiety, and the client was mostly responsible for looking after her and ensuring her well-being.

Risk

Suicidality

No active ideation, although usually present without intent during her depressive episodes. Passive suicidal ideation (frequency: every few weeks, lasting for a few hours on end). The client reports having control over these thoughts. No past attempts of suicide. No past or current self-harming behaviors.

Risk to others

Yes ____ No __**X**__

Sexual, emotional, or physical abuse

Yes __**X**__ No _____

The client reported being verbally and physically abused by her husband in the past. After his brother's passing during the COVID-19 pandemic, the husband changed for the better, as noted by the client and her family members.

Psychosocial Relevant Information

Familial conflict

Yes __X__ No ________

School related information (relations with peers, academic functioning)

The client reported being a shy but extroverted kid. She described herself as reserved around the ages of 3, 4, and 5. Around elementary school, she was much more outgoing and had many friends. When she reached 13 years of age, she felt a shift; she became more insecure and self-conscious, followed by the onset of her anxiety and depression. She considered herself a normally average student, but her grades declined when she reached high school. She also had fewer friends.

Financial hardship

Yes ______ No __**X**__

Recent and current stressors

- Her daughters being abroad for academic purposes.
- Her lack of progress in her weight loss journey.
- Her physical pain, stiffness, and swelling of the body due to fibromyalgia.

Functionality

While the client is able to function, she reports her functionality as "forceful". She feels like she has no energy for basic tasks. Additionally, she is experiencing a sense of apathy towards others and a decreased motivation to reach out to them. She also feels like she is neglecting her physical health due to her depressive state.

Other relevant information

The client reported being close to her siblings and receiving support from them. Growing up, the household was chaotic due to her mother's mental health decline and suicidality and her brother's lifestyle. There would be bursts of good times with the family, but the environment was generally unstable and sporadic. The client was burdened with a lot of responsibility at a young age as she had to care for her mother's physical and emotional needs.

History of previous mental health interventions (including responsiveness)

The client has been to therapy three times, with the most recent time being at the aforementioned organization that she felt uncomfortable with. The therapy was short-lived as the client did not feel like the therapist was competent. Previously, the client was in psychotherapy at the same clinical training site as present, but the therapy was also short-lived as the therapist-in training had graduated. The client therefore recalls it being a nice experience but not enough for results to be tangible. She initially was in psychotherapy for a few years on and off at a different organization, and the main modality was cognitive-behavioral. She recalls working on a specific problem with her therapist and benefiting from the sessions.

Motivation and readiness to psychological intervention

The client is very motivated for therapy but also quite anxious about treatment and its outcomes/efficacy. She is frustrated with her declining mental health and reports wanting to start treatment as soon as possible. Nevertheless, she is worried about treatment not being effective and about her case being a hopeless one.

Insight and possible barriers to intervention

Background of and interest in psychology further contributes to the client's insight. Possible barriers to intervention may include reliance on others' opinions. No others of note yet.

Case conceptualization (initial hypothesis)

The client's history of being parentified may have led her to overcompensate in her relationships, offering her time and resources unconditionally while also craving reciprocity. Possible enmeshment with her daughter may stem from an attempt to correct the unhealthy dynamic the client had with her own mother. Her identity seems to be fragmented as she identifies very strongly with the caretaker role she has long occupied.

Appendix 2

Assessment Session Transcript

(As they are both entering the room)
C: Salemtik (wishing her good health), I hope you're feeling better.
T: Thank you very much! Thank you, I am. The whole country was…sick with the flu
(They both sit down)
C: Yeah…A lot of people are getting sick right now.
T: Mhm. Are you doing okay [Client Name]?
C: I'm…I'm doing okay…I'm…the weather- I noticed that the weather really affects me.
T: Mhm. (Nodding)
C: And…I've been doing kinda up and down, honestly.
T: (Nodding)
C: Uhm… I've noticed that walking has been helping me a lot, even- yeah even if for, you know, a short period it's helping a lot.
T: Mhm… (Nodding)
C: Uhm… I still feel, I'm still, uhm, I still feel like I'm pushing myself?
T: Mmm
C: I don't feel depressed- Like I'm- like I'm not functioning- I'm doing everything I need to do, but I'm still feeling uh…a weight. There's some heaviness.
T: Mm…Like it takes a bit more effort for you to do the things.
C: Exactly, exactly. Now I'm not sure…if the medication? If it plays a role in any of this?
T: And uh… What's "this" specifically- so how do you think the medication is playing a role?
C: I don't know if it's kind of like specifically slowing me down, like it's making me feel tired, uhm…
T: Have you recently changed dosage…? Or…had a follow-up with the psychiatrist…?
C: Uhm…I have not, and I need to.
T: Okay. (nodding)
C: I stopped two but a while ago. And they were very light very small- like- (unintelligible A: 2:40) a dose.
T: Mmm…
C: So it wasn't, I don't think very much to do with it. It was- it might be the (unintelligible A: 2:46) I'm not sure. Uhm… I'm hearing a lot of good results from friends and other people about Prozac?
T: Mm… Mhm…
C: And I'm wondering, maybe I can switch, even though I don't want to? I've heard like a lot of- good- results with uhhh Prozac so there isn't this (unintelligible A: 3:07) you know? And… weight gain is a thing for me, even though maybe it's me, it's, you know.
T: Mhm. (Nodding throughout)
C: But now I feel good cause I've been really trying to focus on my diet and eating healthier and…cutting back calories, it's what I wanna do. Uhm… yeah.
T: And these are… very valid questions, is it the medication, is it me, and there's usually more than one set answer-
C: Yeah…
T: Uhm…Now within my area of expertise when it comes to medication I would advise that you consult with your psychiatrist but uhm…uh…could be an option! And

definitely… talking with your psychiatrist could, you know give you some of the answers you're looking for, and, you know eliminate some factors that it might not be.
C: Okay.
T: Yeah but uh, I just wanted to check in on how you were doing generally, kind of set a tone for today's session.
C: Okay.
T: So, as you know- you know first three to four sessions are so that we can extract the information-
C: Right.
T: For today, I would like us to focus a bit more on your childhood. Uhm, have you ever heard of, uhm, a genogram?
C: No, I haven't.
T: Okay, perfect. So, I just wanted to check on your knowledge in regard to this-
C: Okay.
T: Usually, people are not aware of what it is so I'm going to be explaining.
C: Okay.
T: So uhm, I'm sure you've come across a family tree?
C: Mhm.
T: So, you know how we draw a family tree like okay these two people had this many children…
C: Right.
T: and then whoever got married and then had children…So, the genogram is more like the same concept, except we use it in psychology in order to map out the family tree, as well as map out the relationships that exist within this family.
C: Okay.
T: So, how might this help us? It helps us draw transgenerational patterns that might be interesting, it can also give some insight into your family dynamics, be it your husband and your kids, or your family with your siblings and your parents, we can try and see what the dynamic is like, how that might have influenced your presentation and your symptoms currently.
C: Mhm, okay.
T: And you know even if it didn't, it's just good knowledge to have. You know, what kind of system uhm you were raised in and what kind of system you became integrated into.
C: Okay.
T: Does that sound good?
C: Sure! I was just wondering do you mind (takes sunglasses off of the top of her head) I have a prescription, just so I can see you better do you mind if I wear them?
T: Uhm, I don't think so I think I can still see your eyes through them so it should be okay.
C: It's okay. If it's- I'll probably be doing this (raises and lowers glasses repeatedly) because I don't like wearing them but because I can see you so much better.
(Both smile and laugh a little)
T: No worries. As a fellow, uhm, glasses person I understand the struggle.
C: Right (chuckles) okay.
T: So…No worries. Uhm, so first of all, why don't we just start- start with the genogram. We're going to start with you. Okay?
C: Okay.

T: So, you are what we call the IP, or the identified client, you're the area of our focus.
C: Okay.
T: Uh, how would you like to symbolize yourself. So uhm, you can assign any shape to gender-
C: Okay.
T: So, what would you like to assign to yourself?
C: Uhm…A shape in the family?
T: No just a shape. So, let's say some people choose uhm a triangle for women, square for men…
C: Okay…Uhm…I'll do… triangle.
T: Okay. So, triangle. And you would like this to describe women? So, when we have a triangle in the genogram that would be what that is.
C: Women. Okay.
T: Okay, so here we're just creating our own key, so that we can, you know, understand, uhh
C: Okay.
T: -the figure better.
C: Okay.
T: So…now we know that whenever we see a triangle this is a woman in the family, uh what about for men?
C: We'll go with square.
T: Okay, square for men. (noting down) Alright! So, you at the center, okay (drawing) so this is you, and we'll do a circle around it (shows drawing to client) to identify that this is the focus.
C: Okay.
T: Uh, alright so, you are, currently married to your husband.
C: Mhm.
T: So that is a square. We might add the ages, inside of uh the shapes, just in order to have a clearer idea, so you're [client's age]?
C: Yes.
T: Okay. And your husband?
C: He is uh, [husband's age].
T: (noting down) And uhm, you told me you have three kids together.
C: That's right.
T: Okay so two girls, +and a boy.
C: and a boy+
T: So here I'm also going to be noting, one triangle, two triangles, and a square. Okay? And their ages?
C: Uhm… [First daughter's name] is [age], and [second daughter's name] is [age], and [son's name] is [age].
T: (repeating the names as she notes down the information) Okay, and uhm starting with, you know, your current family, I want to ask you about your relationship with your husband. If you were to describe it using any adjective you'd like, how would you describe it and how would you like me to represent it on this paper. So, for some people, if it's a harmonious relationship, we just add two lines. If they're closer, we add another,
C: Okay…
T: Uhm if there's conflict, or abuse, we might add a squiggly line, to, you know, represent this kind of conflict.

C: Okay.
T: Uhm, but at the end of the day these are just, you know, standard or common representations of the relationships, but this is your genogram so whatever line you'd like to use to describe these relationships, you just let me know, and we'll note it down.
C: Okay. Uhm… So, we're speaking now.
T: Yes.
C: Uhm… Supportive, I would say.
T: Okay, so, supportive. Maybe we could have, uhm, a line? You know, just to simplify the harmony between you-
C: Okay.
T: -Or kind of support. So, you were asking me if it's about your relationship now versus before.
C: Right.
T: So, how has it changed from the past to the present.
C: Before it was, uhm, it was abusive.
T: Okay. So, I'm gonna note some notes down.
C: Yes- Abusive, and not- non-supportive.
T: Mhm. I remember you mentioning in a previous session that he was abusive both in terms of the verbal/emotional aspect-
C: yes.
T: -but also the physical.
C: There was physical too, yes.
T: Okay. And I remember, just to like, make sure I'm not missing any information, that changed after his brother passed away.
C: Yes, that's right.
T: Okay…So currently, it's supportive…
C: Yes.
T: Is there any other adjective you'd like to use to describe the relationship?
C: Uhm… (pause: 12 seconds) I mean, I don't know… I guess we could say…loving.
T: Mhm…Loving, and supportive (noting down). So instead of maybe one line, we can add two to just, uhm, add on to this.
C: Sure!
T: Okay? Uhm… Now I'd like to ask you about your, relationship with your kids?
C: Okay.
T: So, each of them separately. So first of all, let's start with… the eldest?
C: Sure.
T: Okay so… How is your relationship with her?
C: (sighs) My relationship with her is… good.
T: Mhm.
C: [First daughter's name] is very, strong willed?
T: Mhm.
C: And she's very, uhm, self-possessed.
T: Mhm.
C: So, we usually get along- very well, very loving very supportive, uhm, we're like friends-
T: Mhm.
C: -to a certain degree. But we do butt heads.
T: Mmm.

C: Because we can both be very stubborn. Yes.
T: Is there any specific line that you think might represent you two best? In terms of your relationship?
C: Uhm… (Pause: 11 seconds) I'm trying to think of a- a good word uhm… I mean for the most part? I would say understanding and loving.
T: Okay.
C: Yes. Because we always come to an understanding even when we uhm- we always quickly resolve things. So, we try to come to an understanding, and the base is always love. Yeah. We don't like to hold- yeah, grudges.
T: Mhm (nodding throughout). So, the basis is love so we identify this with one green line (noting down), and you said that you do butt heads sometimes, you're both stubborn, so there is this kind of-
C: yeah-
T: -tension at times?
C: yes
T: So maybe we can just add a few lines here, to identify that.
C: Yeah.
T: Okay. So, with [second daughter's name]? Uhh, what's your relationship like? So, you've previously told me you are very close?
C: Yes.
T: Uhm, so tell me a bit more about that.
C: Okay, so it's not that we don't, uhh-
T: Mhm.
C: -we don't have our issues here and there, and [second daughter's name] she's also very- she can be stubborn, but in a different way!
T: Okay.
C: She's more…malleable than her sister.
T: Mm, okay.
C: Uhm, it's very…our relationship is fun, and very supportive.
T: Mhm.
C: Uhm…(pause)
T: Do you view her…as a friend?
C: Yes.
T: Okay.
C: And like a daughter who…there's this…endearment. Uhm, let's see here, it's very…it's very loving it's very supportive it's very c-, uhm, compassionate.
T: Mhm…
C: It's understanding. It's a- there's a- there's a- chemistry between us, a strong chemistry, uhm understanding I think?
T: Okay, okay. So, in this case we can add maybe two strong green lines to this?
C: Yeah.
T: To signify that bond?
C: Yeah.
T: Okay. And it's important for you to be able to just, to visualize.
C: Yeah and I feel like- I feel like she's my rock and that she will stand for me no matter what, [second daughter's name].
T: Mhm, mhm… (nodding)

C: [First daughter's name] is different. Uhm. [First daughter's name]- [second daughter's name] to her it's like I'm a red line. You know? Even if- even if I feel like I'm wrong I'm a red line for her. So, she will back me up no matter what. [First daughter's name] is different in that way.
T: Mmm… Mhm…
C: Yeah.
T: So, there are times where you feel like that support, you won't receive it from- from your other daughter but you will receive it from [second daughter's name].
C: Yes…yes.
T: Alright.
C: Yeah. I wanna also mention with [first daughter's name],
T: mhm…
C: (sighs) she has some resentment? Towards me, I feel, and her father.
T: Mmm.
C: She's gotten better, now at not throwing it in my face, but she still will once in a while because she feels that the issues that she has are because of me and her father.
T: Okay.
C: And that makes me very upset at her because I feel like I stuck it through and I stayed, really stayed for them. So, it makes me feel like it was a lost cause.
T: Mhm. Your efforts weren't seen?
C: Yes. Yes.
T: So, she was- she has this resentment it's pretty clear towards the abuse that she witnessed? And the conflict?
C: Yes. That's right. And trust issues. And she doesn't blame the trust issues on me she blames them on her father. But at the same time, it was us, the dynamic of our relationship, and that really- that really pisses me off. Because I- I mean, in this- in that vein I was a victim. I was a victim! And I didn't have a choice that felt right for me, morally and to feel okay with, other than doing my best to stay, and work it out.
T: Mhm (throughout the client's speech). You did your best with what you had.
C: Exactly.
T: And with the resources that were available to you.
C: Yes. (Nodding)
T: And do any of your other kids feel the same way that she does?
C: Not at all. [Second daughter's name] not at all, [son's name] (shakes head) no.
T: Speaking of [son's name], could you describe your relationship with him as well? W-what is it like? Uh…
C: [Son's name] is very harmonious. Uhm… Also…He…We baby him. I have to admit, we baby him, cause he's the boy. Uhm, but it's harmonious.
T: Harmonious.
C: Yeah generally harmonious. Fun-loving. Yeah he likes to joke around a lot with me and- you know I- I take it, you know. But of course, there's limits, and like he knows when it's- he knows when I've- I've had enough of his jokes. But he- it's good! It's harmonious. Generally good. Yeah.
T: Okay, so now I'd like to ask about your husband's relationship with the kids as well.
C: Okay- can I add one more thing with [second daughter's name]? She's very protective of me.
T: Okay.
C: That's the word I wanted to put in there.

T: Okay. Do you feel protected by anyone else in your life? Other than your daughter?
C: (pause) My brother.
T: Mhm. Okay. Anything else you wanna add before we move on?
C: No.
T: Okay. If there's anything that comes up, just stop me as you did a while ago, and just let me know.
C: Okay.
T: Okay. So, uhm again, uh briefly, your husband's relationship with your kids, with each of them.
C: Oh yeah. [First daughter's name] and her father, very harmonious.
T: Mhm.
C: Uhm… she's like the golden child to him.
T: Okay.
C: Uhm…And with [Second daughter's name] …He is uh…more…He's more rough, on her…
T: Mhm…
C: Uh…I think that comes from when she was young, since she was a kid, she had behavioral problems she was very like- she was hyperactive, and she'd get into trouble… She was bullied a bit, too, when she was young. I think that made her act out in a- in a bad way. And so, he was always on her case.
T: Okay…There was a lot of conflict…?
C: There was conflict, yes. I had always, I- sometimes I had to protect her, like- from emotional or physical- he was getting physical with her when she was young. Uhm, but now! It's- it's good! It's pretty harmonious he's still kind of- he feels- I feel- he even says it like he feels like he has to always like- be telling her what to do because she won't do it, or- always- he has to say something a lot for her to do it.
T: Mm… It's complicated.
C: Yeah it's a little complicated. [First daughter's name] for him she's right on track.
T: Mm…
C: you know?
T: So…seems like he had a…lot of expectations?
C: Yeah.
T: And there's someone meeting them and someone else who isn't.
C: That's right. Yes, exactly.
T: Mhm, so here we can add, uhm you know one harmonious line, again with the (miming a squiggly line) line on it to indicate some conflict or disagreement between them.
C: Okay.
T: Uhm, if at any point there's something you think is more fitting, uhm to describe this relationship, uhm or if you wanna create a new kind of symbol to describe it then just let me know.
C: Okay.
T: For now, is that good? Does that sound like it's a good description?
C: Yeah! Yeah.
T: Okay. And I'll show you what it looks like again.
C: Okay.
T: What about…his relationship with his son.
C: Uhm…It's good…It can be…I think a little passive?
T: Okay.

C: But…Passive but it reaches a point where if [Son's name] isn't doing what he needs to do or you know what he should be doing or he's slacking off, he explodes on him.
T: Mm…Okay.
C: you know?
T: I'm thinking here maybe like a dashed line-
C: Yeah!
T: To indicate passivity?
C: Yes. There's lots of love but there's uhm…it's more…it's uhm…how do I say- maybe it's- it's less connected, than with the girls…
T: Mhm, mhm.
C: Uhm, it feels at times. Yes. And in an emotional sense.
T: Mmm…so even more reason for this kind of dash?
C: Yeah.
T: It's a fitting- seems like a good description. Alright! So, uhm, what about your kids to each other?
C: Uhm okay so, [First daughter's name] and [Son's name] very close.
T: Mm…
C: She feels like she has to protect him… and…and…support him…and be very loving- she's very loving to him.
T: Mm…
C: And uhm, [son's name] and [Second daughter's name] …it's good…! But… not as close as her- as [First daughter's name] and [Son's name].
T: Okay.
C: She- [Second daughter's name] kind of- she's better now, uhm, but she still kind of tries to tell him what to do…and boss him around…and she's even told me that she has some resentment, towards him cause he doesn't get in trouble, or…the way she used to be punished…with him we're more lenient.
T: I see...
C: Uhm…But…yes. And then, uhm…
T: Between the girls?
C: [First daughter's name] and [second daughter's name], I have to say, it's tumultuous.
T: Mhm. So maybe like a…squiggly line.
C: Yeah. Yes.
T: Okay.
C: They're very different people. Uhm… There's friendship between them, but there's also this like (making a wave motion with her hand)-
T: Ups and downs.
C: Yes.
T: Mm…okay. Alright! And so uhm… Thank you for sharing that [Client's name]. So uhm now I think we'll be moving on one generation. So, the genogram usually covers at least two generations, but I think it'll be helpful to also show the different dynamics that existed in your uhm, nuclear family, before you got married. So uhm…
C: It's called a geneogram?
T: A ge-no-gram.
C: Genogram.
T: G-e-n-o-gram.
C: Okay.

T: Alright? Okay! So…Now we are going to have another one, for your family. So once again we start at…
C: At me.
T: So, this is… [Client's name], [age] and you are our primary patient, and we said that you had…how many siblings?
C: Three.
T: Three siblings.
C: A sister and two brothers.
T: Okay. So uhm- who is uh- you said-
C: I'm the youngest.
T: You're the youngest.
C: So, we have- uh [listing sibling names]
T: Okay, so uh, we have [repeating the names].
[back and forth about the siblings' ages]
T: And uhm.. your parents?
C: Let's see my father passed away when I was 6, so… I don't know if you wanna… he was [age] when he passed away.
T: [age]. We're going to have an X over him just to indicate that he's deceased.
C: Okay. And my mother is [age].
T: Okay…Mhm.
C: And…that's it! I think.
T: Okay…So now we delve into the…relationships. Uhm, so, what was it like between your father and your mother. Uhm, during the time when he was alive.
C: Okay well, I don't myself remember them ever fighting. And what my mother tells me is that they had a great relationship.
T: Okay.
C: And they never fought. The only time they had an argument was because of us. Like her- uhm- like trying to- uh she would really be preoccupied with like our food, and he wanted her to take care of herself. So uhm, or he would spend money that he doesn't have to get us something. Like a toy or whatever. Those are the little things that uhm. But she says that it was very loving. I don't- I don't remember much- I don't remember, I haven't seen anything that…again, I remember things, but I don't remember seeing them fighting, I don't remember ever seeing anything sad.
T: And uh, would your siblings agree, that the relationship was uhm… was a good one?
C: Uhm…(laugh) recently my brother when I'm there he tells me that they used to fight. That mom says that they "had this perfect relationship" and they didn't. He says something and she says something else.
T: Mhm, so we can maybe indicate both of them? Since you don't remember.
C: Yeah. I remember that he had- my father was very funny! And very loving but he had a very bad temper.
T: Mmm…
C: VERY bad temper.
T: Mhm…okay. Okay.
C: Very.
T: Alright… So just writing it down so I don't forget. Alright, so I put two lines to indicate this one-sided view that it was a harmonious good relationship, and also the dashed line over them to indicate, partly the bad temper on your dad's end, and the conflict that would happen between them.

C: Okay.
T: Alright! So uhm, in their marriage they had four kids?
C: yeah.
T: and what was their relationship like to you and your siblings? So, your mom's relationship to you, your dad's relationship to you, and we're gonna do that across…
C: Uhm… The moments that I remember with my father, most were positive, but in that way I can't really say- I can't give you a word that would describe anything? Because it was like- it was so short, the time, you know that we had together.
T: Mmm.
C: So, I…All I know is uhm- I'm told that he cared a lot for me. He loved me very much. That's all I know.
T: Okay. So, a simple line between you and him. And we can delve more into the relationship when it comes up.
C: Okay.
T: Uhm, okay what about the relationship with you and your mom?
C: (deep breath) me and my mom, (sigh) very close, uhm… very… supportive on my part
T: Mhm.
C: And I feel like I was the mother, a lot of the time.
T: Like you were parentified, in the relationship.
C: Yes, yes. We did a lot of things together. I was always- I was with her most of the time. I was with her more than my siblings were.
T: Mhm, mhm.
C: Uhm… And I guess, I remember that I always had to be understanding and supportive and I felt like I needed to be that. Because she needed that, so much. She needed so much support and help, physically and emotionally. And I was always afraid of losing her. I was always- you know, ready to help her-
T: So, you took on that role, partially because, you were afraid of-
C: I was afraid-
T: -losing her, but also because you felt like she needed those things and there was no one else around to provide her with that?
C: That's right. That's right.
T: Okay…
C: She was even- I don't know if that's important to add but she was, at times when it was bad, so when she would have a nervous breakdown she would, uhm, she would threaten suicide and stuff?
T: Mmm…
C: And I was young, and I would really believe that she would… My siblings were more kind of like, easy-going about it but I would be very afraid.
T: That sounds very scary…And… you know, from a parent…
C: Yeah, she'd even leave the house, not like long term but she'd leave- and during that point I was- so! afraid and terrified, and my siblings would laugh,
T: Ouf…
C: you know, and it's like- this is serious this is not funny, and they would laugh at it! They would laugh at me they would laugh at the whole thing.
T: Mmm… how did that feel for you, at the time?
C: I felt confused! And scared.
T: Mmm…There's this fear, like my mom is threatening to harm herself,
C: right,

T: and at the same time, my siblings-
C: they're not taking it seriously and it's like what's happening? Why am I the one like so afraid? Why are they not afraid?
T: And how old were you?
C: 7, 8, 9? Yeah… this went oooon! Until we all grew up.
T: Mhm. And moved out.
C: Yeah! She always- she still does. She doesn't threaten suicide, but she always says that she wants to die. She'd be better off dead. It's all pain at this age; there isn't anything nice in life… She doesn't… enjoy her life.
T: Mmm…
C: She…nothing brings her joy anymore. Yeah.
T: And at the time, did anything use to bring her joy? When you all lived together?
C: (pause)
T: Or would you say it was the same?
C: It was- it was like- almost the same.
T: Mhm.
C: You know she had a good relationship, she had good supportive friends around her, I remember she loved to dance and she loved music.
T: Mm.
C: Uhm… but yeah… I mean (pause, shrugs), I don't know. She was- she- she's been chronically depressed for most of her life. You know she had times where she was relatively normal and it was fine, but there's trauma that she never took any care of- any attention to.
T: Mmm
C: No attention, to it, at all.
T: Mhm.
C: It was just, you know, my- woe is me- this is- my luck is horrible, it's been bad from the day I was born…
T: Mhm, yeah… So, a lot of the energy in the household was directed towards taking care of her,
C: Yeah!
T: Uhm, when YOU were upset as a child, how was that dealt with in the family?
C: (pause) uhm… sometimes she would uhm… sometimes she would you know calm me or support me or, even if my siblings bothered me or were being rough on me or something you know, she would be like you know, be like I'm the youngest and this and that you know, but uhm I remember more as a teenager, for me, my relationship with her was different from the one my daughters have with me. But I wouldn't always go to her with problems, like school or friends or boys or anything like that, it was more I would go to my sister. But when- when I would get really bad anxiety or uh depression, she'd be like, oh you know "you're going crazy" and "nothing's wrong" and "stop it".
T: Mhm… She dismissed your distress.
C: Yeah… or you know when I did- when I did- when I got engaged she'd be like you know yeah you just miss your- you know you miss your fiancé, and it was so annoying, and it was so hurtful to me.
T: Mmm, it doesn't feel like someone who really-
C: She still does by the way. Like when I- that's why I don't talk to her really anymore if I have like a really bad time, I don't even mention it to her because she'll just comment

and she'll say "change your thinking" and "you have everything" and "you didn't go through what I went through" and she'll just go on and on and discount everything.
T: Yeah…mhm, mhm…
C: Yeah it's always about her pain, always. It's- it's- we can all agree to this.
T: Mhm… it felt like you almost were only there for her, like not as a person with your own troubles and feelings-
C: right, yeah, yeah. She did a lot of trauma dumping, and she still does. Like when I go sometimes I have to leave the room, cause it's constant and it's getting worse as she ages. And it's like I need to breathe I need some room; I can't be there I can only do it for so long. And like, any person, if you're throwing all this shit at them- excuse me- I can say it right?
T: You can yes (both laugh).
C: So just- all this shit, and it's like "mom, stop!" we just- we don't wanna hear- we just wanna see you okay. Like, we're not coming against you and it's not that we don't wanna hear you but it's like- it's the same shit, and you're not- you can't do anything at this point. You have difficult ailments, you have limitations, what's gone is gone, you know- your fiancé, we know the story we've heard it a million times, and it hurts us, and it kills us and baba(dad) died and all this stuff! And then we have the disease, and it paralyzed you- and we've heard it all! I- I can't do it anymore.
T: Mm.
C: And she feels- like when we come to the point where we're like "stop" we put a boundary, and it's like "I can't do this anymore", she gets- uh you feel like she's not- she feels like she's not being heard. When we've been hearing it and hearing it, but it's not our place to fix this. She never, you know, she won't go on medication, she's NEVER been in therapy! Even as a child I knew she needed to go! As a young child I knew! She needs to go get help and she never would! So, it's like I can't do this anymore.
T: Yeah… and the repetition makes sense cause also what makes even more sense is- you weren't given the space to do that as well.
C: Yeah! Yeah but- (crying) it also hurts me is that she doesn't! I feel sad for her! That she never- she was never able to heal! Or, you know get the help that she needed.
T: Mhm…(nodding)
C: (Crying) You know we love her a lot but- and we feel for her very much, but it's like you can only do so much as like- as a- as her child! As a person standing and watching it you can't! You can only do so much! You can't- you can't manage her we're not doctors.
T: Mhm. Mhm… that's a…difficult emotion…
C: Yeah…
T: There's like… two parts of you-
C: Exactly! I always feel very torn! I always feel very torn there's a part of me that, like, is very sad for her and I feel for her and I just- I hope, that, you know I would- I wish that I- we could- we all wish that we could do something to make her life better, but at the same time there's also some anger there. And I know that's not her fault it's all she knew, but it's like there's anger because like I didn't get the care that I need emotionally, and I didn't have anybody there for me who stood there for me or supported me or loved me through MY hard times, so like, why do I have to do this for you!?
T: Mmm… it's like you keep giving and giving and giving-
C: Yeah!
T: -and you're not receiving.

C: Yeah! And they talk about- like, spiritually in religion, that you have to get your parents' approval/make them happy no matter what, but, like, to what extent? You know? There's limits in life, you know? If somebody's abusing you and hurting you, even if it's an indirect way, it's like- you have to have a boundary like- I can't keep being a doormat for you or, you know, your punching bag. And I've told her before like "we're not your punching bag!" you know? I'm not ten years old anymore you can't keep doing this.
T: Mhm. Eventually you did realize that it's taking away from your energy.
C: Yes!
T: And you started setting some boundaries between you?
C: Definitely.
T: Okay.
C: Yeah…
T: So, in this case, it's very interesting to see because at the beginning when I asked you about your relationship with her you told me that it's…very good…
C: Yeah…see it- it was so mixed.
T: There's a lot of, you know, complications that are also taken into account when thinking about this relationship.
C: Yes, yes.
T: Uhm, alright, alright. And would you say that your siblings have a similar relationship with her?
C: Yes.
T: Uhm, were they also parentified?
C: not- no, not parentified like me, no.
T: Mhm.
C: No.
T: But they had these kind of ups and downs with her in terms of-
C: Yes.
T: -like their taking on-
C: Yes. Now, my poor sister, because she's there, and of course I'm a million- I'm thousands of miles away. She's like now the parental, you know.
T: Mm…Mm…
C: But [sister's name] her whole life she's had limits. She has a block. I'll only do so much and then that's enough.
T: Okay…
C: So, she takes care- she'll cook for her, and you know take care of bills and she'll- take her where she needs to go you know she's- physically doing the things that she needs, but emotionally- even my mom says that she doesn't give her much emotionally. She's always been this way. That's just the way she is, you know.
T: There's a consensus about their relationship. They're both aware of it and that's how it is.
C: Exactly.
T: Okay, so is there, some stability in that?
C: Yeah! Yeah. They're okay with it she's okay with it. My mom would, like, for example- my sister comes, like after work or on a weekend, she sits for half an hour and leaves. She would rather her staying with her for a few hours you know spend more time with her, but I know my sister she has- you know she has her life, and at the same time I know my sister also- uhm- sorry but uh- my mom, she can be a downer. It's draining. I

would say like- we love- like I'm the same way, now. We can only take so much of the- the- like the- negative the trauma dumping and the-
T: Mhm…
C: -negativity and the- it's just ugh like all the time. So, she has to make a boundary.
T: Mhmm, I think there's something you said- you said you're the same, now?
C: I'm the same with my mom I can only take so much like- I don't BLAME my sister? You know? In the past, I would, I would be like she should stay and you know she should listen to mom, and that- but now? As I've, you know gotten older it's like- no. You can't.
T: Mm…
C: It's like you don't have to just sit there and take it to your own detriment.
T: Mmm. At the cost of your own-
C: At the cost of your own health! Your mental health.
T: Mm.
C: So, you listen you listen and then, that's enough.
T: Mm.. okay, mm.
C: Yeah I used to- honestly? Like- I feel like I would have killed myself to make sure that she was okay.
T: Mmm…
C: And that was the way it was supposed to be.
T: Mm… And when did that switch happen?
C: (sigh, pause) I think it honestly…happened…not too long ago?
T: Mm…
C: Probably…in the past…(pause) six, seven years?
T: Mhm…
C: Yeah. Not too long ago.
T: And was there anything specific that- opened your eyes to this- other perspective?
C: (pause) Uhm…(pause) Yes, I do, actually… A lot of…anger, towards her.
T: Mm…
C: Cause every time I'd go visit, when I lived here, she would- the first week or two, with my kids being there and everything, everything was fine and dandy, and then afterwards she would kind of make us feel like- we were in the way? And uhm… yeah like, annoyance and, we'd reach a point where we'd feel like we're being chased away. So, it would reach a point where I would take only one kid with me, then it was just me, even though like I would tell her and we would argue and we would fight and I would leave sometimes,
T: Mmm…
C: I'd go to a friend's house and- she would, even when I was there now! During the war. She did the same thing. I mean we were kicked out, my son and I. She'd literally get in our face like "you can't stay here! You can't- you have to go home!" and it- it was very horrible and hurtful. When she started doing that in the past I was like- fuck this, like, who the fuck do you think you are? Like, you're not going to talk to me like that-
T: Mmm…
C: -removing me from my family home, sorry I don't care. It's like- a nice person, a nice mom- this is horrible! What kind of mom treats her kids that way.
T: Mmm…
C: And then we go back, and I know, and she has her problems, and she's this and she's that and like- we try- you know? It's like- make it like it's okay- it's not okay! It's not okay! But she has issues, you know?

T: Mmm…
C: She has issues.
T: So, it was a gradual…multiple encounters with her that gradually led you to realizing that this is not the way-
C: Yes! Yes, I mean look at her she doesn't even care! Like, it maybe comes to the point where like- look at her! Like she doesn't care about anyone except herself so I will care about myself too. I can't do this with you anymore sorry! Like you've shown your true nature, kind of.
T: Mmm… Alright! And, we've talked about-
C: Does that make sense? Does that make-?
T: It does! It does, from what you're saying I can really see your rationale so far, and it's one that's very common in people with similar experiences to you so, it makes perfect sense.
C: Okay.
T: Based on what you're telling me. So, you told me about your relationship with your mom and your sister's relationship to her, what about your brothers?
C: Uhm…
T: How's their relationship to her?
C: So… [Brother A] is kind of- he's kind of- we've always kind of said that he's the favorite one.
T: Mmm…(nodding)
C: And… we don't know why.
T: Mmm… okay…
C: And concerning-
T: And did he feel- uhm, like was it a mutual feeling between them? Or was it like she feels-
C: She favored him!
T: Okay.
C: She favored him. (pause) and… uhm with [Brother B] there was always problems.
T: Mhm. Was he the one who you told me would get into a lot of trouble…
C: Yes, yes.
T: Okay. Alright and I wanted to also just briefly ask about the relationships between your siblings, I know you've given me an idea before, uhm, that it generally was good, so we know that there was a lot of conflict with [Brother B] because of his lifestyle-
C: Yes.
T: -but currently, you all have a- what's your relationship right now? I don't wanna assume anything.
C: Sure, so with all of them together?
T: Uhm… yeah! Or if you'd like to just, specifically your relationship with each of them?
C: Uhm…
T: Like in a brief way.
C: Sure, so with me and [brother B], it's very loving now. And uhm, it's very loving and understanding.
T: Mhm.
C: And…with [brother A], same. Uh…
T: Mhm.
C: And with my sister also there's a friendship.
T: Mhm…

C: And…I look up to my sister I think. She always kind of played like the mother role to me, as much as she could.
T: Mm… You've told me that instead of going to your mom you'd go to her instead.
C: Right, right. Uhm… and like yeah I'd go to her for advice. She would take care of me.
T: Alright.
C: As much as she could. And my mom… now it's…I mean it's okay. It is what it is. So…I think I've accepted that she's never gonna change. And I love her anyway.
T: Mm…
C: (sigh) but I feel saddened, because I didn't know anything at the time, but I feel saddened for myself, how I was treated that way.
T: Mhm.
C: And it's like… I know it could have been much worse, so, uhm…
T: That doesn't cancel out the negative experiences you've had.
C: Right. Sometimes I sit, and like, you know, maybe- I say "God, it could've been so much worse" you know. I've heard- I've seen so many stories, and right I don't wanna cancel out my, you know, hurt and stuff but, yeah, I feel saddened!
T: Mm…
C: That…I wasn't taken care of the way that… I should've been! And I had to really take on a lot. That no child should have to take on, or even witness! To see somebody behave and do those things. You know?
T: Mm… It must have been very difficult.
C: Yeah, and I also wonder, like, why- I wonder why I was affected the most. I always wonder that. And I compare myself to my siblings- I mean, of course they were affected in their own ways. Everybody- there's no way that you can live- LIVE that and not be affected but- I compare myself to them cause I take medication? So, it's like- I suffer, with depression and anxiety-
T: Mmm…
C: And like my siblings they don't get bouts of depression or- like they've never had a problem with anxiety. And so, I always wonder why me?
T: Mmm…What's different.
C: Yeah it's like- I feel like- why were they able to get away with it?
T: Mhm…
C: Or like pass through those things, and still remain like okay and I- why was I affected in this way? And it- it kind of makes me resentful?
T: Mmm…
C: It makes me like-
T: Towards them?
C: Yeah it's like, in a way why did I have to suffer like this? Why did this happen to me?
T: Why are you carrying the burden…
C: Yeah! It's like being exposed to this disease, and it's like why was I the only one who got sick?
T: Mmm… mmm… and, it's a very good question, and there isn't one direct answer.
C: Yeah…
T: Maybe… you were very… like you were the most involved with your mother.
C: (nodding)
T: Uhm… looking after her… so that in its own right has its effect,
C: Yeah.

T: So maybe, you know just for the sake of time, you can reflect on that for next week, and maybe we can delve into it on a deeper level,
C: Yeah.
T: But uhm, from what you're telling me, it seems even in the household you were taking on a LOT, and it wasn't the same for your siblings,
C: Yeah, yeah.
T: So you know, it only makes sense that it would affect you, in multiple ways. So here there are also personality components,
C: That's right.
T: How you react differently to stressors…But yeah. Maybe you can take some time and think about that, and we can share both of our ideas during the next session.

Appendix 3

Genogram

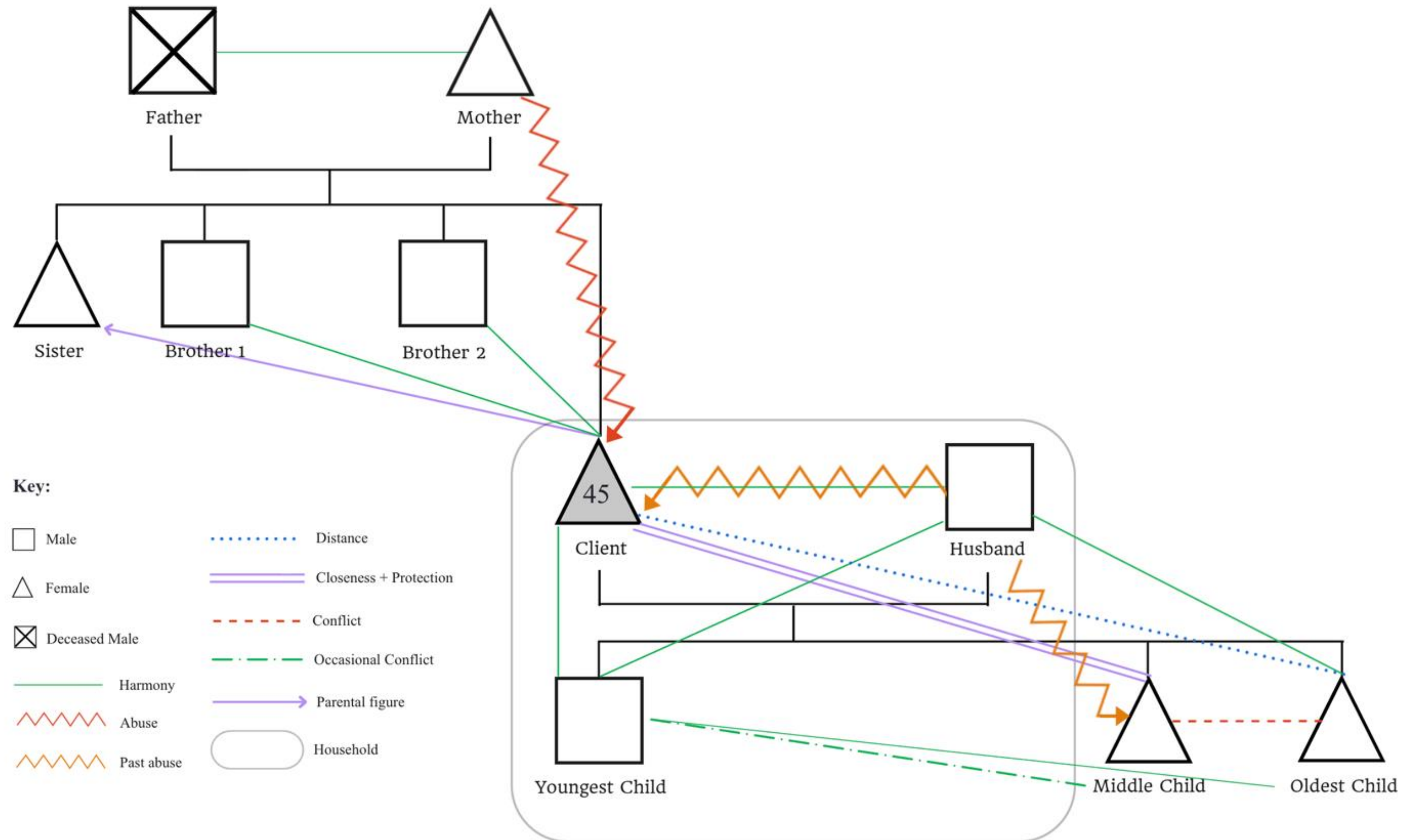

Figure 2. Client's Genogram Across Three Generations

Appendix 4

Treatment Session Transcript

C: (Walking in) I'm sorry I couldn't accommodate you back then.
T: No worries, no worries. It wasn't something urgent, and I was just, you know, checking the possibility. So, don't worry about it at all.
C: Okay, yeah. I put in the suggestion box, that maybe we could start, like, a support group—
T: Mmm…
C: —for people with anxiety and depression, I think that would really be good.
T: Yeah! Yeah, that sounds like a nice idea. Have you not found any other support groups that exist outside of [placement site]?
C: No…
T: Mm…
C: I don't even think I looked, I don't think there are any that exist.
T: I see. I'm not very informed about this, so maybe I'll look into it on a, on a personal level as well —
C: Yeah… thank you.
T: Because, I mean, I think it could be a nice opportunity to connect with others.
C: Yeah, I definitely think it would be good, and it'll help people not feel — cope better, maybe?
T: Mm…
C: And feel more connected?
T: Mm…
C: And not feel, like, isolated, you know?
T: So, can you rephrase — can you repeat that sentence, but instead of saying "people", say
T and C (at the same time): "Me"? (both laugh)
C: Me and others.
T: Yeah.
C: It will help me and so many other people, I think, to feel less isolated, and uhm, to cope better! Yeah.
T: Mm. You feel like you need this connection with people —
C: For sure.
T: — who experience other similar things.
C: Oh yeah. Yeah.
T: Yeah.. Well hopefully they take it into account, and I'll try and see if, you know, there are any opportunities I hear about, I'll relay them to you
C: Okay great.
T: So, is there anything specific you would like to address in this session? Or if you'd like to pick up where we left off…?
C: (nodding) Pick up where we left off, and I would like to talk about something that's been happening to me lately.
T: Okay. Okay.
C: Yeah. But we can first start off where we left off. Honestly, I forget where — what we were talking about.

T: Mm… well, last time you came to the session with a little bit of confusion about, you know, whether to change the meds —
C: Right…
T: — and whether to switch psychiatrists or stay with your original psychiatrist.
C: That's right.
T: So, there was a lot of, uhm, wanting to get better, quickly, understandably,
C: Yes.
T: But that was causing you a lot of confusion because, you know, "what do I do"? So, have you taken some time to think about it, (inaudible)?
C: Uhm, I feel, I think I'm still kind of on the fence about things. I'm, I feel more open — I talked to my husband — and I feel a little more open to maybe take—, adding on a stabilizer to the — a mood stabilizer to the antidepressants, but I don't feel comfortable just being on a mood stabilizer, which the doctor had suggested.
T: Mm…
C: So, and maybe like not like Lamictal itself?
T: Mmm…
C: Because there's some serious side effects that come along with it. Now, maybe 1 in a 1000 or 1 in who knows, but I — it just, it makes me feel anxious about it, yeah. So, like rashes and skin disease, so I would rather, yeah. I would rather just maybe try something else if that's possible.
T: Yeah, and that's something that you can, you can discuss with the psychiatrist herself —
C: I, I, I don't know, honestly, if I should do anything right now? About it? Because now it's going well. You know? I'm okay, I'm doing okay — like I said I could be better, but I feel like it's going well. My days are going okay, they're fine, and I'm getting through and I'm not like all stressed out and crying… I'm not too bad, you know? It's mild. It's mild right now.
T: Mm (all throughout) … Yeah. It's under control, you're able to live with it.
C: Yeah…
T: It's not affecting you too much?
C: No.
T: Alright, so, uhm, do you already have a follow-up scheduled?
C: I don't, I don't, not at this point, no.
T: Alright, alright, so definitely the decision is in your hands. Sometimes, people can fall into this loop, that just because I'm feeling better now, the I don't have to really change anything.
C: Yeah…
T: Sometimes it can be preventative work, so —
C: Definitely.
T: (inaudible) the switch that can happen because of medication, you're still coming to therapy, so now just because you're feeling better, you're not stopping your work with me because —
C: No…
T: you know, it is going to help for the future, for future times where you feel more distressed.
C: Of course.
T: And, of course, there is the medication as well

C: Oh definitely. And, and I still feel, I feel like I still need to be you know, I still need treatment, and I still need to be coming and it's very important to me. Yeah.
T: Yeah. So now you're (inaudible) that you don't want this switch to happen because you're already feeling a bit better now and you don't want this switch to affect you negatively?
C: Hm yeah… yeah, I also — right now, just, I'm just thinking, like, why add a medicine if I'm okay, if I don't need to be adding, taking more medication, you know, putting more medicine into my body? But, of course, if I feel anything, even a little bit, I'm totally, I'm open to making an appointment and seeing what options I have.
T: Absolutely, I get what you mean. The concerns are very valid. But of course, we need to (inaudible) the episodic nature of uh, you know, your struggles.
C: Right.
T: We did talk about, you know, how it's episodic and how the switches happen in between episodes. So uhm, it's just something to keep in mind, and I'm sure you're more than capable of, you know, uhm addressing, you know, your concerns with the necessary professionals.
C: Yeah.
T: And, so, what I'm trying to understand is that you've gotten more clarity in regards to where you stand on all of the decisions you have to make in terms of the psychiatrist, in terms of the medication, in terms of you…
C: Yeah…
T: Okay, and was there anything that helped you come to that place? To reach this point where, "okay, I'm a bit more confident in what to do"?
C: Uhm… I think just time, coming here and talking to you, and speaking about things. Yeah, speaking about things. And feeling more, more like I have options, not that it's just like that's it, like this is what you have to do, and this is the only medication, and that's it.
T: (nodding)
C: No, I know that there are several options, and that's fine, that's okay, and I'm more open to trial, error, if I need to.
T: Yeah.
C: I'd rather do it, honestly, now, like if I'm gonna do it, because I feel like I have the capacity to deal with, like, if it didn't work out, and then change again. So, maybe, *maybe*, it's a good idea within, like, a couple weeks, also possibly talking to the doctor, and getting in there and doing something. What do you think?
T: Even getting their opinion…
C: Yeah.
T: Uhm… what do I think… when it comes to what?
C: What do you think, what do you think about adding a stabilizer — at this point? Do you—is it hard for you because you're not (inaudible)?
T: Uhm, it's not that it's hard… Because I don't necessarily have the full expertise to give advice on this,
C: Okay.
T: But at the same time, I'm just thinking of the episodic nature, the uh, advice that you received from the psychiatrist as well… Taking all of this into account, uhm, I'm not sure, I really am not sure.
C: Right.

T: I think it's safe to keep it at that. Uhm, I understand your concerns, that now I'm feeling better, there's no need, but at the same time, just cause you're feeling better doesn't mean that in the future there might not be some difficulties. So, it could be something to keep in mind.
C: Yeah.
T: Maybe it could be helpful to tackle it now as preventative work, but it really all is relative to, you know, the person very much in the field and knows more than me about the medication.
C: Definitely.
T: So, even if you do book a follow-up, you don't need to have a decision made by then. You could maybe just talk about it again; you could try to plan something with the psychiatrist…
C: I, honestly, I kind of felt, when I, when I went in for my appointment, because I kind of felt a little pressured, cause she was like "what exactly are you doing here?"
T: Mm…
C: She was kind of like not sure or kind of like "what brought you here", kind of like "if you don't want to do X, Y, Z, then…", but I, "but if you don't want to change or add…", but I went in there to talk, to get her opinion…
T: Yeah…
C: You know what I mean? Because that's what I was doing there at the time, and I told her that, but I kind of felt like, you know, she thought I was there to do something with the medicine, actually.
T: And is that affecting you now?
C: Kinda, yeah…
T: With the follow-up?
C: Kind of, to go in again and talk… I just, you know what I mean? Like, I felt like she's not just there to give me her opinion or whatever. She wants to prescribe me something [instead]. She wanted to, you know…
T: Yeah, I can sense that… uhm, you know, just feeling pressured in and of itself during that appointment is probably gonna make you think that "oh this is gonna happen again" and "she's gonna want an answer out of me or a decision or something".
C: Yeah, yeah
T: I get that… that must be difficult as well to, you know, just take in.
C: Exactly. Yeah.
T: So, now, in comparison to last week, it seems that you have at least a bit more clarity, like 10% more clarity at least, in regards to, you know, what's going on. And, at the end of the day, an option could also be calling the psychiatric nurse and asking her if this requires a follow-up appointment or if it's something you can be discussing over the phone.
C: Okay…
T: So, there are several options, and I think what we can take away from this is that the time plays a role. Some time had passed, and you had time to kind of process this slowly, uhm, which I think is very great on your part, considering that you really just wanted to speedrun things and wanted to get better quickly, and it was really difficult for you, so you wanted this decision to come fast. Uhm, but I'm also wondering, last time you were a bit anxious about talking to your husband about the whole situation…
C: Yeah…
T: How was that like for you? Because you told me that it did happen, the conversation.

C: Yeah. It actually — it was, it was brief, and he was supportive about adding something if I needed to. He was not, like, you know, argumentative or like "what are you doing now, you want to add and mix…" and things like that. So, I was happy about that. It was brief and he just told me "Whatever," you know, "whatever you feel like you need to do, then do it. We don't want to mess up the medication," you know, "but if you feel like you're not doing well, then," you know, "make another appointment".
T: Yeah. Was there anything in particular about the conversation — the way you were approaching, the way he was approaching — that made you feel a bit safer and a bit more supported?
C: Uhm, I think yeah, just the fact that he didn't say anything negative — because sometimes he would, you know, and like kind of make me feel defeated. Uhm, he was more supportive, he was just more like "do what you need to do, yeah, take this medicine"
T: Yeah.
C: And I told him; I told him that I've taken it — the Lamictal — before and I didn't like it. It was a short period, but maybe it was too short to tell, and since I was already going through a depressive episode, it was really hard to tell if it was the medicine that was making me feel, like, really flat, or it was just my emotional well-being at the time, my emotional state.
T: Mm… (throughout)
C: Uhm, so, yeah, it was just easier to talk to him this time around.
T: Mm, so you felt like he wasn't criticizing you, he was just there —
C: Exactly.
T: — giving you his point of view, but not in a way that defeats you.
C: Right.
T: That's great.
C: Right.
T: So, (inaudible) what we got next on the — oh was there something you wanted…?
C: Yeah, I wanted to say, I'm doing better, but I'm still not there yet.
T: Mhm…
C: You know what I mean? And I think a lot of, I think a lot of it is the void of my children and being away and still, like, there are a lot of nice things that happened in the past weeks, but I'm still, like, anticipating when I want to see my children, and I want, like, things to — I'm kind of impatient, like waiting for things to unfold with the summer coming, and the travel maybe going back… and I want those things to happen and I need a change, you know? Like, I need a break, like, from the daily routine and stuff. So, I'm having a hard time with the patience of it all, you know? Waiting, and…
T: Mm mm… (nodding throughout)
C: So, yeah…
T: Has it always been like this? Where you feel like you can't wait for things to happen and want things to happen quickly?
C: Yeah… yeah
T: When was the first time you felt like that?
C: Uhm… I honestly don't know. Yeah, I don't know. I've always been pretty impatient, so… yeah.
T: And — just a hunch here, and very hypothetical — uhm, is there anything to do with, you know, the stage of life you're in right now that is affecting all of this?
C: Uhm… no, I never thought about that.

T: Mhm.
C: No, that's not something that comes to mind.
T: Okay, okay.
C: Yeah.
T: Alright, so we've got that to rule out.
C: Yeah.
T: Okay. So, what is it particularly that you want with this? So, what is this, uhm, what's the function of this impatience?
C: What do I think I'll, like, or what does it serve me?
T: Mm. (nods)
C: Uhm, I don't know, I just feel like things will be better or I'll feel I'll feel a lot better once these things unfold and they start happening. You know? I'll feel like, more myself. I think that's why. And again, like, wanting to get better.
T: Mm.
C: Wanting to feel better.
T: So, you're counting on these things…
C: Yes!
T: …to help you (inaudible) and feel better.
C: Yeah, yeah (at the same time). But, but, the truth is, I know deep down it's supposed to come from, like, an inner, like, contentment inside me, right? That's where I want it to come from anyways. I don't want it — I don't wanna rely on those things, but I feel like I'm going that way. You know? Because in the — at the end of the day, all I want is just, like, to feel peace of mind and contented in my being, in my self, in my…life, you know?
T: (nodding throughout)
C: Just, you know, that sense of peace, or that sense of calm. Even when things aren't perfect. That's what I want.
T: And what's getting in the way of that?
C: (Big sigh) Loneliness, honestly.
T: Loneliness?
C: That's the only thing I can say. Even my husband says it. He says, you know, "I know you," like, "I know you and I feel like," you know, "the only thing that's bothering you and not letting you be 100% is loneliness"
T: Mm…
C: Loneliness. Yes.
T: And how do you think he's picked up on that? Is it something that you've discussed with him? Or is it something that he's concluded on his own…?
C: I think both. I think that, well, not, I, I tell him. I talk to him about these things. And comments that I make, you know, like "if the kids were there", or "if I had my friends", etc. etc. So, yeah, he picks it — he's picking up on these things.
T: And what does loneliness mean to you? It's clearly bothering you a lot and causing, like, some anxiety and emptiness… Uhm, what does it mean to you to be lonely?
C: Hm. Not having somebody or — other than my husband, because he can't fulfill all of these things to me. He can't be those, everything to me. So, excluding, not counting on my husband for these things. Not having like, (sigh), someone really to share with the ups and downs. Somebody that, yeah, that I can share times with, somebody that I can share my feelings with, my experiences with. Uhm…with me, you know? not over

the phone, like a friend, but I want somebody there, like I want a friend, or I want somebody close with me.
T: To experience it with you.
C: Exactly. That's like, in the same, geographic (laughs), on the map. So, yeah. And I feel kinda bad because — about something like — my friend (friend's name), I mentioned her before to you — uhm, she… she keeps in touch and I so appreciate it, and she always asks about me, and we talk often, but, like I said, she's not she's not like all stable? In her mind?
T: she also has some difficulties…
C: She has some difficulties — it's hard — she doesn't really — I don't even know how to say it — socially not very attuned. So, it's hard to really, what she says or, it's hard to really take it to heart, I guess? Even though she's trying to be helpful or she's kinda out there, you know? She's kinda out there. And I don't know why, but it makes me feel — this is not my —it kinda makes me feel bad about myself? That I — I'm just gonna say it — that I have a friend like that. Is that —
T: Thanks for sharing that with me…
C: Okay. (laughs) It's so hard to say!
T: Thanks for trusting this space.
C: Yeah cause I do, I do love her, I really do. I care about her, and I love her, and I — and I always want the best for her, and I'm always there for her, but it's just, it's hard to — how do I say — it's just, it's hard to have, like, a real being conversation because she's kind of incapable, I feel. She's not really in touch with that, like, she kind of — she'll go off, like, in different directions. Yeah! And for me it's like (sigh of frustration), this is kind of — this is getting annoying. This is kind of getting annoying. I can only, I can only, like, talk so long with this person, you know? Which is, which is understandable, honestly. But, at the same time I feel bad? Because she considers me like her family, and I consider her very close too, as somebody who knows me very well and who's been there, who's seen a lot of my ups and downs and my things that I've gone through in my life.
T: (Saying mm's and nodding throughout)
C: She's an important person to me, I just feel kind of, like, — it's annoying.
T: You don't always enjoy having the conversations with her.
C: Exactly! One hundred percent. One hundred percent. And I feel like, I really, like, I speak with her from my heart, and I really try to, like, — if she's going through something, she's kind of, she, she's kind of off and of a different, different style, different emotions.
T: Mm…
C: So, it's hard to connect, and that's another thing — so, with that, I don't feel at a full, I don't feel a full connectedness, and it doesn't really make — it doesn't make the loneliness, or the isolated feeling feel better. You know? It doesn't. Yeah.
T: So, the means in order to ease this (inaudible), to ease this, uh, loneliness, is someone to be fully present…
C: Yeah!
T: …with you, to fully receive… your being…
C: One hundred percent.
T: …and, you know, kind of reciprocate…
C: Exactly.
T: …this honest, shared existence.

C: Totally.
T: You feel like that's not capable — she's not capable of doing that with you, and that's pushing you further away.
C: It's not. Mm right.
T: Why do you feel bad that you're feeling this way? Or that you don't really enjoy it?
C: I feel bad because, like, hmm, I think I feel bad because I feel like I'm lying?
T: To her?
C: To me, to myself. And to her.
T: To yourself…
C: Yeah. And to her.
T: Mm…tell me more.
C: I feel that (big sigh), it's a heaviness, like, sometimes when we're talking, like, halfway through — and we could talk for half an hour or an hour, and, like, halfway through I'm, like, "I'm getting tired, I'm getting tired right now", like, and then I can't tell her that. But I'll keep going and try to, like, stay with her and talk with her and listen to her stories and this and what she did, and this happened and bla bla bla. And, and that shows, I am a loyal friend. I'm a good friend; I'm a loyal friend. And it's hard for me to be like, like, — what do I tell her? Like, "I've had enough, I have to go"? I cut it off sometimes, like, "Okay, well…". I try to do something or say something that'll, you know, that'll end the conversation. So, that makes me feel guilty. And she has, she has no idea, you know?
T: Mhm… (throughout)
C: And I wouldn't want her to know, like, that would probably crush her. If I did say, like, "Hey, this is getting annoying", or (laughs)
T: Mm…
C: Yeah.
T: So, you feel bad — and now I'm understanding it a bit better —
C: You know what I mean?
T: You feel bad because you're not being fully honest and authentic with her…
C: Exactly!
T: …and there are all these feelings that you're experiencing while on the phone…
C: Yes!
T: …or even when just thinking about your type of relationship…
C: Right.
T: …and you can't disclose that because you're worried about how she'll receive it, you're, you're worried about —
C: Yeah, she's very sensitive, and she already, haram (poor her), has issues. And, like you could tell by the way she talks, and, like, she's not confident in herself, and she, and she questions herself, and she doesn't even know what a boundary is. She just learned it recently. I mean, she didn't even know what a boundary was. Like, her psych— her psychology, she tells me, is zero. I think it's called emotional intelligence, or something? Maybe? Like, she's taken a 0 on psychology. For me, like, I've taken some of it, I got A's— when I was doing sociology, psychology. So, it was like, she's like "I'm like— I got like a D, a C in psychology, I'm so bad…" (laughs) She speaks like that. And, um, so, yeah… I feel like I'm on another level. And she's on a level. (laughs) You know?
T: Do you feel responsible for her?
C: Responsible…

T: Mm.
C: Um…(pause) I do kinda. I do kinda. Can you elaborate exactly more about what you mean by that?
T: Yeah. Yeah, definitely. Just from the way you're talking about her, and you're kind of talking about her as this person who's really incapable, who's unable to, kind of, you know, um handle things on her own…
C: Mhm, mm, mm
T: …and that's your duty as a friend to stick around even if you're distressed, even if you're having a hard time; you have to be there for her because 1) it's your responsibility, and 2) because she, kind of, *needs* you, in a way.
C: Mm…
T: Do you feel like that resonates?
C: Yeah, definitely.
T: It's a lot to deal with, honestly…
C: Yeah.. (chuckles)
T: …you know, to feel like it's an obligation, almost, but at the same time, not feeling like you can be honest.
C: Exactly, yeah. So, I try, like I try to take care of myself. Like, she wants to chat, like, let's just say "Oh, can you chat tonight?", I'll be like "I can't, I have this and this, possibly maybe tomorrow" so I can give myself some breathing room, you know. Um…it's not all bad, but it gets to the point where it's a little too much, and I don't really know what to say at that point, so it's better to, I feel like, just to like kinda keep it off or avoid (inaudible) until the next time
T: So, here I'm noticing that, even in the presence of others in your life, this sense of loneliness is still there because they're not providing you with what you need in this relationship.
C: Mhm.
T: Is there any relationship that does provide you with this sense of connectedness, with a decreased sense of isolation?
C: Um…(pause) not 100% no, no honestly. Uh, even with my children, it's not 100%.
T: Mm…
C: Yeah, to be totally honest, if I'm being honest with myself, yeah! It's not 100%, no.
T: How does it feel to say that? That it's not 100%?
C: It feels like I'm just being honest. It feels good.
T: It feels good…
C: It's not 100%...
T: Mhm.
C: No…
T: And do you think there's any relationship where it could be 100%? Like, an absolutely perfect kind of connectedness at all times?
C: No.
T: Mhm…
C: No…But! There is, there is, like, um, enough with other relationships. It's not perfect, but it's enough…
T: You feel like you're getting what you need…
C: I feel what I need… I feel like I'm getting what I'm needing. I, really honestly, I miss my sister. I wanna, I feel like I should reach out to her, I wanna tell her that I miss her. I always feel comforted, and I always feel, um, connected when I talk to her. We

haven't been talking that often, you know, everyone's busy with their lives and stuff, and she used to check in on me more, and I miss that. So, um, yeah I miss her. And I really miss my other best friend, (friend's name), who I haven't heard from… in months.
T: Mhm mhm (throughout). Was she the one you told me you texted her last and she hasn't replied?
C: Yes. And that's another thing that's like — I'm like "what the fuck?", you know? That's like, not very nice…And I'm — I've reached out to you, like, several times, and even on Mother's Day — which was a while back, there — I did that, and I still haven't heard from her.
T: Mhm…
C: Which is, like, this is how she is. But it's, like…
T: It stings!
C: Yeah!
T: How does it feel that your sister hasn't reached out in a while and that your other best friend —
C: It hurts! It adds too, it adds to these feelings, it really does. It bothers me and then sometimes I think "Am I being too sensitive?"
T: Mhm…
C: "Am I—" no! I don't think I'm being too sensitive.
T: Mhm…
C: You know? Somebody reached out to you, reach back. It doesn't take that long; it takes a minute. Actually even, like, tell me — like, we've told each other — even if you're, like, really busy, just one sentence: "I'm so busy, I'll get back to you, but I'm thinking about you". That's good, and that's it!
T: Mhm, mhm… (nodding)
C: And it's like, I don't know what the hell is going on with her. Sometimes, honestly, I feel like just being honest with her, and I have been before where, like, "In effort to honor our relationship, I feel like it takes you forever to get back to me, and I don't know what's going on with you, and it worries me. Like, can you, like, reply? Hello, like, where are you?"
T: Mhm.
C: And then it's just, the things she says, (friend's name), the things that she says does not match her, her— the things that she says to me don't match her actions; "I'm so worried about you there, and I think about you, like, all the time" and this and that. But it's like, where is this going to help? You don't even answer me.
T: It feels like a contradiction where she's telling you that she cares so much… but at the same time…
C: Yeah! And she cares, she cares so much. I'm her very best friend, and she makes that very clear to me and to everybody, it's, like, well, where's the action? I don't know, it's annoying.
T: Absolutely.
C: Yeah.
T: Do you feel like this sense of being apart from others and not getting what you need from them increases this feeling of loneliness and isolation?
C: Totally! Totally.
T: And that gets in the way of your well-being in general…
C: Yeah! Is that normal?

T: Mhm.
C: It is? Is that me being codependent?
T: Tell me a bit more about that. Have you felt codependent before?
C: I feel kind of, like, I — what is, what is code— can you, can you give me the definition?
T: I'm not sure about the, like, dictionary definition. Codependence is usually where you can't really exist on your own. You're fully, fully dependent on each other.
C: Okay…
T: So, a unit could be two people who need each other in every single area of life…
C: Oh…
T: …otherwise, they're just unable to, kind of, like, proceed. Now, this is more or less the definition. I could be a little off, but uhm, it's also important to consider the context, it's important to consider how this word is being used in society now…
C: Right, it's a phrase that's thrown around by everyone.
T: Exactly, so a lot of people say, let's say "I'm so OCD" and it's just about —
C: Right, and it's not — yeah…
T: So, a lot of words are being taken out of context recently, so it's important to also just keep that in mind…
C: Even— yeah, bipolar…
T: Mhm!
C: "You're so bipolar" …
T: "The weather is so bipolar" …(chuckles)
C: Yes, yes.
T: So, things have gotten, like, a bit more, uhm, commonly used in a not very accurate way. So, tell me a bit more about your experience with this codependence, with, you know…
C: Okay. Like, in order to be, well, I mean, normal, I mean, it's kinda — I feel like it's normal, but another side of me is questioning like, "Do I need to hear from them?", or "Do I need them that bad?" Like, "Can't I get that from myself?"
T: Mhm.
C: But, then I know that I'm a human being and it's like we're social and we want to connect.
T: A connection… exactly.
C: So, I don't know, I mean I don't think I'm being — I, deep down, I don't think I'm being codependent.
T: Mm…
C: I think that it's just, like, the critical side of me.
T: Codependence is, for example, being unable to come to (center name) unless somebody comes with you (inaudible), like, "I really really feel like I can't live without this person".
C: Okay.
T: Uhm, to me, it sounds like you're craving this human connection. You want people involved in your life; you want to care and be cared for.
C: Right.
T: It's such a pillar of, like, human existence.
C: Okay.
T: Have you heard this anywhere before? Someone called you codependent? Or is it just coming from —

C: It’s coming, totally coming from me. Yeah.
T: Mm… and have you felt this way before or is this the first time this thought has crossed your mind?
C: I — no, I have thought about it before. Yeah, I used to think I was codependent with my best friend, (friend’s name), the one that lived with us and all that. I felt like we were kind of codependent. It kinda was. Kind of, in a way. It was hard to do stuff without each other, and I think she was more dependent on me; she would get super jealous if I went out with other friends or did other things without her, which is normal to a point, which is kinda normal — we all get a little jealous sometimes, but not, like, where you’re not gonna talk to me anymore… but,
T: Yeah.
C: But, whatever.
T: Do you think your experience with her is influencing the way you view relationships now, or?
C: I feel like my relationship with her really influenced my relationships down the line, you know?
T: Mhm…
C: Yeah. Because she always needed, she always, uhm, always needed help, and I was, like, always there to help her fix things and make things better, and to listen to her… Uhm, so, this is a pattern.
T: Mm… I see what you mean.
C: And my mother, too. This is a pattern, but…
T: Now it’s (friend’s name)
C: …now it’s (friend’s name), it’s the same thing. Uhm, everybody, honestly! And I, I mean, I do care. I know that I m a caring person and I know that I do, I do, like, I do give, I do give freely not because of anything that’s like, like old trauma or anything. It’s not because, not just because of that. You know? Because I am that way.
T: Yeah.
C: But a lot of it, too, is, like, from, you know, patterns.
T: I see what you mean. A part of you wants to give, but at the same time, this is a role that you’ve gotten used to.
C: Exactly. Giving, giving, but then you have to take care of yourself, you know? So, yeah.
T: And how do you try and do that?
C: Oh… (sighs)
T: How do you find the balance between caring for someone and also looking after yourself and taking some time off?
C: Uhm, being honest, I think.
T: Mhm.
C: Being honest, and, like, not like, like — cause boundaries — not always being available to that person. Not always, not — yeah. Because it’s, like, it would be so draining and impossible.
T: Mhm…
C: Yeah.
T: And you’ve — you’re experiencing this firsthand, as well.
C: Yeah. Sometimes, honestly, I don’t know, I feel like if I did say anything it would really like, it would probably terminate our friendship. If I really told her kind of what I was feeling, it might hurt her so bad that, like, you know?

T: Mhm.
C: And I definitely don't want to do that because she's already so — she's like, she can't handle it, I don't think. Haram.
T: Do you think there's some kind of compromise that could be done, whereby there's something else that you could be doing that safeguards your friendship but also safeguards your own wellbeing in that relationship?
C: Uhm, do you have any suggestions for that?
T: Hm, not at the top of my head, but you did mention, you know, boundary setting, and I'm wondering how this could be applied practically, or if, you know, there's something you feel like you're ready to kind of test out and experiment with that could, you know, could set some limits to how much you're giving.
C: Yeah.
T: Or how much you're taking on, as well.
C: Exactly. I'm not sure how I would do that, honestly.
T: Mhm.
C: Uhm, I do try to be honest with her, like, uhm, or try to, like, redirect her, you know? When I feel like she's kinda going off…
T: Mm…
C: …and, like, uhm, just to get serious. It's kinda silliness, just silliness, and like a ditziness, and for me, it's like, "Are you serious, really?" Like, "Is this for real right now?" Like, "Is she really doing this? Is she really saying what she's saying?" And it's just, I don't know, I don't know exactly what I would say to her where she would get the point without getting hurt. You know?
T: Mm..
C: Yeah.
T: Yeah, if that's not something you're willing to do, you don't have to. But, for example, you did mention how when you have these calls with her, halfway through you start getting tired, you feel like it's really taking a lot from your energy.
C: Right, so then and there.
T: So, how about, just then and there, you excuse yourself, continue this another time, take some time for yourself and rejuvenate this energy that was lost during the conversation.
C: Okay. (phone rings) Sorry.
T: It's okay.
C: Okay I can answer this later. (pause) Do you think — is that normal? Is it, I know it's hard to say what's normal and what's not normal, but like, I feel alone in it. Like, sometimes I feel — I think some, some of us, a lot of people have friends like that.
T: Feel alone in the friendship…
C: Yeah, you know? Like do other people have people like that in their lives? Or do, I feel alone it in, I feel alone in that.
T: It sounds really lonely, because you're out there and you're sharing but you don't really feel heard, and your authenticity is not being reciprocated.
C: Yeah, even though, haram, she tries, like she's genuine, but we're both mentally on different kind of levels, you know? And, so, yeah, I'm just like "Do other people have friends like this? Like who deals with this? Or even who maintains friendships with these people?"
T: Mm…

C: Sometimes I think to myself, like the dark side of me is like "What am I, why am I still dealing with her?"
T: Like "Is this friendship worth maintaining?" …
C: Yeah! And then I'm like, I always feel bad. I, honestly, I could never, like, not talk to her. I know that about myself. So, the only solution would be, is yes, boundaries.
T: Mm… (nodding)
C: Yeah.
T: I get where you're coming from.
C: Unless she hurt me, unless she did something major, you know?
T: Yeah.
C: Yeah…
T: Like, currently, it feels like, you know, finding this middle ground is what could, you know, uhm, help protect your relationship, but also protect you.
C: Thank you, yes, exactly.
T: Yeah, that sounds fair! And, if I were in your shoes — I'm trying to, kind of, think about this — I'd also feel very unheard, very alone, like I'm the only one, you know, trying and trying in this relationship…
C: Yeah!
T: …but I'm not getting my needs, even if she is trying…
C: Right.
T: …maybe she's not capable of fulfilling what you need from this relationship.
C: Right, 100%.
T: Yeah. It doesn't necessarily have to mean that anyone is completely in the wrong.
C: Right.
T: At the end of the day, we're all human, we all make mistakes.
C: Correct.
T: But at the same time, you're allowed to feel alone, and you're allowed to have some resentment towards her because there's something that you need from her and she's not providing that.
C: Okay. Yeah.
T: How did it feel to hear that from me?
C: It felt good, yeah. It feels like I'm being heard and seen, and my feelings are being validated.
T: Mhm…
C: Which is what I'm speaking.
T: It's also what you're doing for yourself! I mean, even in the conversations you're having with me, you've stopped yourself and you say, like, "No, this isn't codependence, I feel like that's normal". You also are trying to remind yourself that I am allowed to feel these feelings. I am allowed to feel alone in this because A, B, C.
C: Yeah.
T: And this is clearly affecting me. And that's, you know, maybe one of the most important things you can be doing for yourself, is giving yourself this acknowledgement that I am going through this and it's normal for me to be going through this.
C: Yeah. Do you think it would be safe, at some point, like, it would be okay to tell her "I don't feel like I'm being heard"? "I don't feel like I'm being seen the way I see you"? Or…
T: To be honest…
C: To be honest?

T: And do you think that's something I could answer?
C: Yeah! I think so.
T: The way I'm thinking about this is I don't really know her, and I don't know the types of situations she would react to. I don't know the type of relationship you have in depth, as well, so, at the end of the day, you're the expert in your own life, and you're the expert when it comes to her, in comparison to me at least.
C: Right.
T: So, uhm, slowly but surely, I think you will grow to find that answer within yourself, uhm, and you will know if the time is right and, you know, you have to say it. At the end of the day, being honest to her is not only serving your relationship with her; it's also serving you.
C: Correct.
T: But I, I do see your point that there might be a time in which that is going to be helpful, and a time at which it is going to be more distressful. So, uh, unfortunately there's no answer that I could give you, but at the same time, you know, same thing with time; last session, you were also confused about the psychiatrist and medication… Giving yourself some time to explore will unravel a lot, you know.
C: Yeah, that's true.
T: And that was just one week, so imagine if you give it even more time, to try and think about it with more clarity.
C: Okay. Yeah.
T: How are you feeling?
C: Fine!
T: Still okay?
C: Yeah.
T: Do you have any questions or anything before we end the session?
C: Uhm…hm, not in particular. I'm kinda thinking about how we have to end in July, and uhm, I'm disappointed, of course, but should I get on that list now? Should I get back on that list now?
T: The waiting list, you mean?
C: Yeah.
T: I'm not sure what the logistics are like at the clinic, but maybe you could discuss this with them, and I could try and see if I could have an answer by our next session to coordinate together. Uh, but yeah it is really unfortunate that we had so little time to work together…
C: Yeah.
T: …and I really appreciate you and your honesty in our sessions. It really does help with the whole process by a longshot.
C: Great.
T: So, uh, thank you for this, and we'll definitely talk more about this termination and whatever can come up in our following sessions.
C: Okay.
T: Alright?
C: Okay sounds good.
T: Thank you for today (patient's name), and I hope you have a good week.
C: Thank you. You too.
T: Bye.
C: Bye-bye.

Appendix 5

Session Notes in SOAP Format

Session 1

Subjective concerns:

Source and Reason for Referral: The client was undergoing psychotherapy for 3 weeks at […] but did not have a good experience with them. It was either her or her daughter who found out about […], which led her to call and book an appointment. After getting the appointment, she terminated with […].

Presenting Problem: The client reported struggling from depression. During her episodes, she is unable to eat, get out of bed, socialize, or complete any basic tasks.

Onset: Symptoms became apparent at 14.

Antecedent (traumatic or triggering events): At 14, the client was housing her best friend who comes from a very broken family. Both she and the friend were struggling with their anxieties, but the client received no support from the friend. She would instead feel constantly attacked by her, which made her feel bad. At 16, the client was engaged to marry her now-husband. Her family was very apprehensive of this and would push her to rethink her decision, telling her that she is very young. This made her doubtful of herself and exacerbated her depression and anxiety symptoms.

Current stressors: Her daughters being abroad for academic purposes- Her lack of progress in her weight loss journey- Her physical pain, stiffness, and swelling of the body due to fibromyalgia.

Current medication and medical issues: The client is still following up with her psychiatrist, […]. She is on 5 different medications to manage her fibromyalgia, cholesterol, depression, and anxiety.

Substance use: The client smokes half a pack of cigarettes per day. She only drinks socially, and when she does, it is in moderation. No other substance use reported.

Suicide risk assessment: No active ideation, although usually present without intent during her depressive episodes. Passive suicidal ideation. Frequency: every few weeks, lasting for a few hours on end. The beneficiary claims to have control over these thoughts. No past attempts of suicide. No past or current self-harming behaviors

Abuse: The client reported being verbally and physically abused by her husband in the past. After his brother's passing during the COVID-19 pandemic, the husband changed for the better, as noted by the client and her family members.

Family mental health history: The client's mother has also struggled with depression and anxiety, and the client was mostly responsible for looking after her and ensuring her well-being.

Goals and expectations from therapy: - Stronger coping- More compassion towards oneself- Increased motivation- More positive prospect towards life.

Objective

The client was cooperative, although she looked depressed and would cry on multiple occasions throughout the session. Loud speech, but other MSE criteria are unremarkable.

Intervention

Intake session. Consent form was covered, and basis for working alliance was established. Validation and space were given to the client when she was distressed.

Plan

Continue intake.

Session 2

Subjective concerns:

Educational Background: Graduated high school and completed only 1 year of junior college majoring in psychology. Her husband was not supportive of her education, so she stopped.

Occupation: Stay at home mom.

Onset of symptoms: As mentioned in the previous session, onset of symptoms started at 14 and presented as anxiety and social avoidance. The client started feeling symptoms of depression initially as a result of that.

Severity of distress: 8 or 9 out of 10

Factors that improve symptoms: - Therapy and medication- Having support from friends and family - Going out - Practicing self-care (getting hair and nails done) - Buying something for herself

Factors that worsen symptoms: - Not engaging in self-care practices - Sleeping - The winter - Neglecting oneself and feeling unable to look after oneself - Arguments with husband and kids - Not taking medication

NB: The client reported feeling weak due to the fact that she is still struggling with her mental health while on medication.

Impact on daily life domains: While the client is able to function, she reports her functionality as "forceful". She feels like she has no energy for basic tasks. Additionally, she is experiencing a sense of apathy towards others and a decreased motivation to reach out to them. She also feels like she is neglecting her physical health due to her depressive state.

School related information: The client reported being a shy but extroverted kid. She described herself as reserved around the ages of 3, 4, and 5. Around elementary school, she was much more outgoing and had many friends. When she reached 13 years of age, she felt a shift; she became more insecure and self-conscious, followed by the onset of her anxiety and depression. She considered herself a normally average student, but her grades declined when she reached high school. She also had fewer friends.

Other childhood and family related information: The client reported being close to her siblings and receiving support from them. Growing up, the household was chaotic due to her mother's mental health decline and suicidality and her brother's lifestyle. There would be bursts of good times with the family, but the environment was generally

unstable and sporadic. The client was burdened with a lot of responsibility at a young age as she had to care for her mother's physical and emotional needs.
3 most important events: 1. Father's passing [year]: The client thinks that a lot of things, including her mental health and state, would be different had her father still been around. She believes that the family lost a sense of stability and support and that they grew to be less resilient because of this. 2. Getting married [year]: While it was a very exciting time for the client, she feels as though it represents the loss of her independence. 3. Having first daughter [year]: the client describes this as her best moments, feeling pure joy and love.
Additional general concerns: Nothing feels rewarding, life is meaningless, and my best years are past me. She senses a mismatch between her needs and husbands catering to said needs. She feels like the people around her may be tired of her mental state, thus preventing her from reaching out to seek support.
Objective:
The client was visibly distressed throughout the session, crying at several instances. Nevertheless, she displayed a great amount of engagement and was cooperative throughout the session.
Intervention:
Continuation of intake.
Plan:
Finalization of intake and formal assessment of depression and anxiety.

Session 3

Subjective concerns:
During the genogram construction, the client expressed the following main points:
- Her eldest daughter is resentful towards her parents' past unhealthy dynamic
- The client feels bad about this resentment because she pushed through the relationship for the sake of her kids
- The client was parentified by her mother; a lot of burden and responsibility that her siblings did not bear
- She took on this role out of fear of losing her mother and out of obligation as no one else was taking care of her
- Does not remember much about her father, other than that he had a really bad temper
- Mother was dismissive to the client's negative experiences and distress
- The client would seek out her sister in times of distress instead
- The client has been hurt by her mother but also feels sorry for her

Objective:
The client was cooperative throughout the session, expressing herself openly. She cried when the ambivalence towards her mother was addressed. MSE criteria unremarkable.
Intervention:
Session was dedicated to collaboratively construct the client's genogram.
Developmental history was partially taken during this activity too.
Plan:

Finalize intake and administer psychometrics.

Session 4

Subjective concerns:

The client arrived to the session and began crying. She reported almost canceling due to how she was feeling but came to the session because it is her "safe space". She has been feeling more depressed and hopeless, as well as "out of control" and "not normal". Passive suicidal ideations present but no active or intent. No support from her husband who sees her in distress. Daughters are also do not always have the capacity to support her in her distress. Guilt for receiving practical help from husband around the house; thoughts of "I should be doing this".

Objective:

The client was visibly distressed, crying for most of the session. Nevertheless, she was still cooperative during the session, trying to engage.

Intervention:

Validation and empathetic questioning. Containment was done to make the client feel safe enough to sit with her negative emotions. Probing to explore the roots of her thoughts. Treatment plan (cognitive restructuring + behavioral activation) was explained upon the client's request.

Plan:

Finalize intake.

Session 5

Subjective concerns:

Updates about recent psychiatry appointment: The client's psychiatrist switched one of her medications for another and introduced new medications to cater to her concerns. She is already feeling better.

The client also shared information based on the following intake questions asked:

Functionality and wellness: - The client reported doing better than last week, rating her distress a 4/10 - Mood is fluctuating, anxiety is also fluctuating but client reports being more in control of how much it affects her - Concentration is intact, but the client feels restless often - Eating and hygiene are unremarkable, except for weight loss concerns (no criteria for eating disorders) - She is monitoring her blood pressure due to a recent episode

History of previous mental health interventions:

- […] psychotherapy from 2010 to 2018 (on and off); it was beneficial as the client and her therapist were working on a specific problem. Stopped due to increasing fees.
- […] psychotherapy around 2 years ago; it was helpful but short lived as only a few sessions were offered.
- […] psychotherapy 1-2 months ago; unhelpful and the client sensed that the therapist was incompetent, so she terminated.

Current interpersonal relationships: The client notes that she does not feel supported by those around her, especially in Lebanon. The friends she made in Lebanon are more on the shallow side, and she has not formed a deep trustful bond with them. She notes that

in the US, she could share all her thoughts with her friends without feeling judged. However, she has recently realized that she generally feels inferior and not respected around almost everyone, but especially around her family.
Coping and motivation: The client does the following to cope: smoking, listening to music, taking a walk, going for a drive, playing a game on her phone, talking to her husband, and shopping. What keeps her going despite the difficulties is the belief that she is a good person who is deserving, loved, resilient, and a fighter.
Values: The client is of a Muslim background and reports having a relationship with God but not being "overly religious" and strict about it. As for her values, she noted love, friendship, loyalty, and family ties.
Core belief: The client often thinks and believes that she is weak.
Objective:
The client was calm and cooperative. She seemed somehow nervous towards the end of the session, particularly when asking about the course and details of treatment. Otherwise, her mood was elevated compared to last week and other MSE criteria are unremarkable.
Intervention:
Finalization of intake. Normalization and reassurance for the client's difficult experiences.
Plan:
Formulate collaboratively and plan for treatment.

Session 6

Subjective concerns:
Past symptomatology at onset: Crying, feeling like there is no joy/energy. Heart palpitations. Choking sensations. Feeling afraid.
History of interventions before psychotherapy: At 18, the client was sent to the psychiatrist by her mother due to her struggles. She was prescribed Zoloft which she only took for 1 month as she could not come to terms with her needing medication. After that, she spent 5-6 years unmedicated until her symptoms got worse. She then was prescribed Paxil.
The client shared concerns about her friend flying in to Lebanon soon: With her friend in the country, she feels a pressure to be well and not show her struggles. The client also described a past of people pleasing tendencies, difficulty setting boundaries, and needing validation from others; she would often second guess people's emotions and reactions and break down trying to do well for them. Upon probing, the client shared that this may have been linked to her parentified role as well as the abuse she endured.
History of abuse: The client previously disclosed having been abused by her husband during her marriage. During this session, she also disclosed having been physically abused by her father and mother growing up. Her father would often beat her and her siblings with a stick/rod, and her mother would restrain, blindfold, and lock her in a room. She was also bullied and ridiculed by her siblings, although they now have a calm and supportive relationship.

Objective:
The client appeared down and concerned. Although preoccupied with negative emotions, she still was very cooperative during the session. Other MSE criteria unremarkable.
Intervention:
Probing to help the beneficiary make links between her past and present. Validating past harmful experiences and providing reassurance where helpful. Socratic questioning.
Plan:
Collaboratively formulate and plan for treatment.

Session 7

Subjective concerns:
The client was engaged in a collaborative formulation during this session, and she noted the following:
Predisposing factors:
- Mother's psychological difficulties and being parentified
- Anger that was witnessed from her mother and father + abuse
- Substance use (uncle) that may have predisposed her to forming a nicotine dependence
- Personal traits such as not being expressive and feeling shame

Precipitating factors:
- High school experience: she was alone, insecure and anxious
- Best friend moving in: toxic relationship, negative view of herself and her struggles were internalized
- Getting engaged and married: she notes that it was too soon; she was still growing and her life changed drastically very early on

NB: the client noted having a fear of loss and fear of death towards the end of the session
Objective:
The client's mood was euthymic, and she had the space to actively engage in the formulation. She would cry at certain instances, especially when she realizes how much she has been through. Other MSE criteria unremarkable.
Intervention:
- Introduction of formulation and its importance
- Collaborative formulation according to the 4 Ps model
- Linking the factors to current presentation

Plan:
Continue formulation, plan for treatment, introduce cognitive restructuring

Session 8

Subjective Concerns: (Continuation of formulation)
Perpetuating factors:
- Daughter being away as she is studying abroad
- Feeling distant from her loved ones and lacking support
- Being a stay-at-home mom and lacking accomplishment/a career

Protective factors:

- She found difficulty thinking of these
- Being at therapy, willingness to change (shared by me)

After the treatment plan was shared, the patient conveyed that:

- She is hopeful and excited about starting treatment
- She is also anxious about the effectiveness of treatment

Additional general concerns:

- Feeling out of control
- Feeling on edge all the time

Objective:
The client was cooperative and hopeful throughout the session, although also visibly anxious towards the end of the session. She cried while sharing concerns about feeling out of control and always on edge. Other MSE criteria unremarkable.

Intervention:
Collaborative formulation was finalized with the client, and a tentative treatment plan was shared. The treatment plan consists of cognitive restructuring, behavioral activation, and the incorporation of existential elements to tackle the client's concerns regarding lost time and meaning in life. Empathetic reflections were used throughout and a reminder about the treatment process being an experiment was relayed so as to decrease the client's anxiety about the effectiveness of treatment. She was also reminded of the importance of honesty and communication so we can track progress, adapt treatment to her benefit, and ensure her comfort throughout. Homework: identify and take note of thoughts when in distress.

Plan:
Revisit the client's thoughts when in distress and continue with cognitive restructuring, introducing the thought record.

Session 9

Subjective Concerns:
The client shared the following since our last session:

- Follow-up with psychiatrist; medication was altered as the previous combination was making her feel on edge
- The client also came with a list of thoughts that she noted down when she was feeling distressed throughout the week.

Concerns discussed that relate to the thoughts she noted include:

- Feeling tired to have to fight through another day
- Feeling like she is "just a mother"
- Worrying about her older daughter coming to Lebanon
- Missing her younger daughter

The client also shared some positive experiences and future aspirations that she has:

- She had once taken an art workshop during which she felt liberated and connected to her true self
- She went to the gym and felt good about herself this past week

- The client and her husband always wanted to travel when their kids grew up and moved out
- She would also like to take a class and learn something new

Objective:
The client appeared tired, and her mood was depressed. Nevertheless, she was cooperative and enthusiastic to share and express. Other MSE criteria unremarkable.
Intervention:
The session was dedicated to the discussion about the client's homework about noting down her distressing thoughts and applying one of them to the thought record sheet together. The purpose of the thought record was relayed, and each section was explained to the client before application. The thought of "I am just a mother" was used as an example, and I guided the client through the entire sheet. Checking in on her mood by the end of this exercise, the client had felt better.
HW: complete the thought record about the most distressing thought experienced during the following week.
Plan:
Check in regarding thought record and resume exploration of client's thoughts and experiences.

Session 10

Subjective Concerns:
General updates from the past week include:
- Negative physical side effects due to medication change
- Feeling disoriented and shocked at recent news of her mother being hospitalized.
- She wants to be there for her mother, but her being in a different country makes her feel “out of control”.
- The client had filled the thought record out about a distressing situation but had forgotten to bring the sheet in with her.

The client’s emotions in regard to feeling out of control were explored in relation to the thought record as well, and the following was noted:
- The client places an importance on what others think; she wants to appear perfect or at least put together for others
- If she does not, she feels out of control
- Upon probing, it appears that this is a combination of societal expectations, personal preference, and the learned belief that she will face negative consequences if she did not do what she “had” to do
- Further exploration led the client to disclose that control equates strength and power for her, which also relates to her image in front of others and her ability to prove that she is capable

Objective:
The client was distressed throughout the session but felt more at ease as time went by. The more disclosure she partook in, the more relieved she felt, as can be told by her facial expressions and nonverbal signs. However, when distressed, she tends to speak in a much louder tone. Otherwise, MSE criteria are unremarkable.
Intervention:

Guiding questions were used to explore the core of the distress shared by the client's thought record experience. Probing for thoughts, emotions, and beliefs was practiced by both me and the client collaboratively in session.

Plan:

Resume practice of thought record and probe for further beliefs that tap into her identity, existence, and meaning.

Session 11

Subjective Concerns :

The client came to the session with the following updates and concerns:

- She titrated off of Topamax over 1-1.5 weeks as it has been making her feel on edge, numb, and anxious
- She has been feeling better over the past 2-3 days after this titration
- Her older daughter's stay in Lebanon was nice, and the client was able to distance herself from her usual triggers (mess around the house, etc.)
- She is planning to travel to see her younger daughter in the summer, which is something she is looking forward to

The client also brought up distress regarding her husband traveling soon:

- She is anticipating a lot of distress as well as feelings of aloneness, fear, and emptiness
- Upon probing, the client shared that she somehow feels abandoned, and that it is a feeling that came up for her when her daughters left for college
- To the client, feeling abandonment also encompasses a loss of feeling wanted and needed
- The first time she felt anything close to a sense of abandonment was after her father's passing
- Further probing also led the client to share that she likes to feel needed by others as it ties very closely to her self-worth

Objective:

The client was visibly calmer than during other sessions, appearing slightly uplifted although still distressed about various matters. Other MSE criteria unremarkable.

Intervention:

I checked in with the client about how she has been doing as it had been 2 weeks since our last session. Guiding questions were asked to explore the depth of the client's experience and the concerns she was sharing. When the topic of abandonment was brought up, probing about the first instance of abandonment was done and reflected upon. The space and guidance for the client to link her past and current experiences were also provided.

HW: complete thought record.

Plan:

Check in regarding thought record and explore the client's experience of her self-worth.

Session 12

Subjective Concerns:

The client came to the session with concerns about her well-being:

- Feeling anxious, tired, and suicidal

- Active ideation via prescription medication nearly every day for a few minutes, repeatedly
- She tried to distract herself from the thoughts, and it works until the thoughts resurface
- Distress is exacerbated by her husband's absence due to being abroad

More about the client's feelings and experience was shared:

- She feels isolated from herself, lonely, and tired
- She misses when she was able to just be, as now she is fighting to live every day
- To a certain extent, she feels abnormal and wonders if she is possessed; "why is this happening to me, especially given that I lead a good life?"

The client also shared her concerns about treatment:

- She notes that she is aware of her maladaptive beliefs
- While she is trying to engage in the thought record, she worries that it is not enough

Objective:

The client was crying throughout the session. She was visibly distressed, and her mood was more depressed than before. Nevertheless, she was cooperative and attentive throughout the session.

Intervention:

- Normalization and validation of her experience
- Psychoeducation about depression through the biopsychosocial model and reminder of the shared formulation
- Pointing out that while cognitive work is important, her unsatisfactory experience of it may indicate deeper matters to be addressed
- Reiterating the areas of work to be addressed as per her shared goals
- Development of a safety plan (written and given to the client)

Plan:

Explore the client's concerns on a deeper level, strengthen coping strategies and address core matters that tap into her identity and experience of life

Session 13

Subjective Concerns:

The client addressed the following updates from the past week:

- She has been feeling "good"; more uplifted, less worried, more relaxed, and feeling motivated
- Concerns about whether this is due to medication effects, external positive changes, or a differential bipolar diagnosis
- Positive life changes include becoming closer to a friend in Lebanon, daughter graduating, husband and daughter coming to Lebanon soon, and consistent exercise.

However, she also shared the following concerns:

- She noted not judging herself if a bipolar diagnosis was applicable, but worrying about my own judgment towards the shift in her mood
- She is afraid of her feeling good as she does not know how long it will last and is worried about another depressive episode taking place
- The client also has concerns about natural disasters taking place. Onset: after Lebanon earthquake 2 years ago. Frequency of concern: almost every night.

NB: During the session, the patient noted experiencing only one manic/hypomanic episode in her life, particularly at the beginning of her marriage. She is unsure whether or not it was substance induced as she was on Paxil and was also taking pain killers that she noted made her feel "euphoric".

Objective:

The client appeared more uplifted, energetic, and talkative. Facial expressions are congruent with this uplifted mood as the client was smiling genuinely. Faster pace of speech and louder tone of voice. Often difficult to interrupt.

Intervention:

- Probing questions were asked to get more clarity about the client's new emotional experience
- Screening for manic or hypomanic symptoms was done as per the client's concerns
- A reiteration of the session being a safe and judgement free space was done to reassure the client about her concerns
- Reminder of the episodic nature of MDD was also given to the client due to her concerns about the next episode and the longevity of her lighter mood
- The client's coping strategies were focused on and discussed
- Links were made between her previous concerns (lost identity and isolation) and the current positive changes that are making her feel better (building connection, engaging in enjoyable activities)
- Screening for PTSD symptoms was also done

Plan

Further assess PTSD symptoms and check in regarding anxious thoughts and coping strategies.

Session 14

Subjective Concerns:

The client came to the session with concerns about her psychiatry appointment at the center:

- While she felt very comfortable with the psychiatrist, she was also ambivalent about the psychiatrist's suggestion of stopping all her meds and starting one mood stabilizer
- She feels confused about what to do and is afraid of the possible negative consequences of change
- The client also conveyed that she feels rushed to make a decision due to her wanting to feel better quickly

- She also is confused about whether she should speak about this with her husband due to fear of judgement and lack of support

The client also conveyed interpersonal concerns from the past week:
- She is upset at the friend she recently made for not reaching out to her to hang out
- She felt isolated once more, thought that she is no fun to be around, and felt angry and upset
- She has been finding it difficult to meet friends that share a similar mentality and approach to life, which is making her feel more isolated
- While she finds it awkward to confront her friend about her desire to get closer, she may consider it after they have spent more time together

Objective:
The client appeared less energetic than during our last session. She looked concerned, sad, and perplexed. Otherwise. her engagement levels were maintained, and she was very cooperative during the session.
Intervention:
The client was given space to process her psychiatry appointment and the effects it had on her thoughts and emotions. She was encouraged to reflect on her fears and think of the pros and cons related to the matter. The client was also validated for her concerns given her long journey of change with medication and well-being. When speaking of her interpersonal concerns, the client was asked to reflect on how her sense of isolation ties into her other concerns, as well as that of feeling rushed. She was encouraged to share her thoughts and feelings honestly with those around her as she does with me, when she feels it is right. Her main takeaway from the session was to take her time and remind herself that she is already on her therapeutic journey.
Plan:
Check in regarding mood, strengthen coping, reassess for anxiety and PTSD symptoms in relation to natural disasters if still relevant to patient's current concerns.

Session 15

Subjective Concerns:
The client had updates about her disclosed confusion from last session:
- She had spoken to her husband and felt supported about her possible medication change
- She is feeling better now, thus wanting to consider the change of meds when she feels worse
- She felt somehow pressured by the psychiatrist about knowing what she wants, which is hindering her booking a follow up to further discuss her options

The client also addressed her feelings of loneliness:
- Both she and her husband believe that at the core of her difficulties lies her feelings of loneliness and isolation
- The client feels let down by the fact that her sister and best friend have not reached out as of recent, making her feel more lonely
- She reflected on one of her friendships where she feels alone, particularly with her friend who is psychologically vulnerable

- The client feels alone and drained during their interactions
- Upon probing, the client disclosed feeling responsible for this friend and attributed this role she is taking to her previous experiences with her mother and another friend
- The client had concerns about whether it is normal for her to have such negative feelings towards her friend and how to proceed with the relationship

Objective:
The client was euthymic and cooperative during the session, sharing openly about her concerns. Other MSE criteria unremarkable.
Intervention:
The client was first psycho-educated about the function of medication and the importance of adhering even when she feels better. However, I reflected on my lack of expertise in regard to medication and advised her to discuss this further with a psychiatrist. Much probing was conducted to understand the client's experience of loneliness, the gaps in which her needs are not fulfilled, and the links between her current interpersonal relationships and those she has had in the past. Normalization and validation were used throughout to provide the client with a safe space, given her doubts about the normalcy of her experiences.
Plan:
Resume exploration of the client's loneliness and isolation.

Session 16

Subjective Concerns:
General updates and current concerns:
- The client noted feeling better over the past two or so weeks, particularly in terms of mood and feelings of connectedness
- Positive life events: daughter getting married, meeting groom's family, reconnecting with friends, feeling not alone
- The client also shared that she has been noticing an increased fear and anxiety about any situation that may lead to a tragic death

More about the origins and development of this fear was shared:
- It started round a year ago after a visit to "Balou3 Bal3a", a waterfall with a rocky bridge in front of it.
- The client felt an immense fear when she reached the place, seeing others walk the bridge and worrying about them falling off of it
- Since then, she has been more and more afraid of natural disasters or any situation that may lead her to die painfully
- Trigger took place a week ago when she and her husband were driving on a mountainous road; worried about falling off the mountain and dying; needing distraction
- She noted being aware that the probability of such things happening is not high, but her fear overpowers her logic

Upon probing, the client's core fear around control was revealed and discussed further:
- Client initially reported fear surrounding dying tragically.

- More was later shared about not being able to avoid it or do anything about it
- The client mentioned feeling scared because she would feel like she lost control, which would eventually lead her to die
- Further probing led the client to link her need for control to the role that she was expected to fill as a caretaker since she was a child

The client shared more concerns revolving around her identity as well:

- She noted having long been "stuck" in the caretaker role, both when she was a child, up until she became a mother, as well as the present
- She also struggles to find her own voice and to listen to it, although she has been trying to give herself time to check in with herself about her own needs before accommodating for others
- The client shared that the role she has been filling as a caretaker left her with feeling with a grand feeling of responsibility, which ultimately left her needing to be in control of things for the well-being of herself and others around her
- She also shared that an obstacle to prioritizing herself is the negative reactions from those around her, worrying about them no longer liking her and conflict taking place
- This is largely influenced by her negative experiences with both her mother and the friend who used to live with them

Objective:
The client was calm, cooperative, and engaged in the session. No MSE criteria of note was observed.
Intervention:
The client was first checked in on regarding her mood, and she was encouraged to reflect on the factors that can help her maintain her bettered emotional state. She was approached with empathy and curiosity when she mentioned her fear and anxiety. Questions were asked to better understand the onset, triggers, and underlying core fears. Links between the client's history and current symptomatology were collaboratively made and discussed, while validating and normalizing the progression of this fear. A plan was set for the final sessions to focus on the client's identity struggles and empower her own adult voice.
Plan:
Explore the client's struggles with identity, helping her trace patterns and brainstorm ways in which she can empower her own voice as an adult.

Session 17

Subjective concerns:
The client came to the session with concerns about Lebanon:

- She has recently been feeling irritable and limited in Lebanon, wanting to go back to the US
- She does not feel like she has the space to fully be herself, and she cannot receive the support that she needs from those around her
- The client notes that there is much more room for her to be herself in the US; get a decent job, have support, be around family, and not worry about practical things

- She wants the space in which she can fully be herself

Last week's session contents were also highlighted while reflecting on what the client is still struggling with:

- She noted the anxiety is frustrating and wants to get rid of it
- She acknowledges the link between her anxiety and need for control, and we were able to reflect on the roots of this
- She asked me for practical tools to help deal with such negative feelings

NB: Negative feelings about termination were also brought up.

Objective

The client was cooperative and visibly less distressed. She was calmer than usual, but still engaged and attentive.

Intervention

Probing and guiding questions were used to explore the client's current struggles, needs, and progress. I reflected on how she is aiming to go back to the US can be taken as a sign that she is putting in the effort to put herself and her well-being first. We collaboratively thought about the obstacles that hinder her from doing that in Lebanon, thinking of other ways in which she is looking after herself. When the topic of anxiety came up, I encouraged the client to reflect on tools and exercises she already knows to help tackle anxious thoughts and feelings. I also introduced the mindfulness train exercise to help her sit with distress and not let it overtake her. when did the stress surrounding termination came about, I made sure to validate her emotions while also reflecting on her progress as a means to empower her further. I asked her to think of the relationship between her identity, her need for control, as well as her past experiences for the next session.

Plan

Discuss the relationship between her identity, need for control, past experiences, and resulting anxieties while exploring remaining obstacles.

Session 18

Subjective Concerns

The client came to the session with concerns about irritability and frustrations about Lebanon:

- She feels limited and bound by the country
- Simple things related to everyday life have been leaving her more irritable, such as traffic and electricity troubles
- She acknowledges that she cannot do much about leaving as of now
- With collaborative probing, the client shared that being in Lebanon has left her with less freedom, more responsibility, and a blurred identity
- She notes being too American for Lebanon but too Lebanese for the US, and she is unsure if moving back to the US will make her happy

Upon probing, her need for connection was further emphasized:

- The client noted missing her family and friends abroad
- She envies those in Lebanon or the US who have the luxury of visiting family whenever they want

- What she longs for is a sense of community and connectedness, and being in the US may facilitate that

Triggers for her depressive episodes and links to her needs were established:

- The client noted that she is not currently feeling depressed, but she is feeling very drained and exhausted
- She feels like she does not have the right to feel this way given that her responsibilities are less in comparison to her husband's
- She noted that her husband also often minimizes her experience and reminds her of how many responsibilities he is upholding
- When asked, the client shared that the repression of her distress is what leads to her depressive episodes
- She does not tend to share her concerns on a casual basis, but rather prefers to confide in someone when things become too heavy
- Given that her main need is that of connection, the client reflected on the fact that she may need to connect more authentically with those whom she loves
- She feels bad that her sister does not reach out to her as much as she would like for her to do so

Objective

The client was quieter than usual and initiating content less during this session. Nevertheless, she was cooperative and engaged.

Intervention

The client was given space to share her experience and was asked several guiding questions to better understand her concerns. Links to the themes that were highlighted in past sessions were established, including responsibility and connection to others. The client was encouraged to think of ways in which she can reinforce her need for connection while staying in Lebanon, leading to a collaborative suggestion of reaching out to her sister/other trusted people about her concerns and difficulties. She was invited to reflect on how this may both strengthen the communication, making it more authentic, while also granting her a space to share her own experience and receive support from those she loves.

Plan

Highlight further coping strategies and complete termination.

Session 19

Subjective concerns

The client came to the session with some concerns she has been having:

- She has recently connected with a friend who is trying to venture in her career, and hearing this made the client feel incompetent and less fulfilled.
- She also felt guilty about feeling this way, emphasizing that she was happy for the friend and was just triggered by hearing the news.
- The client also relayed concerns about her anxiety increasing in intensity over taking a specific road to the mountains.

Summary of blueprint for change:

- The client has learned that she does not have to be responsible for everything, and that she is more than the roles she has taken on in her life.
- Over the therapeutic process together, the client has been trying to "catch" her thoughts and reframe them, trying to approach triggering situations differently.
- She still thinks that she needs to further work on her coping as well as her underlying anxieties that have been increasing as of recent and aims to continue seeking professional help while applying her personal coping strategies.
- The client is aware of the indicators of setback that include less self-care, dysregulated sleep, more apathy towards others, and more.
- She also acknowledges her awareness, her love for psychology, and her openness to discussion and learning that have likely aided her on this journey.

Additional feedback about the therapeutic journey:

- The client wished we had more time and is disappointed that it is coming to an end
- However, she would have liked for the work to include more advice from my end, as well as more direction

Objective

The client was calm, cooperative, and very attentive in this last session. She exhibited concise yet meaningful answers to the questions I would ask and appeared emotionally conflicted at the fact that this journey is ending. She asked for a hug as we were saying our goodbyes.

Intervention

Termination session. The client was given some time at the beginning to discuss her concerns and collaboratively relate them to previous themes discussed, providing some suggestions to cope when necessary. I also introduced a worksheet, called blueprint for change, which consists of questions that prompt reflection on the therapeutic journey and planning for the future.

Questions include:

- What have you learned about yourself and the difficulties you've been struggling with?
- What changes have you been making and how are they helping?
- What are your remaining areas of vulnerability or sensitivity?
- What do you think would be helpful to do to work on your vulnerabilities and sensitivities?
- What danger signs will you, or others who know you well, notice if you're in danger of having a setback?
- What steps should you take if you have a setback?
- Who are the main sources of support in your life?
- What personal strengths do you have that have helped you to benefit from therapy?

The worksheet was filled with the client's answers and given back to her to keep. A couple of additional questions asking for both her positive and negative feedback were also addressed. When sharing her negative feedback, I tried to relay my hopes for hearing it earlier, and I tried to reframe it as a learning experience for us both; she now knows her preference in therapeutic approach, and I learned to maybe check in earlier on if there are any discomforts for the client. As such, termination was complete.

Plan

Refer internally to psychotherapy and future group therapy.

Appendix 6

Psychometric Scores

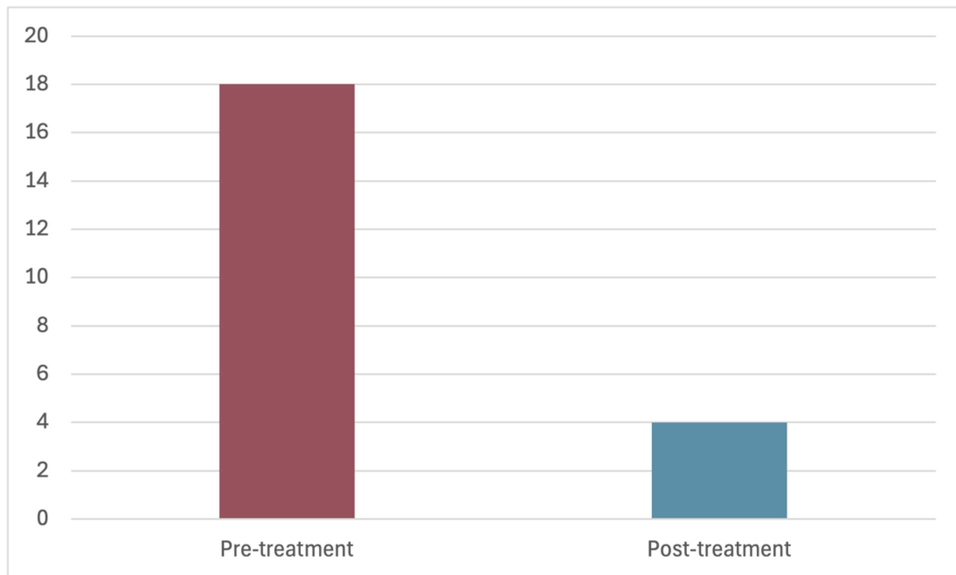

Figure 3. Participant's PHQ-9 Scores Over the Course of Treatment

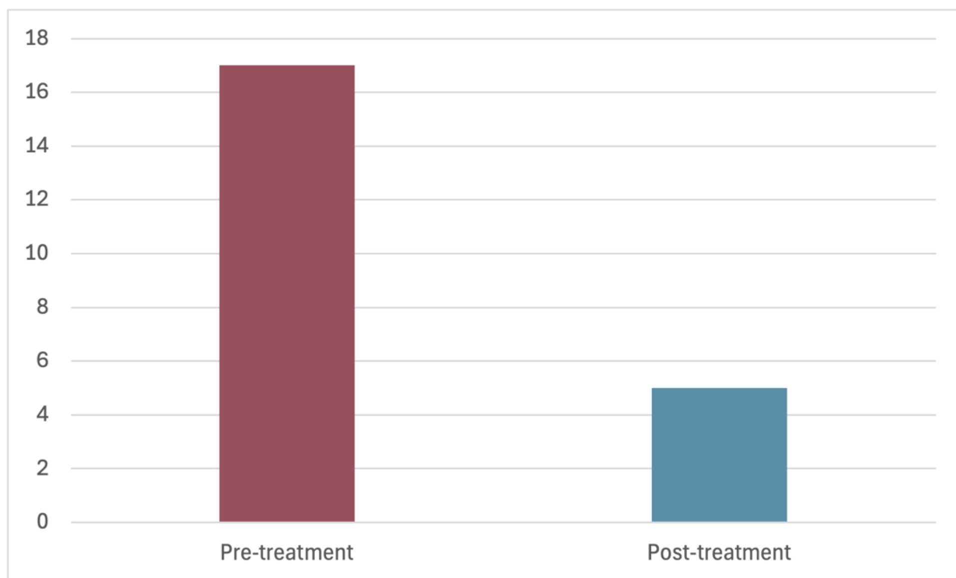

Figure 4. Participant's GAD-7 Scores Over the Course of Treatment

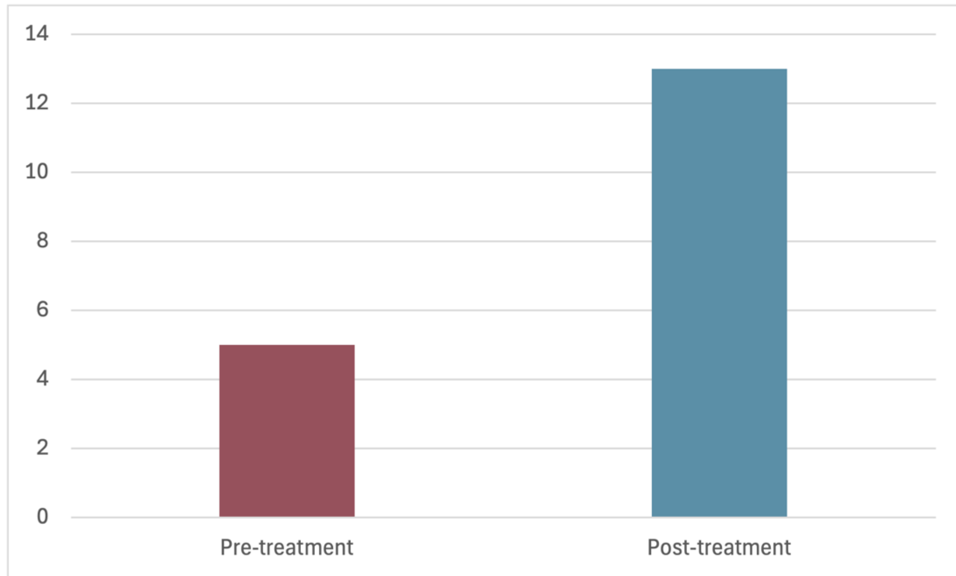

Figure 5. Participant's WHO-5 Scores Over the Course of Treatment

Appendix 7

Reflexive Diaries

Session 1
The first session with this new client left me feeling comfortable but also overwhelmed. her openness in the session was something I appreciated, and I had also felt a strong sense of empathy for the struggles she was relaying. slowly but surely, the bigger picture was becoming clearer, and I could only imagine how her fibromyalgia was adding on to her mental health difficulties. as she spoke of her daughters, she reminded me of someone in my life, something which I should keep an eye on and keep outside of our sessions. she seems to be a person who both extends a lot of herself to others but also knows what she wants.

Session 2
Empathy towards this client is building up the more I speak to her, especially given how harsh she seems to be on herself. While she views her difficulties as weakness, I could only imagine the type of words and interactions she has had with the people in her life that led her to such a belief…It is difficult to hear the environment from which she has come from as well as the past she has been through. I wonder how her relationship with her mother is affecting her current mental state? she seems to have carried a big burden from a young age, leading her to getting married early with little to no support from those around her. I can only imagine how something like that may stick to a person's being throughout their life and manifest in different ways going forward.

Session 3
The genogram, although included a lot of information the client had already disclosed in the previous sessions, also allowed space for her to share new information. This was the first time the client shares that her father was a man of bad temper, and I am sat here thinking about how much she has endured, as well as how clear and often occurring this temper was so that she remembers it from her formative years. This was a lighter session for me to handle emotionally, but I can still sense a form of heaviness when reflecting on the different relationships in this client's life. When she spoke of the ambivalence towards her mother and cried, I found myself truly immersed in that and felt quite emotional. How cruel is it to be hurt by someone whom you had hoped would have your back.

Session 4
With the client's increased distress, I found myself almost rushing to "save" her, and I was glad to be aware of it. At this point in my therapist-in-training journey, I have become much more comfortable allowing negative emotions to fully take up the space of the session. It was okay for me to also allow myself to feel such emotions, especially when I had realized how the feeling of aloneness is exacerbating the client's negative experience. At this point, I began to sense an existential theoretical inclination, especially due to the client's cultural background and current concerns with identity and connection. She seems to have spent so much of her life being there for others and operating on "should"s, and I hope that she may come closer to giving herself some space in the world. For now, I was considering CBT techniques to help restructure her maladaptive thoughts and beliefs surrounding weakness and the roles she must play in life.

Session 5
Although the client touched upon difficult subjects and feelings, I felt quite hopeful. I could really see the ambivalence the client holds towards herself; on one hand she feels weak, but on the other, she knows she is a good person deserving of good things in life. I think I've learned that the work done in therapy heavily influences both parties in a session; sometimes, it is helpful to ask more hopeful questions, or questions that can shed light on the client's protective factors. For one, it helped me, as a clinician, recognize that there exists a light despite the heaviness of the client's current experience. Additionally, it allowed the client an opportunity to reflect on her strengths and what keeps her going. While this may be common knowledge to many, I personally needed the revelation that therapy does not always need to be heavy, especially as a beginner therapist-in-training who feels inclined to fix everything!

Session 6
I felt the need to seek my supervisors after this session, as the client shared her history of abuse that extended back to her childhood. It was quite heavy for me to bear, especially knowing her struggles in the present. There seems to be much more that the client has endured than what she had initially disclosed to me, and I am starting to consider possible PTSD or CPTSD presentations. Aside from that, her formulation has become clearer to me, especially now that she has personally hypothesized the effect of her parentification on her interpersonal relationships.

Session 7
Honestly, I feel a bit behind in terms of the progress we are making, as we are still formulating collaboratively and highlighting apparent links and patterns. The client herself had disclosed that she is tired of feeling the way she does, which oftentimes led to me feeling pressured to do the work with her quickly. As a therapist-in-training, I have to actively remind myself that therapy is not meant to be accelerated, and every step we are taking together in sessions is naturally going to bring her closer to her goals so as long as we have honest communication and good alliance. Something that makes me happy to see is the client's level of insight which, to me, is already a large step taken in the direction of healing. She seems to be psychologically minded with a willingness to better herself and her circumstances, too. I think those are great protective factors that can serve the both of us in our work together.

Session 8
I found myself speaking for longer than I am used to in this session as I was introducing the preliminary treatment plan and reminding the client of the most important things to keep in mind as we embark on this journey together. while it was received well, it felt more unnatural to "lecture"; I find myself the most authentic when I exist and partake in the client's phenomenology, allowing her to take control of her session and being present as a helpful guide for her. I know that a balance is often well advised, especially given the time limitations we have at the clinical site, but I personally grew fonder of a less structured way of work. I was glad, however, to finally start on extensive work with this client. While we have both been trusting of the process, I believe we both also want her to feel a sense of relief, progress, and liberation. I hope that she has sensed the building of foundations for such outcomes thus far, nonetheless.

Session 9

I felt a small sense of personal accomplishment today as a hypothesis of mine was confirmed by the client herself. She had noted some thoughts from the past week, one of which being "I am just a mother". Ever since she mentioned her history of parentification and early marriage, I had hypothesized a lack of clarity in personal identity and a strong identification with the role of the caregiver that she was indirectly assigned early on. While working through this thought together, I could see how much lighter the client felt when noticing all other parts of her that exist outside of that role. On a personal level, I was happy to engage in work related to the client's identity as my clinical hunch towards the roots of her difficulties leaned much in that direction. With her feeling better by the end of the session, I felt a sense of relief; this may have been attributed to my wanting for her to feel better but also to my personal fear of not doing well on the job and not being as helpful to her. I notice that I still worry about that, even if I know that therapy is a journey that is everything but linear.

Session 10

With the client's natural elaboration on the concept of control, it felt like everything was tying in together. She had been given a large responsibility since childhood, immediately went on to have her own children which requires responsibility, and she has also always felt quite inferior. It made perfect sense to me that she may have a need for control so as to compensate for her perceived weaknesses and to prove herself as still reliable and valuable to others. I did not want to challenge her just yet and instead just wanted to understand what control meant to her and why it was important. It seemed that relaying her experience out loud even helped her make sense of it. I honestly was just thinking of how tired she must be having carried, and still carrying, everyone's well-being as her own.

Session 11

Given last session's content and disclosure, the client's fear and sadness related to her husband's travels is understandable. the fact he will physically no longer be there may bring her closer to the reality that she is responsible for a lot. I felt the need to jump to problem solving but took time to step back and be curious. The understanding that I have gained about the client's presenting problems and history have allowed me to immerse myself in her experience and truly feel with her. to some extent, I am capable of understanding where she comes from about a lot of subjects, and I am mindful of that interfering with my role as an external, mostly objective guide. Additionally, I wonder why the thought record was not completed for this session and am questioning any barriers or resistance that is yet to be uncovered.

Session 12

Painful session through and through. the client was extremely distressed with active ideation. while I was seeing her pain all throughout, it was as though I had a rediscovery this session. she has really been fighting all these years, and she is seeking me for help. to a certain extent, I felt this sense of responsibility that she always found so familiar. Resistance for the thought record was more apparent, and her vocalization of said resistance helped us both; I felt a little less helpless and ready to embark on deeper exploration of her subjective experience. I can't exactly place why I felt less helpless.

Maybe it's because of her active input? Her readiness to work with a mode of therapy that better resembles myself as a clinician and my interests?

Session 13
Many interesting emotions come up when reflecting on this session. I felt challenged, happy, confused, and hesitant. Challenged because of the client's suggestion of a bipolar diagnosis, happy because she was comfortable to share her fear of my judgement, confused due of my own uncertain clinical judgement, and hesitant about my input in the session and the implications it may have on the client's life. She was dealing with her own uncertainties, and I was, too. At that moment, it may have been more difficult for me to disclose our shared sentiments due to my fear of inexperience. While I believe I dealt with it well, maybe some more personal disclosure would have not been harmful, but rather grounding for the both of us.

Session 14
In the client's times of confusion, I have noticed that she trusts for me to have answers. Despite my lack of extensive knowledge, she places a great level of trust and confidence in my judgement; although this would pressure me at the beginning and lead me to lean into accommodating, I can now better understand why, thus leading me to more effective methods. Over time, I grew to understand the client's need for external input as stemming for her own exhaustion of taking matters into her own hands. Despite her need for control, she still feels weak and insecure, which leads her to seek guidance from those around her. As this became more apparent to me, I slowly let go of the pressure to provide an answer and settled into gentle empowerment and allowing space for her own voice, thoughts, and judgment.

Session 15
While there has been no concrete evidence for improvement, I can sense the client's slowly but surely growing understanding of her existential struggles. Her experience of loneliness and responsibility are two main pillars for her distress and maintained difficulties, and what makes me happy is that those are statements whose conclusions she has personally come to, at her own pace. While she still doubts herself, I can see that she has grown more confident in her judgement and input about her own experiences. I felt strangely proud of her for gaining more insight, but also proud of myself for being patient and going with the flow of this fluctuating therapeutic journey. As someone who ultimately values structure and order, it is in my role as a clinician that I have found myself most comfortable letting go of them.

Session 16
On one hand, I was happy to hear that the client had been doing much better, especially given the many positive developments in her life. On the other hand, I was wary of shifting the focus of the therapeutic piece due to the limited number of sessions left. Nevertheless, it is still the client's own space, and I will try my best to make sense of her different concerns in a way that seems comprehensive. As such, her concerns regarding nature and death anxiety were closely related to the aforementioned theme of control. It was during this session that I truly fell in love with this field all over again; noticing the patterns, drawing similarities, observing the various difficulties that all tie into the same core issues. To the client, the core issues revolved around her identity as a caretaker as

well as the resulting persistent feelings of responsibility and need for control. As time passes, the flow of the sessions is surely relating back to her goals as well as to our established existential formulation.

Session 17

The client seems to be moving closer towards her genuine self, noting core issues that prevent her from being fully fulfilled in Lebanon. However, I notice that I tend to feel a bit more helpless when situational obstacles come to surface. in this case, I found myself feeling like there really are limited resources when the client exists in an environment that feels limiting to her. our work, however, was still focused on trying to understand this frustration of hers as a positive step towards prioritizing herself, which also helped me reframe my own thoughts and concerns. Things have been clearing up and it seems that the client now really understands the depth of her struggles and how her situational context is affecting her well-being. This may be a great opportunity to focus on building authentic connections and enhancing those that already exist and mean a lot to the client herself, even with the obstacle of physical distance.

Session 18

This session was similar in theme to the last, delving more into the relational obstacles that come with her physical distance and being in Lebanon. she also addressed a sense of isolation not only from others, but from both cultures to which she belongs, adding another layer of aloneness and identity confusion. when probing further, I felt apologetic for the client's behaviors towards her distress, as she tends to repress a lot of it until it becomes too much. I would like her to understand that there are things she could also be trying to bridge this communication gap and to establish a more authentic connection with her loved ones. however, it appears that the client's history of being dismissed by others in the past and the sometimes in the present, alongside her tendency to reach out to others more than others reach out to her, have left her with a feeling of further isolation and disconnection, as well as a possible belief that she is not supported or loved when she is struggling. I think I could have addressed my reflections during the session in ways that may have been helpful for the client.

Session 19

I was expecting for various concerns to come up even in the termination session, particularly about the client's anxiety (understandably). I was a bit wary about giving it too much time as I wanted to use the session to collaboratively reflect on the work done throughout this process. nevertheless, I found it interesting that the client still seeks me as a source of validation, a person to approach for answers, a trusted confidant. while I am happy that she trusts my judgment and our relationship, I worry about enabling this pattern of hers by sometimes offering her this validation. I tried to reflect on the times this has happened, and I think I was able to balance times where I would validate and give advice versus others where I would encourage her autonomy. speaking of being wary and having some conflicting feelings, the client also addressed her preference towards wanting more direction and advice in our sessions. While I think I handled it relatively well, I kept thinking of whether this was merely a preference or a result of her overwhelming responsibilities over the course of her life. Is this something she prefers, or has she grown tired of being responsible and wants to have others bear it for her now? Must I have addressed this in this last session of ours? I feel quite sad that our journey is

ending, partially because I feel like we did not have ample time to truly address her deeply rooted concerns, but also maybe because she had some disappointments regarding lack of practical solutions and advice. I wonder if I wanted this journey to continue so I could help her further or continue to prove myself… Nevertheless, I think I pushed myself out of my comfort zone during this therapeutic process and, although not perfectly, helped draw some awareness to the clients struggles that happened to be deeper than just textbook DSM symptomatology. I think it was a good opportunity for me to experiment with an existential lens given that I was supervised and supported by a great team; it gave me a deeper understanding of the client's experience and enhanced my own interest in the theoretical approach.

Appendix 8

Table 2. Code System

Code System	Second Iteration	Frequency	Sub-themes	Themes
Code System		495		
need for communication	aloneness	51	relational ruptures	Interpersonal Needs and Ruptures
relational need				
others' input				
longing for community				
aloneness				
imbalance of effort in communication				
lack of belonging				
splitting	confusion and self-doubt	19	disconnection from oneself	Identity Disruption and Reconnection
self-doubt				
dependence on external feedback				
hesitation/uncertainty in herself				
reclaiming identity	connection to self	9	reclaiming identity	Identity Disruption and Reconnection
sense of self				
connection to self				
constant fear and lack of safety	constant fear and lack of safety	13	deficit of protection	Absence of Security
loss of safety				
aggression from others				
coping strategy	coping strategy	14	strength and coping	Therapeutic Processes and Change
countertransference	countertransference	12	therapist's experience	Therapeutic Processes and Change
depth of difficulties				
history of substance-induced mania	external influences on client’s well-being	19	deficit of protection	Absence of Security
external influences on client’s well-being				
risk factor				
past abuse				
cultural subtext				
fear of loss	fear of loss	16	deficit of protection	Absence of Security
fear of no control				
abandonment				
control				
change				

guilt	guilt	10	internalized roles	Identity Disruption and Reconnection
societal norms				
impatience	impatience	4	intolerance of uncertainty	Absence of Security
insight	insight	16	strength and coping	Therapeutic Processes and Change
loss of parental figure	loss of parental figure	6	deficit of protection	Absence of Security
loss of paternal figure				
lack of authenticity	loss of sense of self	34	disconnection from oneself	Identity Disruption and Reconnection
blurred boundaries				
loss of sense of self				
identity confusion				
lack of freedom				
use of we				
no reciprocation	loss of trust	30	relational ruptures	Interpersonal Needs and Ruptures
lack of support				
dismissal				
fear of judgement				
loss of trust				
minimization of fear by others				
potential resistance to primary intervention	search for meaning	3	strength and coping	Therapeutic Processes and Change
existential goals				
meaning of friendship	meaning of friendship	6	foundations for connection	Interpersonal Needs and Ruptures
possible fusion with daughter				
importance of honesty	need for authenticity	4	reclaiming identity	Identity Disruption and Reconnection
need for authenticity				
need for control	need for control	5	intolerance of uncertainty	Absence of Security
need for support	need for support	9	foundations for connection	Interpersonal Needs and Ruptures
maternal link	parentification	15	internalized roles	Identity Disruption
parentification				

				and Reconnection
prioritization of others	prioritization of others	14	internaliz ed roles	Identity Disruption and Reconnection
readiness to change client strength future aspirations agency protective factor hope and motivation	protective factor	32	strength and coping	Therapeutic Processes and Change
meaning of good relationship	relationship with daughter	5	foundatio ns for connectio n	Interpersonal Needs and Ruptures
self-reliant repression as an emotional trigger repression of emotions	repression of emotions	4	disconnec tion from oneself	Identity Disruption and Reconnection
resentment unhealthy dynamics	resentment	10	relational ruptures	Interpersonal Needs and Ruptures
responsibility helplessness feeling overwhelmed protection sacrifice	responsibility	50	internaliz ed roles	Identity Disruption and Reconnection
value of self self-blame view of self need to prove oneself insecurity need for validation positive self-view avoidance negative self-view	fluctuating self-worth	28	disconnec tion from oneself	Identity Disruption and Reconnection
challenge tendency to problem solve doubt about competence importance of physical presence apprehension towards leading understanding of loneliness feeling conscious therapist pressure	therapist doubt about competence	30	therapist's experienc e	Therapeutic Processes and Change

apprehension about progress				
therapist interest	therapist growth and confidence	12	therapist's experienc e	Therapeutic Processes and Change
increased therapist confidence				
client-therapist compatibility				
therapist preference				
decreased hopelessness				
containment				
authenticity				
need for experiential work	understanding of depression	15	disconnec tion from oneself	Identity Disruption and Reconnection
understanding of depression				

Appendix 9

Table 3. Excluded Codes

Code	**Frequency**	**Reason for exclusion**
therapy as a safe space	1	Fits under FM1 but not thematically
therapist/researcher awareness of clashing roles	1	Irrelevant to research question
differential diagnosis	1	Irrelevant to research question
discrepancy	1	Irrelevant to research question
client's frustration	1	Coded segment is not clinically relevant
understanding of anxiety	2	Irrelevant to research question
opposing realities across generations	1	Irrelevant to research question
optimistic view on relationships	1	Does not fit thematically

Appendix 10

Table 4. Coded Segments

Code	Coded segments
aloneness	I had realized how the feeling of aloneness is exacerbating the client's negative experience reflexive diaries: 8 - 8 (0) At this point, I began to sense an existential theoretical inclination, especially due to the client's cultural background and current concerns with identity and connection. reflexive diaries: 8 - 8 (0) the client's fear and sadness related to her husband's travels is understandable reflexive diaries: 23 - 23 (0) she also addressed a sense of isolation not only from others, but from both cultures to which she belongs, adding another layer of aloneness and identity confusion. reflexive diaries: 37 - 37 (0) the client's history of being dismissed by others in the past and the sometimes in the present, alongside her tendency to reach out to others more than others reach out to her, have left her with a feeling of further isolation and disconnection, as well as a possible belief that she is not supported or loved when she is struggling reflexive diaries: 37 - 37 (0)
	Both she and the friend were struggling with their anxieties, but the client received no support from the friend soap notes: 8 - 8 (0) Her family was very apprehensive of this and would push her to rethink her decision, telling her that she is very young. soap notes: 9 - 9 (0) Her daughters being abroad for academic purposes soap notes: 10 - 10 (0) Additionally, she is experiencing a sense of apathy towards others and a decreased motivation to reach out to them. soap notes: 47 - 47 (0)

She feels like the people around her may be tired of her mental state, thus preventing her from reaching out to seek support.
soap notes: 54 - 54 (0)

The client was parentified by her mother; a lot of burden and responsibility that her siblings did not bear
soap notes: 66 - 66 (0)

She took on this role out of fear of losing her mother and out of obligation as no one else was taking care of her
soap notes: 67 - 67 (0)

No support from her husband who sees her in distress.
soap notes: 80 - 80 (0)

Daughters are also do not always have the capacity to support her in her distress.
soap notes: 80 - 80 (0)

Daughter being away as she is studying abroad
soap notes: 147 - 147 (0)

Feeling distant from her loved ones and lacking support
soap notes: 148 - 148 (0)

Missing her younger daughter
soap notes: 174 - 174 (0)

She is anticipating a lot of distress as well as feelings of aloneness, fear, and emptiness
soap notes: 213 - 213 (0)

She feels isolated from herself, lonely, and tired
soap notes: 233 - 233 (0)

She is upset at the friend she recently made for not reaching out to her to hang out
soap notes: 280 - 280 (0)

She felt isolated once more, thought that she is no fun to be around, and felt angry and upset
soap notes: 281 - 281 (0)

She has been finding it difficult to meet friends that share a similar mentality and approach to life, which is making her feel more isolated
soap notes: 282 - 282 (0)

Both she and her husband believe that at the core of her difficulties lies her feelings of loneliness and isolation
soap notes: 297 - 297 (0)

The client feels let down by the fact that her sister and best friend have not reached out as of recent, making her feel more lonely
soap notes: 298 - 298 (0)

She reflected on one of her friendships where she feels alone, particularly with her friend who is psychologically vulnerable
soap notes: 299 - 299 (0)

She has recently been feeling irritable and limited in Lebanon, wanting to go back to the US
soap notes: 341 - 341 (0)

She notes being too American for Lebanon but too Lebanese for the US, and she is unsure if moving back to the US will make her happy
soap notes: 363 - 363 (0)

The client noted missing her family and friends abroad
soap notes: 365 - 365 (0)
She envies those in Lebanon or the US who have the luxury of visiting family whenever they want
soap notes: 366 - 366 (0)

Given that her main need is that of connection, the client reflected on the fact that she may need to connect more authentically with those whom she loves
soap notes: 374 - 374 (0)

She feels bad that her sister does not reach out to her as much as she would like for her to do so
soap notes: 375 - 375 (0)

I was- so! afraid and terrified, and my siblings would laugh,
assessment session transcript: 331 - 331 (0)
Why am I the one like so afraid? Why are they not afraid?
assessment session transcript: 339 - 339 (0)

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maybe we could start, like, a support group
treatment session transcript: 4 - 4 (0)

C: It will help me and so many other people, I think, to feel less isolated, and uhm, to cope better! Yeah.
treatment session transcript: 23 - 23 (0)

you need this connection with people —
C: For sure.
treatment session transcript: 24 - 25 (0)

I think a lot of, I think a lot of it is the void of my children and being away
treatment session transcript: 125 - 125 (0)

Even my husband says it. He says, you know, “I know you,” like, “I know you and I feel like,” you know, “the only thing that’s bothering you and not letting you be 100% is loneliness”
treatment session transcript: 155 - 155 (0)

not over the phone, like a friend, but I want somebody there, like I want a friend, or I want somebody close with me.
treatment session transcript: 161 - 161 (0)

it’s hard to have, like, a real being conversation
treatment session transcript: 169 - 169 (0)

But, at the same time I feel bad? Because she considers me like her family, and I consider her very close too, as somebody who knows me very well and who’s been there, who’s seen a lot of my ups and downs and my things that I’ve gone through in my life.
treatment session transcript: 169 - 169 (0)

I speak with her from my heart, and I really try to, like, — if she’s going through something, she’s kind of, she, she’s kind of off and of a different, different style, different emotions.
treatment session transcript: 173 - 173 (0)

So, it’s hard to connect, and that’s another thing — so, with that, I don’t feel at a full, I don’t feel a full connectedness, and it doesn’t really make — it doesn’t make the loneliness, or the isolated feeling feel better. You know? It doesn’t. Yeah.
treatment session transcript: 175 - 175 (0)

So, the means in order to ease this (inaudible), to ease this, uh, loneliness, is someone to be fully present…
treatment session transcript: 176 - 176 (0)

even in the presence of others in your life, this sense of loneliness is still there because they’re not providing you with what you need in this relationship
treatment session transcript: 222 - 222 (0)

	And I'm — I've reached out to you, like, several times, and even on Mother's Day — which was a while back, there — I did that, and I still haven't heard from her. treatment session transcript: 241 - 241 (0) even if you're, like, really busy, just one sentence: "I'm so busy, I'll get back to you, but I'm thinking about you". That's good, and that's it! treatment session transcript: 251 - 251 (0) where's the action treatment session transcript: 257 - 257 (0) C: But, then I know that I'm a human being and it's like we're social and we want to connect. treatment session transcript: 285 - 285 (0) I feel alone in it. treatment session transcript: 343 - 343 (0) I'm kind of thinking about how we have to end in July, and uhm, I'm disappointed, of course, but should I get on that list now? Should I get back on that list now? treatment session transcript: 397 - 397 (0)
confusion and self-doubt	She was dealing with her own uncertainties, and I was, too. reflexive diaries: 27 - 27 (0) In the client's times of confusion, I have noticed that she trusts for me to have answers reflexive diaries: 29 - 29 (0) Despite her need for control, she still feels weak and insecure, which leads her to seek guidance from those around her reflexive diaries: 29 - 29 (0) I found it interesting that the client still seeks me as a source of validation, a person to approach for answers, a trusted confidant. reflexive diaries: 39 - 39 (0)
	Concerns about whether this is due to medication effects, external positive changes, or a differential bipolar diagnosis soap notes: 253 - 253 (0)
	And I'm wondering, maybe I can switch, even though I don't want to?

assessment session transcript: 28 - 28 (0)

C: Does that make sense? Does that make-?
assessment session transcript: 449 - 449 (0)

But that was causing you a lot of confusion because, you know, “what do I do”
treatment session transcript: 40 - 40 (0)

Uhm, I feel, I think I’m still kind of on the fence about things
treatment session transcript: 41 - 41 (0)

I, I, I don’t know, honestly, if I should do anything right now
treatment session transcript: 47 - 47 (0)

So, maybe, *maybe*, it’s a good idea within, like, a couple weeks, also possibly talking to the doctor, and getting in there and doing something
treatment session transcript: 77 - 77 (0)

What do you think?
treatment session transcript: 77 - 77 (0)

I’m just gonna say it
treatment session transcript: 165 - 165 (0)

It bothers me and then sometimes I think “Am I being too sensitive?”
treatment session transcript: 247 - 247 (0)

C: It is? Is that me being codependent?
treatment session transcript: 265 - 265 (0)

C: Okay. Like, in order to be, well, I mean, normal, I mean, it’s kinda — I feel like it’s normal, but another side of me is questioning like, “Do I need to hear from them?”, or “Do I need them that bad?” Like, “Can’t I get that from myself?”
treatment session transcript: 283 - 283 (0)

Do you think — is that normal?
treatment session transcript: 343 - 343 (0)

“Do other people have friends like this? Like who deals with this? Or even who maintains friendships with these people?”
treatment session transcript: 347 - 347 (0)

	Do you think it would be safe, at some point, like, it would be okay to tell her “I don’t feel like I’m being heard”? “I don’t feel like I’m being seen the way I see you”? Or… treatment session transcript: 379 - 379 (0)
connection to self	I could see how much lighter the client felt when noticing all other parts of her that exist outside of that role reflexive diaries: 19 - 19 (0) While she still doubts herself, I can see that she has grown more confident in her judgement and input about her own experiences. reflexive diaries: 31 - 31 (0) the client seems to be moving closer towards her genuine self, noting core issues that prevent her from being fully fulfilled in Lebanon. reflexive diaries: 35 - 35 (0)
	She had once taken an art workshop during which she felt liberated and connected to her true self soap notes: 176 - 176 (0) She wants the space to fully be herself soap notes: 344 - 344 (0)
	I would like to talk about something that’s been happening to me lately treatment session transcript: 31 - 31 (0) I don’t feel comfortable just being on a mood stabilizer, which the doctor had suggested. treatment session transcript: 41 - 41 (0) no! I don’t think I’m being too sensitive treatment session transcript: 249 - 249 (0) C: So, I don’t know, I mean I don’t think I’m being — I, deep down, I don’t think I’m being codependent. treatment session transcript: 287 - 287 (0)
constant fear and lack of safety	She took on this role out of fear of losing her mother and out of obligation as no one else was taking care of her soap notes: 67 - 67 (0) Does not remember much about her father, other than that he had a really bad temper

	soap notes: 68 - 68 (0) The client previously disclosed having been abused by her husband during her marriage. During this session, she also disclosed having been physically abused by her father and mother growing up. soap notes: 116 - 116 (0) Mother's psychological difficulties and being parentified soap notes: 127 - 127 (0) Anger that was witnessed from her mother and father + abuse soap notes: 128 - 128 (0)
	he was getting physical with her when she was young assessment session transcript: 219 - 219 (0) he explodes on him assessment session transcript: 239 - 239 (0) And very loving but he had a very bad temper. assessment session transcript: 299 - 299 (0) C: VERY bad temper. assessment session transcript: 301 - 301 (0) when she would have a nervous breakdown she would, uhm, she would threaten suicide and stuff? assessment session transcript: 327 - 327 (0) she'd even leave the house, not like long term but she'd leave- and during that point I was- so! afraid and terrified assessment session transcript: 331 - 331 (0) this went oooon! Until we all grew up assessment session transcript: 341 - 341 (0) She always- she still does assessment session transcript: 343 - 343 (0)
coping strategy	The client smokes half a pack of cigarettes per day. soap notes: 12 - 12 (0) She reported almost canceling due to how she was feeling but came to the session because it is her "safe space" soap notes: 80 - 80 (0)

The client does the following to cope: smoking, listening to music, taking a walk, going for a drive, playing a game on her phone, talking to her husband, and shopping.
soap notes: 102 - 102 (0)

She went to the gym and felt good about herself this past week
soap notes: 177 - 177 (0)

the client was able to distance herself from her usual triggers
soap notes: 210 - 210 (0)

She is planning to travel to see her younger daughter in the summer, which is something she is looking forward to
soap notes: 211 - 211 (0)

She tried to distract herself from the thoughts
soap notes: 230 - 230 (0)

consistent exercise.
soap notes: 254 - 254 (0)

walking has been helping me a lot
assessment session transcript: 12 - 12 (0)

I think I've accepted that she's never gonna change
assessment session transcript: 483 - 483 (0)

C: It will help me and so many other people, I think, to feel less isolated, and uhm, to cope better! Yeah.
treatment session transcript: 23 - 23 (0)

I feel like I still need to be you know, I still need treatment, and I still need to be coming and it's very important to me
treatment session transcript: 63 - 63 (0)

Uhm… I think just time, coming here and talking to you, and speaking about things. Yeah, speaking about things. And feeling more, more like I have options, not that it's just like that's it, like this is what you have to do, and this is the only medication, and that's it.
treatment session transcript: 73 - 73 (0)

C: Being honest, and, like, not like, like — cause boundaries — not always being available to that person. Not always, not — yeah. Because it's, like, it would be so draining and impossible.
treatment session transcript: 319 - 319 (0)

countertransference	I had also felt a strong sense of empathy for the struggles she was relaying reflexive diaries: 2 - 2 (0) as she spoke of her daughters, she reminded me of someone in my life reflexive diaries: 2 - 2 (0) It is difficult to hear the environment from which she has come from as well as the past she has been through reflexive diaries: 4 - 4 (0) I am sat here thinking about how much she has endured, as well as how clear and often-occurring this temper was so that she remembers it from her formative years. reflexive diaries: 6 - 6 (0) I can still sense a form of heaviness when reflecting on the different relationships in this client's life. reflexive diaries: 6 - 6 (0) With the client's increased distress, I found myself almost rushing to "save" her reflexive diaries: 8 - 8 (0) I personally needed the revelation that therapy does not always need to be heavy, especially as a beginner therapist-in-training who feels inclined to fix everything reflexive diaries: 10 - 10 (0) It was quite heavy for me to bear, especially knowing her struggles in the present reflexive diaries: 12 - 12 (0) The client herself had disclosed that she is tired of feeling the way she does reflexive diaries: 14 - 14 (0) I honestly was just thinking of how tired she must be having carried, and still carrying, everyone's well-being as her own. reflexive diaries: 21 - 21 (0) while I was seeing her pain all throughout, it was as though I had a rediscovery this session. reflexive diaries: 25 - 25 (0) she has really been fighting all these years, and she is seeking me for help.

	reflexive diaries: 25 - 25 (0)
external influences on client's well-being	I could only imagine how her fibromyalgia was adding on to her mental health difficulties reflexive diaries: 2 - 2 (0)
	The client reported being verbally and physically abused by her husband in the past. soap notes: 14 - 14 (0) There would be bursts of good times with the family, but the environment was generally unstable and sporadic. soap notes: 49 - 49 (0) She is planning to travel to see her younger daughter in the summer, which is something she is looking forward to soap notes: 211 - 211 (0) Positive life changes include becoming closer to a friend in Lebanon soap notes: 254 - 254 (0) husband and daughter coming to Lebanon soon soap notes: 254 - 254 (0) NB: During the session, the patient noted experiencing only one manic/hypomanic episode in her life, particularly at the beginning of her marriage. She is unsure whether or not it was substance induced as she was on Paxil and was also taking pain killers that she noted made her feel "euphoric". soap notes: 259 - 259 (0) The client noted feeling better over the past two or so weeks, particularly in terms of mood and feelings of connectedness soap notes: 312 - 312 (0) reconnecting with friends, feeling not alone soap notes: 313 - 313 (0) She notes being too American for Lebanon but too Lebanese for the US, and she is unsure if moving back to the US will make her happy soap notes: 363 - 363 (0) What she longs for is a sense of community and connectedness, and being in the US may facilitate that soap notes: 367 - 367 (0)
	weather really affects me

	assessment session transcript: 8 - 8 (0) weight gain is a thing for me assessment session transcript: 28 - 28 (0) I have to admit, we baby him, cause he's the boy assessment session transcript: 197 - 197 (0) She was- she- she's been chronically depressed for most of her life. assessment session transcript: 353 - 353 (0)
	I think a lot of, I think a lot of it is the void of my children and being away treatment session transcript: 125 - 125 (0) I need a break, like, from the daily routine and stuff treatment session transcript: 125 - 125 (0) I'll feel a lot better once these things unfold and they start happening. treatment session transcript: 143 - 143 (0) It feels like I'm being heard and seen treatment session transcript: 373 - 373 (0)
fear of loss	She took on this role out of fear of losing her mother and out of obligation as no one else was taking care of her soap notes: 67 - 67 (0) the client noted having a fear of loss and fear of death towards the end of the session soap notes: 135 - 135 (0) Upon probing, it appears that this is a combination of societal expectations, personal preference, and the learned belief that she will face negative consequences if she did not do what she "had" to do soap notes: 197 - 197 (0) Upon probing, the client shared that she somehow feels abandoned, and that it is a feeling that came up for her when her daughters left for college soap notes: 214 - 214 (0) The first time she felt anything close to a sense of abandonment was after her father's passing soap notes: 216 - 216 (0)

Distress is exacerbated by her husband's absence due to being abroad
soap notes: 231 - 231 (0)

She is afraid of her feeling good as she does not know how long it will last and is worried about another depressive episode taking place
soap notes: 257 - 257 (0)

The client also has concerns about natural disasters taking place.
soap notes: 258 - 258 (0)

she was also ambivalent about the psychiatrist's suggestion of stopping all her meds and starting one mood stabilizer
soap notes: 275 - 275 (0)

She feels confused about what to do and is afraid of the possible negative consequences of change
soap notes: 276 - 276 (0)

She is feeling better now, thus wanting to consider the change of meds when she feels worse
soap notes: 294 - 294 (0)

The client also shared that she has been noticing an increased fear and anxiety about any situation that may lead to a tragic death
soap notes: 314 - 314 (0)

The client mentioned feeling scared because she would feel like she lost control, which would eventually lead her to die
soap notes: 324 - 324 (0)

I was always afraid of losing her. I was always- you know, ready to help her-
assessment session transcript: 321 - 321 (0)

C: Yeah. Sometimes, honestly, I don't know, I feel like if I did say anything it would really like, it would probably terminate our friendship. If I really told her kind of what I was feeling, it might hurt her so bad that, like, you know?
treatment session transcript: 323 - 323 (0)

I'm kinda thinking about how we have to end in July, and uhm, I'm disappointed, of course, but should I get on that list now? Should I get back on that list now?

	treatment session transcript: 397 - 397 (0)
guilt	The client feels bad about this resentment because she pushed through the relationship for the sake of her kids soap notes: 65 - 65 (0) The client has been hurt by her mother but also feels sorry for her soap notes: 71 - 71 (0) Guilt for receiving practical help from husband around the house; thoughts of "I should be doing this". soap notes: 80 - 80 (0) The client had concerns about whether it is normal for her to have such negative feelings towards her friend and how to proceed with the relationship soap notes: 302 - 302 (0) She feels like she does not have the right to feel this way given that her responsibilities are less in comparison to her husband's soap notes: 370 - 370 (0) She also felt guilty about feeling this way, emphasizing that she was happy for the friend and was just triggered by hearing the news. soap notes: 386 - 386 (0)
	It's so hard to say! treatment session transcript: 167 - 167 (0) But, at the same time I feel bad? Because she considers me like her family, and I consider her very close too, as somebody who knows me very well and who's been there, who's seen a lot of my ups and downs and my things that I've gone through in my life. treatment session transcript: 169 - 169 (0) So, that makes me feel guilty. And she has, she has no idea, you know? treatment session transcript: 193 - 193 (0) Yeah! And then I'm like, I always feel bad. I, honestly, I could never, like, not talk to her. I know that about myself. So, the only solution would be, is yes, boundaries. treatment session transcript: 351 - 351 (0)

impatience	The client herself had disclosed that she is tired of feeling the way she does reflexive diaries: 14 - 14 (0)
	The client also conveyed that she feels rushed to make a decision due to her wanting to feel better quickly soap notes: 277 - 277 (0) She noted the anxiety is frustrating and wants to get rid of it soap notes: 346 - 346 (0)
	I'm kind of impatient, like waiting for things to unfold with the summer coming, and the travel maybe going back… and I want those things to happen and I need a change, you know? treatment session transcript: 125 - 125 (0)
insight	her formulation has become clearer to me, especially now that she has personally hypothesized the effect of her parentification on her interpersonal relationships. reflexive diaries: 12 - 12 (0) Something that makes me happy to see is the client's level of insight which, to me, is already a large step taken in the direction of healing. reflexive diaries: 15 - 15 (0) I can sense the client's slowly but surely growing understanding of her existential struggles reflexive diaries: 31 - 31 (0) what makes me happy is that those are statements whose conclusions she has personally come to, at her own pace reflexive diaries: 31 - 31 (0) Things have been clearing up and it seems that the client now really understands the depth of her struggles and how her situational context is affecting her well-being reflexive diaries: 35 - 35 (0)
	Upon probing, the client shared that this may have been linked to her parentified role as well as the abuse she endured. soap notes: 115 - 115 (0) She notes that she is aware of her maladaptive beliefs soap notes: 237 - 237 (0)

	She noted being aware that the probability of such things happening is not high, but her fear overpowers her logic soap notes: 320 - 320 (0) She acknowledges the link between her anxiety and need for control, and we were able to reflect on the roots of this soap notes: 347 - 347 (0) She acknowledges that she cannot do much about leaving as of now soap notes: 361 - 361 (0) The client is aware of the indicators of setback that include less self-care, dysregulated sleep, more apathy towards others, and more. soap notes: 392 - 392 (0)
	I don’t wanna rely on those things, but I feel like I’m going that way. treatment session transcript: 149 - 149 (0) C: Yeah. Because she always needed, she always, uhm, always needed help, and I was, like, always there to help her fix things and make things better, and to listen to her… Uhm, so, this is a pattern. treatment session transcript: 305 - 305 (0) C: And my mother, too. This is a pattern, but… treatment session transcript: 307 - 307 (0) C: …now it’s (friend’s name), it’s the same thing. Uhm, everybody, honestly! And I, I mean, I do care. I know that I m a caring person and I know that I do, I do, like, I do give, I do give freely not because of anything that’s like, like old trauma or anything. It’s not because, not just because of that. You know? Because I am that way. treatment session transcript: 309 - 309 (0) C: But a lot of it, too, is, like, from, you know, patterns. treatment session transcript: 311 - 311 (0)
loss of parental figure	She believes that the family lost a sense of stability and support and that they grew to be less resilient because of this. soap notes: 51 - 51 (0) The first time she felt anything close to a sense of abandonment was after her father’s passing soap notes: 216 - 216 (0)

	Let’s see my father passed away when I was 6 assessment session transcript: 287 - 287 (0) Because she needed that, so much. She needed so much support and help, physically and emotionally. assessment session transcript: 321 - 321 (0) What kind of mom treats her kids that way assessment session transcript: 441 - 441 (0) That…I wasn’t taken care of the way that… I should’ve been! assessment session transcript: 491 - 491 (0)
loss of sense of self	At this point, I began to sense an existential theoretical inclination, especially due to the client’s cultural background and current concerns with identity and connection. reflexive diaries: 8 - 8 (0) it felt more unnatural to “lecture” reflexive diaries: 17 - 17 (0) I had hypothesized a lack of clarity in personal identity reflexive diaries: 19 - 19 (0) strong identification with the role of the caregiver that she was indirectly assigned early on reflexive diaries: 19 - 19 (0) To the client, the core issues revolved around her identity as a caretaker as well as the resulting persistent feelings of responsibility and need for control. reflexive diaries: 33 - 33 (0) she also addressed a sense of isolation not only from others, but from both cultures to which she belongs, adding another layer of aloneness and identity confusion. reflexive diaries: 37 - 37 (0)
	She believes that the family lost a sense of stability and support and that they grew to be less resilient because of this. soap notes: 51 - 51 (0) Getting married [year]: While it was a very exciting time for the client, she feels as though it represents the loss of her independence. soap notes: 52 - 52 (0)

Having first daughter [year]: the client describes this as her best moments, feeling pure joy and love.
soap notes: 53 - 53 (0)

The friends she made in Lebanon are more on the shallow side, and she has not formed a deep trustful bond with them.
soap notes: 101 - 101 (0)

With her friend in the country, she feels a pressure to be well and not show her struggles.
soap notes: 115 - 115 (0)

she would often second guess people's emotions and reactions and break down trying to do well for them
soap notes: 115 - 115 (0)

Best friend moving in: toxic relationship, negative view of herself and her struggles were internalized
soap notes: 133 - 133 (0)

Daughter being away as she is studying abroad
soap notes: 147 - 147 (0)

Being a stay-at-home mom and lacking accomplishment/a career
soap notes: 149 - 149 (0)

Feeling like she is "just a mother"
soap notes: 172 - 172 (0)

She feels isolated from herself, lonely, and tired
soap notes: 233 - 233 (0)

She has been finding it difficult to meet friends that share a similar mentality and approach to life, which is making her feel more isolated
soap notes: 282 - 282 (0)

She noted having long been "stuck" in the caretaker role, both when she was a child, up until she became a mother, as well as the present
soap notes: 327 - 327 (0)

She also struggles to find her own voice and to listen to it
soap notes: 328 - 328 (0)

She does not feel like she has the space to fully be herself, and she cannot receive the support that she needs from those around her
soap notes: 342 - 342 (0)

She feels limited and bound by the country
soap notes: 359 - 359 (0)

With collaborative probing, the client shared that being in Lebanon has left her with less freedom, more responsibility, and a blurred identity
soap notes: 362 - 362 (0)

She notes being too American for Lebanon but too Lebanese for the US, and she is unsure if moving back to the US will make her happy
soap notes: 363 - 363 (0)

C: Yes. Because we always come to an understanding even when we uhm- we always quickly resolve things. So, we try to come to an understanding, and the base is always love. Yeah. We don’t like to hold- yeah, grudges.
assessment session transcript: 141 - 141 (0)

C: Yeah it’s always about her pain, always. It’s- it’s- we can all agree to this.
assessment session transcript: 367 - 367 (0)

it felt like you almost were only there for her, like not as a person with your own troubles and feelings
assessment session transcript: 368 - 368 (0)

Yeah I used to- honestly? Like- I feel like I would have killed myself to make sure that she was okay.
assessment session transcript: 425 - 425 (0)

C: Yeah, I definitely think it would be good, and it’ll help people not feel — cope better, maybe?
treatment session transcript: 14 - 14 (0)

What do you think?
treatment session transcript: 77 - 77 (0)

To me, to myself
treatment session transcript: 189 - 189 (0)

And it’s hard for me to be like, like, — what do I tell her? Like, “I’ve had enough, I have to go”?

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	treatment session transcript: 193 - 193 (0) So, that makes me feel guilty. And she has, she has no idea, you know? treatment session transcript: 193 - 193 (0) I think she was more dependent on me; she would get super jealous if I went out with other friends or did other things without her, which is normal to a point, which is kinda normal — we all get a little jealous sometimes, but not, like, where you're not gonna talk to me anymore… treatment session transcript: 299 - 299 (0)
loss of trust	I could only imagine the type of words and interactions she has had with the people in her life that led her to such a belief reflexive diaries: 4 - 4 (0) she seems to have carried a big burden from a young age, leading her to getting married early with little to no support from those around her reflexive diaries: 4 - 4 (0) the client's history of being dismissed by others in the past and the sometimes in the present, alongside her tendency to reach out to others more than others reach out to her, have left her with a feeling of further isolation and disconnection, as well as a possible belief that she is not supported or loved when she is struggling reflexive diaries: 37 - 37 (0)
	Her husband was not supportive of her education, so she stopped. soap notes: 29 - 29 (0) She senses a mismatch between her needs and husbands catering to said needs. soap notes: 54 - 54 (0) Mother was dismissive to the client's negative experiences and distress soap notes: 69 - 69 (0) No support from her husband who sees her in distress. soap notes: 80 - 80 (0) The client notes that she does not feel supported by those around her, especially in Lebanon

soap notes: 101 - 101 (0)

However, she has recently realized that she generally feels inferior and not respected around almost everyone, but especially around her family.
soap notes: 101 - 101 (0)

She was also bullied and ridiculed by her siblings, although they now have a calm and supportive relationship.
soap notes: 116 - 116 (0)

Mother's psychological difficulties and being parentified
soap notes: 127 - 127 (0)

Best friend moving in: toxic relationship, negative view of herself and her struggles were internalized
soap notes: 133 - 133 (0)

Feeling distant from her loved ones and lacking support
soap notes: 148 - 148 (0)

She also is confused about whether she should speak about this with her husband due to fear of judgement and lack of support
soap notes: 278 - 278 (0)

She felt somehow pressured by the psychiatrist about knowing what she wants, which is hindering her booking a follow up to further discuss her options
soap notes: 295 - 295 (0)

This is largely influenced by her negative experiences with both her mother and the friend who used to live with them
soap notes: 331 - 331 (0)

She does not feel like she has the space to fully be herself, and she cannot receive the support that she needs from those around her

soap notes: 342 - 342 (0)

She noted that her husband also often minimizes her experience and reminds her of how many responsibilities he is upholding

soap notes: 371 - 371 (0)

They would laugh at me they would laugh at the whole thing.

assessment session transcript: 333 - 333 (0)

But I wouldn't always go to her with problems, like school or friends or boys or anything like that, it was more I would go to my sister
assessment session transcript: 361 - 361 (0)

But when- when I would get really bad anxiety or uh depression, she'd be like, oh you know "you're going crazy" and "nothing's wrong" and "stop it".
assessment session transcript: 361 - 361 (0)

it was so annoying, and it was so hurtful to me
assessment session transcript: 363 - 363 (0)

she'll say, "change your thinking" and "you have everything" and "you didn't go through what I went through" and she'll just go on and on and discount everything.
assessment session transcript: 365 - 365 (0)

she would kind of make us feel like- we were in the way.
assessment session transcript: 437 - 437 (0)

"you can't stay here! You can't- you have to go home!"
assessment session transcript: 439 - 439 (0)

Like she doesn't care about anyone except herself
assessment session transcript: 447 - 447 (0)

I kind of felt a little pressured, cause she was like "what exactly are you doing here?"
treatment session transcript: 91 - 91 (0)

I felt like she's not just there to give me her opinion or whatever. She wants to prescribe me something [instead].
treatment session transcript: 99 - 99 (0)

just the fact that he didn't say anything negative — because sometimes he would, you know, and like kind of make me feel defeated
treatment session transcript: 111 - 111 (0)

C: And then it's just, the things she says, (friend's name), the things that she says does not match her, her— the things that she says to me don't match her actions; "I'm so worried about you there, and I think about you, like, all the time" and

	this and that. But it's like, where is this going to help? You don't even answer me. treatment session transcript: 255 - 255 (0)
search for meaning	Additionally, I wonder why the thought record was not completed for this session and am questioning any barriers or resistance that is yet to be uncovered. reflexive diaries: 23 - 23 (0) Resistance for the thought record was more apparent, reflexive diaries: 25 - 25 (0)
	Because in the — at the end of the day, all I want is just, like, to feel peace of mind and contented in my being, in my self, in my…life, you know? treatment session transcript: 149 - 149 (0)
meaning of friendship	She notes that in the US, she could share all her thoughts with her friends without feeling judged soap notes: 101 - 101 (0) She also felt guilty about feeling this way, emphasizing that she was happy for the friend and was just triggered by hearing the news. soap notes: 386 - 386 (0)
	C: So, we usually get along- very well, very loving very supportive, uhm, we're like friends- assessment session transcript: 133 - 133 (0) But we do butt heads assessment session transcript: 135 - 135 (0) C: It's understanding. It's a- there's a- there's a- chemistry between us, a strong chemistry, uhm understanding I think? assessment session transcript: 165 - 165 (0) C: And with my sister also there's a friendship. assessment session transcript: 477 - 477 (0)
relationship with daughter	C: And like a daughter who…there's this…endearment. Uhm, let's see here, it's very…it's very loving it's very supportive it's very c-, uhm, compassionate. assessment session transcript: 163 - 163 (0) she's my rock and that she will stand for me no matter what, assessment session transcript: 171 - 171 (0) Even if- even if I feel like I'm wrong I'm a red line for her. So, she will back me up no matter what.

	assessment session transcript: 173 - 173 (0) C: Okay- can I add one more thing with [second daughter's name]? She's very protective of me. assessment session transcript: 201 - 201 (0)
	I always feel comforted, and I always feel, um, connected when I talk to her. treatment session transcript: 239 - 239 (0)
need for authenticity	this session was similar in theme to the last, delving more into the relational obstacles that come with her physical distance and being in Lebanon reflexive diaries: 37 - 37 (0)
	She wants the space to fully be herself soap notes: 344 - 344 (0) She feels limited and bound by the country soap notes: 359 - 359 (0)
	I think I feel bad because I feel like I'm lying? treatment session transcript: 187 - 187 (0)
need for control	she may have a need for control so as to compensate for her perceived weaknesses and to prove herself as still reliable and valuable to others reflexive diaries: 21 - 21 (0) As such, her concerns regarding nature and death anxiety were closely related to the aforementioned theme of control. reflexive diaries: 33 - 33 (0) To the client, the core issues revolved around her identity as a caretaker as well as the resulting persistent feelings of responsibility and need for control. reflexive diaries: 33 - 33 (0)
	More was later shared about not being able to avoid it or do anything about it soap notes: 323 - 323 (0) which ultimately left her needing to be in control of things for the well-being of herself and others around her soap notes: 329 - 329 (0)
need for support	Despite her need for control, she still feels weak and insecure, which leads her to seek guidance from those around her

	reflexive diaries: 29 - 29 (0)
	She senses a mismatch between her needs and husbands catering to said needs. soap notes: 54 - 54 (0) She reported almost canceling due to how she was feeling but came to the session because it is her "safe space" soap notes: 80 - 80 (0) She also is confused about whether she should speak about this with her husband due to fear of judgement and lack of support soap notes: 278 - 278 (0) She had spoken to her husband and felt supported about her possible medication change soap notes: 293 - 293 (0) She feels bad that her sister does not reach out to her as much as she would like for her to do so soap notes: 375 - 375 (0)
	I went in there to talk, to get her opinion… treatment session transcript: 93 - 93 (0) I think a lot of, I think a lot of it is the void of my children and being away treatment session transcript: 125 - 125 (0) I, really honestly, I miss my sister. treatment session transcript: 239 - 239 (0)
parentification	I wonder how her relationship with her mother is affecting her current mental state? reflexive diaries: 4 - 4 (0) her formulation has become clearer to me, especially now that she has personally hypothesized the effect of her parentification on her interpersonal relationships. reflexive diaries: 12 - 12 (0) strong identification with the role of the caregiver that she was indirectly assigned early on reflexive diaries: 19 - 19 (0)
	The client's mother has also struggled with depression and anxiety, and the client was mostly responsible for looking after her and ensuring her well-being

	soap notes: 15 - 15 (0) The client was burdened with a lot of responsibility at a young age as she had to care for her mother's physical and emotional needs. soap notes: 49 - 49 (0) The client was parentified by her mother; a lot of burden and responsibility that her siblings did not bear soap notes: 66 - 66 (0) The client would seek out her sister in times of distress instead soap notes: 70 - 70 (0) Upon probing, the client shared that this may have been linked to her parentified role as well as the abuse she endured. soap notes: 115 - 115 (0) Mother's psychological difficulties and being parentified soap notes: 127 - 127 (0) Upon probing, the client disclosed feeling responsible for this friend and attributed this role she is taking to her previous experiences with her mother and another friend soap notes: 301 - 301 (0)
	And I feel like I was the mother, a lot of the time assessment session transcript: 317 - 317 (0) Even as a child I knew she needed to go! assessment session transcript: 373 - 373 (0) She always kind of played like the mother role to me, as much as she could. assessment session transcript: 479 - 479 (0) C: Right, right. Uhm… and like yeah I'd go to her for advice. She would take care of me. assessment session transcript: 481 - 481 (0)
	I, really honestly, I miss my sister. treatment session transcript: 239 - 239 (0)
prioritization of others	she seems to be a person who both extends a lot of herself to others but also knows what she wants reflexive diaries: 2 - 2 (0) She seems to have spent so much of her life being there for others and operating on "should"s,

reflexive diaries: 8 - 8 (0)

she had been given a large responsibility since childhood, immediately went on to have her own children which requires responsibility, and she has also always felt quite inferior.
reflexive diaries: 21 - 21 (0)

Getting married [year]: While it was a very exciting time for the client, she feels as though it represents the loss of her independence.
soap notes: 52 - 52 (0)

With her friend in the country, she feels a pressure to be well and not show her struggles.
soap notes: 115 - 115 (0)

The client also described a past of people pleasing tendencies, difficulty setting boundaries, and needing validation from others
soap notes: 115 - 115 (0)

Mother's psychological difficulties and being parentified
soap notes: 127 - 127 (0)

She does not tend to share her concerns on a casual basis, but rather prefers to confide in someone when things become too heavy
soap notes: 373 - 373 (0)

I didn’t have a choice that felt right for me, morally and to feel okay with, other than doing my best to stay, and work it out
assessment session transcript: 189 - 189 (0)

I’m sorry I couldn’t accommodate you back then
treatment session transcript: 2 - 2 (0)

C: Yeah, I definitely think it would be good, and it’ll help people not feel — cope better, maybe?
treatment session transcript: 14 - 14 (0)

To me, to myself
treatment session transcript: 189 - 189 (0)

halfway through I’m, like, “I’m getting tired, I’m getting tired right now”, like, and then I can’t tell her that. But I’ll

	keep going, and try to, like, stay with her and talk with her and listen to her treatment session transcript: 193 - 193 (0) So, that makes me feel guilty. And she has, she has no idea, you know? treatment session transcript: 193 - 193 (0)
protective factor	her openness in the session was something I appreciated reflexive diaries: 2 - 2 (0) she seems to be a person who both extends a lot of herself to others but also knows what she wants reflexive diaries: 2 - 2 (0) I could really see the ambivalence the client holds towards herself; on one hand she feels weak, but on the other, she knows she is a good person deserving of good things in life. reflexive diaries: 10 - 10 (0) sometimes, it is helpful to ask more hopeful questions, or questions that can shed light on the client's protective factors reflexive diaries: 10 - 10 (0) Additionally, it allowed the client an opportunity to reflect on her strengths and what keeps her going. reflexive diaries: 10 - 10 (0) Something that makes me happy to see is the client's level of insight which, to me, is already a large step taken in the direction of healing. reflexive diaries: 15 - 15 (0) She seems to be psychologically minded with a willingness to better herself and her circumstances, too. reflexive diaries: 15 - 15 (0) I can sense the client's slowly but surely growing understanding of her existential struggles reflexive diaries: 31 - 31 (0)
	The client reported being close to her siblings and receiving support from them soap notes: 49 - 49 (0) She reported almost canceling due to how she was feeling but came to the session because it is her "safe space" soap notes: 80 - 80 (0)

Mood is fluctuating, anxiety is also fluctuating but client reports being more in control of how much it affects her
soap notes: 93 - 93 (0)

What keeps her going despite the difficulties is the belief that she is a good person who is deserving, loved, resilient, and a fighter.
soap notes: 102 - 102 (0)

As for her values, she noted love, friendship, loyalty, and family ties.
soap notes: 103 - 103 (0)

She found difficulty thinking of these
soap notes: 151 - 151 (0)

Being at therapy, willingness to change (shared by me)
soap notes: 152 - 152 (0)

She is hopeful and excited about starting treatment
soap notes: 154 - 154 (0)

She is also anxious about the effectiveness of treatment
soap notes: 155 - 155 (0)

The client and her husband always wanted to travel when their kids grew up and moved out
soap notes: 178 - 178 (0)

She would also like to take a class and learn something new
soap notes: 179 - 179 (0)

She had spoken to her husband and felt supported about her possible medication change
soap notes: 293 - 293 (0)

The client noted feeling better over the past two or so weeks, particularly in terms of mood and feelings of connectedness
soap notes: 312 - 312 (0)

although she has been trying to give herself time to check in with herself about her own needs before accommodating for others
soap notes: 328 - 328 (0)

She asked me for practical tools to help deal with such negative feelings

	soap notes: 348 - 348 (0) I reflected on how she is aiming to go back to the US can be taken as a sign that she is putting in the effort to put herself and her well-being first. soap notes: 353 - 353 (0) reflecting on her progress as a means to empower her further. soap notes: 353 - 353 (0) Over the therapeutic process together, the client has been trying to "catch" her thoughts and reframe them, trying to approach triggering situations differently. soap notes: 390 - 390 (0) She also acknowledges her awareness, her love for psychology, and her openness to discussion and learning that have likely aided her on this journey. soap notes: 393 - 393 (0) she now knows her preference in therapeutic approach soap notes: 410 - 410 (0)
	C: Uhm… I still feel, I'm still, uhm, I still feel like I'm pushing myself? assessment session transcript: 14 - 14 (0) C: But now I feel good cause I've been really trying to focus on my diet and eating healthier and…cutting back calories, it's what I wanna do. Uhm… yeah. assessment session transcript: 30 - 30 (0)
	I feel more open treatment session transcript: 41 - 41 (0) Uhm… I think just time, coming here and talking to you, and speaking about things. Yeah, speaking about things. And feeling more, more like I have options, not that it's just like that's it, like this is what you have to do, and this is the only medication, and that's it. treatment session transcript: 73 - 73 (0)
repression of emotions	This was the first time the client shares that her father was a man of bad temper. reflexive diaries: 6 - 6 (0) I felt apologetic for the client's behaviors towards her distress, as she tends to repress a lot of it until it becomes too much.

	reflexive diaries: 37 - 37 (0)
	When asked, the client shared that the repression of her distress is what leads to her depressive episodes soap notes: 372 - 372 (0) She does not tend to share her concerns on a casual basis, but rather prefers to confide in someone when things become too heavy soap notes: 373 - 373 (0)
	it's very interesting to see because at the beginning when I asked you about your relationship with her you told me that it's…very good assessment session transcript: 392 - 392 (0)
resentment	when we come to the point where we're like "stop" we put a boundary, and it's like "I can't do this anymore", she gets- uh you feel like she's not- she feels like she's not being heard assessment session transcript: 373 - 373 (0) there's anger because like I didn't get the care that I need emotionally, and I didn't have anybody there for me who stood there for me or supported me or loved me through MY hard times, so like, why do I have to do this for you!? assessment session transcript: 381 - 381 (0) I can't keep being a doormat for you assessment session transcript: 385 - 385 (0) I'm not ten years old anymore you can't keep doing this. assessment session transcript: 385 - 385 (0) A lot of…anger, towards her. assessment session transcript: 435 - 435 (0) And like my siblings they don't get bouts of depression or- like they've never had a problem with anxiety. And so, I always wonder why me? assessment session transcript: 495 - 495 (0) C: Yeah it's like- I feel like- why were they able to get away with it? assessment session transcript: 497 - 497 (0)

	C: Or like pass through those things, and still remain like okay and I- why was I affected in this way? And it- it kind of makes me resentful? assessment session transcript: 499 - 499 (0) C: Yeah it's like, in a way why did I have to suffer like this? Why did this happen to me? assessment session transcript: 503 - 503 (0) C: Yeah! It's like being exposed to this disease, and it's like why was I the only one who got sick? assessment session transcript: 505 - 505 (0)
responsibility	she seems to have carried a big burden from a young age, leading her to getting married early with little to no support from those around her reflexive diaries: 4 - 4 (0) She seems to have spent so much of her life being there for others and operating on "should"s, reflexive diaries: 8 - 8 (0) she had been given a large responsibility since childhood, immediately went on to have her own children which requires responsibility, and she has also always felt quite inferior. reflexive diaries: 21 - 21 (0) I honestly was just thinking of how tired she must be having carried, and still carrying, everyone's well-being as her own. reflexive diaries: 21 - 21 (0) the fact he will physically no longer be there may bring her closer to the reality that she is responsible for a lot. reflexive diaries: 23 - 23 (0) to a certain extent, I felt this sense of responsibility that she always found so familiar. reflexive diaries: 25 - 25 (0) the client's need for external input as stemming for her own exhaustion of taking matters into her own hands. reflexive diaries: 29 - 29 (0) To the client, the core issues revolved around her identity as a caretaker as well as the resulting persistent feelings of responsibility and need for control. reflexive diaries: 33 - 33 (0)

the client also addressed her preference towards wanting more direction and advice in our sessions.
reflexive diaries: 39 - 39 (0)

I kept thinking of whether this was merely a preference or a result of her overwhelming responsibilities over the course of her life. Is this something she prefers, or has she grown tired of being responsible and wants to have others bear it for her now?
reflexive diaries: 39 - 39 (0)

The client was burdened with a lot of responsibility at a young age as she had to care for her mother's physical and emotional needs.
soap notes: 49 - 49 (0)

Guilt for receiving practical help from husband around the house; thoughts of "I should be doing this".
soap notes: 80 - 80 (0)

With her friend in the country, she feels a pressure to be well and not show her struggles.
soap notes: 115 - 115 (0)

Worrying about her older daughter coming to Lebanon
soap notes: 173 - 173 (0)

She wants to be there for her mother, but her being in a different country makes her feel “out of control”.
soap notes: 192 - 192 (0)

Upon probing, it appears that this is a combination of societal expectations, personal preference, and the learned belief that she will face negative consequences if she did not do what she “had” to do
soap notes: 197 - 197 (0)

She is anticipating a lot of distress as well as feelings of aloneness, fear, and emptiness
soap notes: 213 - 213 (0)

Distress is exacerbated by her husband’s absence due to being abroad
soap notes: 231 - 231 (0)

She reflected on one of her friendships where she feels alone, particularly with her friend who is psychologically vulnerable
soap notes: 299 - 299 (0)

Upon probing, the client disclosed feeling responsible for this friend and attributed this role she is taking to her previous experiences with her mother and another friend
soap notes: 301 - 301 (0)

The client also shared that she has been noticing an increased fear and anxiety about any situation that may lead to a tragic death
soap notes: 314 - 314 (0)

The client felt an immense fear when she reached the place, seeing others walk the bridge and worrying about them falling off of it
soap notes: 317 - 317 (0)

Further probing led the client to link her need for control to the role that she was expected to fill as a caretaker since she was a child
soap notes: 325 - 325 (0)

The client shared that the role she has been filling as a caretaker left her with feeling with a grand feeling of responsibility
soap notes: 329 - 329 (0)

With collaborative probing, the client shared that being in Lebanon has left her with less freedom, more responsibility, and a blurred identity

soap notes: 362 - 362 (0)

However, she would have liked for the work to include more advice from my end, as well as more direction

soap notes: 396 - 396 (0)

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that makes me very upset at her because I feel like I stuck it through and I stayed, really stayed for them. So, it makes me feel like it was a lost cause.
assessment session transcript: 185 - 185 (0)

Because I- I mean, in this- in that vein I was a victim. I was a victim! And I didn't have a choice that felt right for me,

morally and to feel okay with, other than doing my best to stay, and work it out.
assessment session transcript: 189 - 189 (0)

I- sometimes I had to protect her, like- from emotional or physical- he was getting physical with her when she was young
assessment session transcript: 219 - 219 (0)

She feels like she has to protect him… and…and…support him…and be very loving- she's very loving to him.
assessment session transcript: 253 - 253 (0)

very close, uhm… very… supportive on my part
assessment session transcript: 315 - 315 (0)

C: And I feel like I was the mother, a lot of the time.
assessment session transcript: 317 - 317 (0)

C: Yes, yes. We did a lot of things together. I was always- I was with her most of the time. I was with her more than my siblings were.
assessment session transcript: 319 - 319 (0)

I always had to be understanding and supportive and I felt like I needed to be that
assessment session transcript: 321 - 321 (0)

I need to breathe I need some room
assessment session transcript: 369 - 369 (0)

if you're throwing all this shit at them
assessment session transcript: 369 - 369 (0)

we've heard it all! I- I can't do it anymore.
assessment session transcript: 371 - 371 (0)

Even as a child I knew she needed to go!
assessment session transcript: 373 - 373 (0)

You know we love her a lot but- and we feel for her very much, but it's like you can only do so much as like- as a- as her child!
assessment session transcript: 377 - 377 (0)

I wish that I- we could- we all wish that we could do something to make her life better
assessment session transcript: 381 - 381 (0)

	Yeah I used to- honestly? Like- I feel like I would have killed myself to make sure that she was okay. assessment session transcript: 425 - 425 (0) C: And that was the way it was supposed to be. assessment session transcript: 427 - 427 (0) And I had to really take on a lot. That no child should have to take on, or even witness! assessment session transcript: 491 - 491 (0) it seems even in the household you were taking on a LOT, and it wasn't the same for your siblings, assessment session transcript: 514 - 514 (0)
	I'm sorry I couldn't accommodate you back then treatment session transcript: 2 - 2 (0) For me, like, I've taken some of it, I got A's treatment session transcript: 207 - 207 (0) she's very sensitive, and she already, haram (poor her), has issues treatment session transcript: 207 - 207 (0) she's not confident in herself, and she, and she questions herself, and she doesn't even know what a boundary is treatment session transcript: 207 - 207 (0) C: And I definitely don't want to do that because she's already so — she's like, she can't handle it, I don't think. Haram. treatment session transcript: 325 - 325 (0) Yeah! And then I'm like, I always feel bad. I, honestly, I could never, like, not talk to her. I know that about myself. So, the only solution would be, is yes, boundaries. treatment session transcript: 351 - 351 (0)
fluctuating self-worth	Empathy towards this client is building up the more I speak to her, especially given how harsh she seems to be on herself. reflexive diaries: 4 - 4 (0) she views her difficulties as weakness reflexive diaries: 4 - 4 (0)

I could really see the ambivalence the client holds towards herself; on one hand she feels weak, but on the other, she knows she is a good person deserving of good things in life.
reflexive diaries: 10 - 10 (0)

she may have a need for control so as to compensate for her perceived weaknesses and to prove herself as still reliable and valuable to others
reflexive diaries: 21 - 21 (0)

Despite her need for control, she still feels weak and insecure, which leads her to seek guidance from those around her
reflexive diaries: 29 - 29 (0)

The client reported feeling weak due to the fact that she is still struggling with her mental health while on medication.
soap notes: 46 - 46 (0)

she became more insecure and self-conscious
soap notes: 48 - 48 (0)

She feels like the people around her may be tired of her mental state, thus preventing her from reaching out to seek support.
soap notes: 54 - 54 (0)

However, she has recently realized that she generally feels inferior and not respected around almost everyone, but especially around her family.
soap notes: 101 - 101 (0)

What keeps her going despite the difficulties is the belief that she is a good person who is deserving, loved, resilient, and a fighter.
soap notes: 102 - 102 (0)

The client often thinks and believes that she is weak.
soap notes: 104 - 104 (0)

she would often second guess people's emotions and reactions and break down trying to do well for them
soap notes: 115 - 115 (0)

Personal traits such as not being expressive and feeling shame
soap notes: 130 - 130 (0)

High school experience: she was alone, insecure and anxious
soap notes: 132 - 132 (0)

Best friend moving in: toxic relationship, negative view of herself and her struggles were internalized
soap notes: 133 - 133 (0)

The client places an importance on what others think; she wants to appear perfect or at least put together for others
soap notes: 195 - 195 (0)

Further exploration led the client to disclose that control equates strength and power for her, which also relates to her image in front of others and her ability to prove that she is capable
soap notes: 198 - 198 (0)

She noted not judging herself if a bipolar diagnosis was applicable, but worrying about my own judgment towards the shift in her mood
soap notes: 256 - 256 (0)

She felt isolated once more, thought that she is no fun to be around, and felt angry and upset
soap notes: 281 - 281 (0)

The client had concerns about whether it is normal for her to have such negative feelings towards her friend and how to proceed with the relationship
soap notes: 302 - 302 (0)

She also shared that an obstacle to prioritizing herself is the negative reactions from those around her; worrying about them no longer liking her and conflict taking place
soap notes: 330 - 330 (0)

She has recently connected with a friend who is trying to venture in her career, and hearing this made the client feel incompetent and less fulfilled.
soap notes: 385 - 385 (0)

The client has learned that she does not have to be responsible for everything, and that she is more than the roles she has taken on in her life.
soap notes: 389 - 389 (0)

Because I- I mean, in this- in that vein I was a victim. I was a victim! And I didn’t have a choice that felt right for me,

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	morally and to feel okay with, other than doing my best to stay, and work it out. assessment session transcript: 189 - 189 (0)
	it kinda makes me feel bad about myself? That I — I'm just gonna say it — that I have a friend like that. treatment session transcript: 165 - 165 (0) And, and that shows, I am a loyal friend. I'm a good friend; I'm a loyal friend. treatment session transcript: 193 - 193 (0) For me, like, I've taken some of it, I got A's treatment session transcript: 207 - 207 (0) It bothers me and then sometimes I think "Am I being too sensitive?" treatment session transcript: 247 - 247 (0)
therapist doubt about competence	Honestly, I feel a bit behind in terms of the progress we are making reflexive diaries: 14 - 14 (0) The client herself had disclosed that she is tired of feeling the way she does, which oftentimes led to me feeling pressured to do the work with her quickly. reflexive diaries: 14 - 14 (0) I found myself speaking for longer than I am used to in this session reflexive diaries: 17 - 17 (0) I find myself the most authentic when I exist and partake in the client's phenomenology, allowing her to take control of her session and being present as a helpful guide for her reflexive diaries: 17 - 17 (0) I was glad, however, to finally start on extensive work with this client. reflexive diaries: 17 - 17 (0) I believe we both also want her to feel a sense of relief, progress, and liberation. reflexive diaries: 17 - 17 (0) I felt a small sense of personal accomplishment today as a hypothesis of mine was confirmed by the client herself reflexive diaries: 19 - 19 (0)

With her feeling better by the end of the session, I felt a sense of relief
reflexive diaries: 19 - 19 (0)

this may have been attributed to my wanting for her to feel better
reflexive diaries: 19 - 19 (0)

but also to my personal fear of not doing well on the job and not being as helpful to her
reflexive diaries: 19 - 19 (0)

I notice that I still worry about that, even if I know that therapy is a journey that is everything but linear.
reflexive diaries: 19 - 19 (0)

I felt the need to jump to problem solving but took time to step back and be curious.
reflexive diaries: 23 - 23 (0)

she has really been fighting all these years, and she is seeking me for help.
reflexive diaries: 25 - 25 (0)

I felt a little less helpless and ready to embark on deeper exploration of her subjective experience
reflexive diaries: 25 - 25 (0)

Challenged because of the client's suggestion of a bipolar diagnosis
reflexive diaries: 27 - 27 (0)

confused due of my own uncertain clinical judgement
reflexive diaries: 27 - 27 (0)

hesitant about my input in the session and the implications it may have on the client's life
reflexive diaries: 27 - 27 (0)

At that moment, it may have been more difficult for me to disclose our shared sentiments due to my fear of inexperience
reflexive diaries: 27 - 27 (0)

although this would pressure me at the beginning and lead me to lean into accommodating
reflexive diaries: 29 - 29 (0)

	I was happy to hear that the client had been doing much better, especially given the many positive developments in her life reflexive diaries: 33 - 33 (0) I was wary of shifting the focus of the therapeutic piece due to the limited number of sessions left. reflexive diaries: 33 - 33 (0) However, I notice that I tend to feel a bit more helpless when situational obstacles come to surface reflexive diaries: 35 - 35 (0) while I am happy that she trusts my judgment and our relationship, I worry about enabling this pattern of hers by sometimes offering her this validation. reflexive diaries: 39 - 39 (0) Must I have addressed this in this last session of ours? reflexive diaries: 39 - 39 (0) I wonder if I wanted this journey to continue so I could help her further or continue to prove myself… reflexive diaries: 39 - 39 (0)
	anticipating when I want to see my children treatment session transcript: 125 - 125 (0) “if the kids were there”, or “if I had my friends” treatment session transcript: 159 - 159 (0) Not having like, (sigh), someone really to share with the ups and downs. treatment session transcript: 161 - 161 (0) Somebody that, yeah, that I can share times with, somebody that I can share my feelings with, my experiences with. treatment session transcript: 161 - 161 (0) not over the phone, like a friend, but I want somebody there, like I want a friend, or I want somebody close with me. treatment session transcript: 161 - 161 (0)
therapist growth and confidence	When she spoke of the ambivalence towards her mother and cried, I found myself truly immersed in that and felt quite emotional. reflexive diaries: 6 - 6 (0)

I have become much more comfortable allowing negative emotions to fully take up the space of the session
reflexive diaries: 8 - 8 (0)

For one, it helped me, as a clinician, recognize that there exists a light despite the heaviness of the client's current experience
reflexive diaries: 10 - 10 (0)

every
step we are taking together in sessions is naturally going to bring her closer to her goals so as long as we have honest communication and good alliance
reflexive diaries: 14 - 15 (0)

The understanding that I have gained about the client's presenting problems and history have allowed me to immerse myself in her experience and truly feel with her
reflexive diaries: 23 - 23 (0)

I can't exactly place why I felt less helpless. Maybe it's because of her active input? Her readiness to work with a mode of therapy that better resembles myself as a clinician and my interests?
reflexive diaries: 25 - 25 (0)

maybe some more personal disclosure would have not been harmful but rather grounding for the both of us.
reflexive diaries: 27 - 27 (0)

I can now better understand why, thus leading me to more effective methods
reflexive diaries: 29 - 29 (0)

I felt strangely proud of her for gaining more insight, but also proud of myself for being patient and going with the flow of this fluctuating therapeutic journey.
reflexive diaries: 31 - 31 (0)

As someone who ultimately values structure and order, it is in my role as a clinician that I have found myself most comfortable letting go of them
reflexive diaries: 31 - 31 (0)

It was during this session that I truly fell in love with this field all over again; noticing the patterns, drawing similarities, observing the various difficulties that all tie into the same core issues.

	reflexive diaries: 33 - 33 (0) I think it was a good opportunity for me to experiment with an existential lens given that I was supervised and supported by a great team; it gave me a deeper understanding of the client's experience and enhanced my own interest in the theoretical approach. reflexive diaries: 39 - 39 (0)
understanding of depression	During her episodes, she is unable to eat, get out of bed, socialize, or complete any basic tasks soap notes: 5 - 5 (0) While the client is able to function, she reports her functionality as "forceful". She feels like she has no energy for basic tasks. Additionally, she is experiencing a sense of apathy towards others and a decreased motivation to reach out to them. She also feels like she is neglecting her physical health due to her depressive state. soap notes: 47 - 47 (0) Nothing feels rewarding, life is meaningless, and my best years are past me soap notes: 54 - 54 (0) She has been feeling more depressed and hopeless, as well as "out of control" and "not normal". soap notes: 80 - 80 (0) Crying, feeling like there is no joy/energy. soap notes: 113 - 113 (0) Feeling tired to have to fight through another day soap notes: 171 - 171 (0) She misses when she was able to just be, as now she is fighting to live every day soap notes: 234 - 234 (0) To a certain extent, she feels abnormal and wonders if she is possessed soap notes: 235 - 235 (0) While she is trying to engage in the thought record, she worries that it is not enough soap notes: 238 - 238 (0)

She has been feeling “good”; more uplifted, less worried, more relaxed, and feeling motivated
soap notes: 252 - 252 (0)

The client noted that she is not currently feeling depressed, but she is feeling very drained and exhausted
soap notes: 369 - 369 (0)

I’m not functioning- I’m doing everything I need to do
assessment session transcript: 16 - 16 (0)

specifically slowing me down, like it’s making me feel tired
assessment session transcript: 20 - 20 (0)

I forget where — what we were talking about.
treatment session transcript: 33 - 33 (0)

I’m getting through and I’m not like all stressed out and crying… I’m not too bad, you know?
treatment session transcript: 47 - 47 (0)

Appendix 11

Reflection

I:

First and foremost, I think that I have found myself much more naturally approaching the process of therapy over time, especially given that this client is one of my newest ones. While my comfort and confidence in navigating being a therapist in training entails the intricacies of the beginning stages such as covering consent, managing expectations, and relaying the general process of therapy, it also includes my ability to emotionally relate and connect with the client. I usually am a very rational person who frankly (and ironically) struggles with emotions, and this is something I have been trying to be mindful of and put effort into for the sake of both me and the clients I see in the clinic. Over time, it had required less effort on my end; the empathy and emotional connection flowed naturally when I existed as another human being in the session. As long as I was there actively and authentically, I found myself able to naturally offer the client what they needed on an emotional level. Aside from my personal reflections, feedback from the client also helped me realize this; the client comes from a background where she lacks support, and over the course of our sessions, she has really become more honest and communicative and has grown to be more comfortable in the space of the clinic.

However, it was not this easy for either myself or the client at the beginning of this journey; while the client had some apprehension about therapy due to a past negative experience, I also had some countertransference to deal with in regard to the client and her presenting problem. The client shares the name of someone who is close to me and struggles with similar matters; that, in itself, brought about different emotions for me. I had to put in effort to separate the person in the clinic from the person I knew and free myself of any biases or assumptions. Additionally, a difficulty I faced with this client was related to her age-relevant struggles which I may not fully comprehend. The client also comes from a different background, both in terms of nationality and religion, thus requiring more effort from me to immerse myself in her experience and understand where she may be coming from.

On a more personal note, I have long recognized my anxiety in the sessions as a beginning therapist, especially when it comes to being comfortable with silence and allowing space for it. While the sessions conducted with various clients over the past few months has helped in granting me exposure to this, I still notice that kind of anxiety resurfacing with this particular client. She is understandably a distressed person who truly wants to get better as soon as she can and in any way that she can; that alone, especially when vocalized in the session, can somehow make way for me to feel the pressure of conducting the assessment phase as quickly as possible and start with the treatment phase. While I recognize that all components of the assessment phase are essential and will better inform treatment, I do still find myself rushing certain aspects of assessment because of the pressure I feel to help her feel better. This translated to sometimes stopping myself from asking important questions that could have given me more clarity about her case. Even during the transcribed assessment session, there were instances during which I felt like certain subjects could have been given more time and attention, especially at times when I would notice the client’s distress. I was occupied

with wanting to complete the genogram during this one session, and I believe that affected the quality and depth of the information I was receiving at times.

Generally, I have noticed my increased comfort and confidence throughout my conducted sessions; however, I must still be aware of my personal biases and anxieties that may hinder me from 1) being fully present in the session, and 2) actively and effectively guiding the client on her therapeutic journey.

II:

Working on this case both in the context of psychotherapy as well as part of my graduate thesis project has allowed me to add a layer of depth to my thinking when approaching other clients, cases, or even real-life situations. The uncertainty and doubt that accompanied me throughout the different stages of working on this study have only proven to me that my interests, be they theoretical, practical, or academic in nature, contribute largely to the richness of the work I am producing. I have learnt to trust myself more in my clinical practice and orientation, to exist fully and meaningfully with the clients in the room, and to aim for constant improvement on a professional and personal level. That would not have been possible without the consultation I received from my peers and supervisors; it allowed me to reflect more deeply on alternative explanations for my case and different factors to consider that were not as clear to me. Despite my growing confidence and my engagement in a phenomenological approach in the sessions, I believe my presence was sometimes still driven by my anxiety, even if I did not realize it at the time. While this is anticipated and normal, it may have been more beneficial to reflect on how I was feeling in the moment and allow the answer to help both myself and the client on this journey. I would have also liked to incorporate more tools that may have helped the client to reflect more deeply about her experiences outside the session (journaling, etc.). Nevertheless, I am very pleased with the insights, passion, and knowledge this case has provided me. This entire experience was a magnifying glass through which I could really understand the client's experience of depression and how her past and current experiences have shaped it and continue to do so. It was also a reminder of the weight of humility and confidence, of safety and risk, and of connection and withdrawal, both from my side and hers.

REFERENCES

Allen, K., Kern, M. L., Rozek, C. S., McInerney, D. M., & Slavich, G. M. (2021). Belonging: a review of conceptual issues, an integrative framework, and directions for future research. *Australian Journal of Psychology*, *73*(1), 87–102. https://doi.org/10.1080/00049530.2021.1883409

Ashraf, M., Mohamed, A., Sayed, H., Muhammad, O., Gamal, M., & Abouelazayem, M. (2023). Childhood Abuse and Depression in Adulthood: review article. *The Egyptian Journal of Hospital Medicine*, *93*(1), 7793–7796. https://doi.org/10.21608/ejhm.2023.329215

Baroncelli, C. M. C., Lodder, P., Van Der Lee, M., & Bachrach, N. (2025). The role of enmeshment and undeveloped self, subjugation and self-sacrifice in childhood trauma and attachment related problems: The relationship with self-concept clarity. *Acta Psychologica*, *254*, 104839. https://doi.org/10.1016/j.actpsy.2025.104839

Binder, P. (2022). The call of the unlived life: On the psychology of existential guilt. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.991325

Bogaerts, A., Claes, L., Schwartz, S. J., Becht, A. I., Verschueren, M., Gandhi, A., & Luyckx, K. (2018). Identity Structure and Processes in Adolescence: Examining the directionality of Between- and Within-Person Associations. *Journal of Youth and Adolescence*, *48*(5), 891–907. https://doi.org/10.1007/s10964-018-0931-5

Borchet, J., Lewandowska-Walter, A., Połomski, P., Peplińska, A., & Hooper, L. M. (2021). The relations among types of parentification, school achievement, and quality of life in early Adolescence: an exploratory study. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.635171

Breitbart, W. (2017). Existential isolation. *Palliative & Supportive Care*, *15*(4), 403–404. https://doi.org/10.1017/s1478951517000621

Breitbart, W., Pessin, H., Rosenfeld, B., Applebaum, A. J., Lichtenthal, W. G., Li, Y., Saracino, R. M., Marziliano, A. M., Masterson, M., Tobias, K., & Fenn, N. (2018). Individual meaning-centered psychotherapy for the treatment of psychological and existential distress: A randomized controlled trial in clients with advanced cancer. *Cancer*, *124*(15), 3231–3239. https://doi.org/10.1002/cncr.31539

Burton, L. M., & Jarrett, R. L. (2000). In the Mix, Yet on the Margins: The Place of Families in Urban Neighborhood and Child Development Research. *Journal of Marriage and Family*, *62*(4), 1114–1135. https://doi.org/10.1111/j.1741-3737.2000.01114.x

Chen, N., Jing, Y., & Pang, Y. (2022). Relation between parent and child or peer alienation and life satisfaction: The mediation roles of mental resilience and self-concept clarity. *Frontiers in Psychology*, *13*. https://doi.org/10.3389/fpsyg.2022.1023133

Chirico, I., Esposti, V. D., Ottoboni, G., Druda, Y., Casapulla, R., & Chattat, R. (2023). P74: Psychological interventions for young carers: A systematic review. *International Psychogeriatrics*, *35*(S1), 162–163. https://doi.org/10.1017/s1041610223003009

Cho, A., & Lee, S. (2018). Exploring effects of childhood parentification on adult-depressive symptoms in Korean college students. *Journal of Clinical Psychology*, *75*(4), 801–813. https://doi.org/10.1002/jclp.22737

Chojnacka, B. (2020). The loneliness and isolation of the parentified child in the family. *Paedagogia Christiana*, *45*(1), 83. https://doi.org/10.12775/pch.2020.006

Cook, R. (2023). The development of the adult self: an existential, relational, and developmental approach to our human search for meaning. *Transactional Analysis Journal*, *53*(3), 237–255. https://doi.org/10.1080/03621537.2023.2213955

Dariotis, J. K., Chen, F. R., Park, Y. R., Nowak, M. K., French, K. M., & Codamon, A. M. (2023). Parentification Vulnerability, Reactivity, Resilience, and Thriving: A Mixed Methods Systematic Literature review. *International Journal of Environmental Research and Public Health*, *20*(13), 6197. https://doi.org/10.3390/ijerph20136197

Diamond, S. A. (2018). Existential Therapy and Jungian Analysis: Toward an Existential Depth Psychology. *Journal of Humanistic Psychology*, *61*(5), 665–720. https://doi.org/10.1177/0022167818809915

DiMarzio, K., Parent, J., Forehand, R., Thigpen, J. C., Acosta, J., Dale, C., & Compas, B. (2021). Parent-Child role Confusion: Exploring the role of family processes in the context of parental depression. *Journal of Clinical Child & Adolescent Psychology*, *51*(6), 982–996. https://doi.org/10.1080/15374416.2021.1894943

Engelhardt, J. A. (2012). The Developmental Implications of Parentification: Effects on Childhood attachment. *Graduate Student Journal of Psychology*, *14*, 45–52. https://doi.org/10.52214/gsjp.v14i.10879

Engelhard, E. S., Pitluk, M., & Elboim-Gabyzon, M. (2021). Grounding the connection between psyche and SOMA: Creating a reliable observation tool for grounding

assessment in an adult population. *Frontiers in Psychology*, *12*. https://doi.org/10.3389/fpsyg.2021.621958

Fuller-Thomson, E., Roane, J. L., & Brennenstuhl, S. (2016). Three types of adverse childhood experiences, and alcohol and drug dependence among adults: an investigation using Population-Based data. *Substance Use & Misuse*, *51*(11), 1451–1461. https://doi.org/10.1080/10826084.2016.1181089

Hajjar, R. (2018). *The impact of parentification on mental health and identity in a sample of university students in Lebanon*. https://doi.org/10.62811/th.0198

Hank, K. (2024). Emerging Ideas. Family estrangement and its association with life satisfaction and depressiveness in adulthood. *Family Relations*, *73*(5), 2937–2944. https://doi.org/10.1111/fare.13063

Hayashi, Y., Okamoto, Y., Takagaki, K., Okada, G., Toki, S., Inoue, T., Tanabe, H., Kobayakawa, M., & Yamawaki, S. (2015). Direct and indirect influences of childhood abuse on depression symptoms in patients with major depressive disorder. *BMC Psychiatry*, *15*(1). https://doi.org/10.1186/s12888-015-0636-1

Hoffman, L., Vallejos, L., Cleare-Hoffman, H. P., & Rubin, S. (2014). Emotion, relationship, and meaning as core existential practice: Evidence-Based Foundations. *Journal of Contemporary Psychotherapy*, *45*(1), 11–20. https://doi.org/10.1007/s10879-014-9277-9

Hooper, L. M., Wallace, S. A., Doehler, K., & Dantzler, J. (2012). Parentification, Ethnic Identity, and Psychological Health in Black and White American College Students: Implications of Family-of-Origin and Cultural Factors. *Journal of Comparative Family Studies*, *43*(6), 811–835. https://doi.org/10.3138/jcfs.43.6.811

Infurna, M. R., Reichl, C., Parzer, P., Schimmenti, A., Bifulco, A., & Kaess, M. (2015). Associations between depression and specific childhood experiences of abuse and neglect: A meta-analysis. *Journal of Affective Disorders*, *190*, 47–55. https://doi.org/10.1016/j.jad.2015.09.006

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9. *Journal of General Internal Medicine*, *16*(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Kroenke, K., M.D., & Spitzer, R. L., M.D. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals, 32*(9), 509-515. https://doi.org/10.3928/0048-5713-20020901-06

Kwee, J. L., & Längle, A. (2013). Phenomenology in psychotherapeutic praxis: An introduction to personal existential analysis. *Experiencing EPIS: A Journal of Existential Psychotherapy and Integrative Studies.* https://episjournal.com/journal-2013/phenomenology-in-psychotherapeutic-praxis/

Lagdon, S., Ross, J., Waterhouse-Bradley, B., & Armour, C. (2022). Exploring the Existence of Distinct Subclasses of Intimate Partner Violence Experience and Associations with Mental Health. *Journal of Family Violence*, *38*(4), 735–746. https://doi.org/10.1007/s10896-022-00393-7

Längle, A. (2003). *Existential analysis as a fundamental existential-psychological theory and method*. International Journal of Psychotherapy, 7(1), 23–38.

Längle, A. (2005). *The search for meaning in life and the existential fundamental motivations*. Existential Analysis, 16(1), 16–32

Längle, A. (2007). Emotionality: An existential-analytical understanding and practice. Existential Analysis, 18(1), 41–58.

Längle, A. (2011). The existential fundamental motivations structuring the motivation process. In D. A. Leontiev, *Motivation, consciousness and Self-Regulation* (pp. 27–42). Nova Science Publishers, Inc.

Längle, A. (2012). The search for meaning and affirmation of life. In L. Barnett & G. Madison (Eds.), *Existential therapy: Legacy, vibrancy, and dialogue* (pp. 159–170). Routledge. https://xn--lngle-gra.com/downloads/EA%20Routledge%20final%202011.pdf

Längle, A. (2015a). From Viktor Frankl's logotherapy to existential analytic psychotherapy. *European Psychotherapy*, *12*, 67–83. https://doi.org/10.1002/9781119167198.ch19

Längle, A. (2015b). Existential analytic understanding of emotion: theory and practice. *National Psychological Journal*, *17*(1), 26–38. https://doi.org/10.11621/npj.2015.0104

Längle, A., & Klaassen, D. (2019). Phenomenology and depth in existential psychotherapy. *Journal of Humanistic Psychology*, *61*(5), 745–756. https://doi.org/10.1177/0022167818823281

Lee, R. T., Surenkok, G., & Zayas, V. (2024). Mitigating the affective and cognitive consequences of social exclusion: an integrative data analysis of seven social disconnection interventions. *BMC Public Health*, *24*(1). https://doi.org/10.1186/s12889-024-18365-5

Menzies, R. G., & Menzies, R. E. (2024). Existential Therapies and the Extended Evolutionary Meta-Model: Turning Existential Philosophy into Process-Based

Therapy. *Journal of Contextual Behavioral Science*, 100840. https://doi.org/10.1016/j.jcbs.2024.100840

Merriam, S. B., & Tisdell, E. J. (2016). Qualitative research: A guide to design and implementation (4th ed.). Jossey Bass.

Minuchin, S. (1967). Families of the slum: An exploration of their structure and treatment. Basic Books.

Nakamura, C., & Kawase, M. (2021). Effects of short-term existential group therapy for breast Cancer patients. *BioPsychoSocial Medicine*, *15*(1). https://doi.org/10.1186/s13030-021-00225-y

Necka, E. A., Rowland, L. M., & Evans, J. D. (2020). Social disconnection in Late Life Mental illness – Commentary from the National Institute of Mental Health. *American Journal of Geriatric Psychiatry*, *29*(8), 727–730. https://doi.org/10.1016/j.jagp.2020.08.013

Penner, F., Gambin, M., & Sharp, C. (2019). Childhood maltreatment and identity diffusion among inpatient adolescents: The role of reflective function. *Journal of Adolescence*, *76*(1), 65–74. https://doi.org/10.1016/j.adolescence.2019.08.002

Purpuri, S., Mulatti, C., Filippi, R., & Treccani, B. (2024). Inside the kaleidoscope: unravelling the "feeling different" experience of bicultural bilinguals. *Frontiers in Psychology*, *15*. https://doi.org/10.3389/fpsyg.2024.1376076

Robb, C. E., De Jager, C. A., Ahmadi-Abhari, S., Giannakopoulou, P., Udeh-Momoh, C., McKeand, J., Price, G., Car, J., Majeed, A., Ward, H., & Middleton, L. (2020). Associations of Social Isolation with Anxiety and Depression During the Early COVID-19 Pandemic: A Survey of Older Adults in London, UK. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.591120

Safipour, J., Schopflocher, D., Higginbottom, G., & Emami, A. (2011). The mediating role of alienation in self-reported health among Swedish adolescents. *Vulnerable Groups & Inclusion*, *2*(1), 5805. https://doi.org/10.3402/vgi.v2i0.5805

Sawaya, H., Atoui, M., Hamadeh, A., Zeinoun, P., & Nahas, Z. (2016). Adaptation and initial validation of the Patient Health Questionnaire – 9 (PHQ-9) and the Generalized Anxiety Disorder – 7 Questionnaire (GAD-7) in an Arabic speaking Lebanese psychiatric outpatient sample. *Psychiatry Research*, *239*, 245–252. https://doi.org/10.1016/j.psychres.2016.03.030

Schier, K., Herke, M., Nickel, R., Egle, U. T., & Hardt, J. (2014). Long-Term Sequelae of Emotional Parentification: A Cross-Validation Study using Sequences of Regressions. *Journal of Child and Family Studies*, *24*(5), 1307–1321. https://doi.org/10.1007/s10826-014-9938-z

Schnipke, B., & MacKay, M. (2023). Existential issues in psychotherapy. *PubMed*, *20*(1–3), 72–75. https://pubmed.ncbi.nlm.nih.gov/37122574

Schwartz, S. J., & Unger, J. B. (2010). Biculturalism and context: What is biculturalism, and when is it adaptive? *Human Development*, *53*(1), 26–32. https://doi.org/10.1159/000268137

Schwartz, S. J., Meca, A., Ward, C., Szabó, Á., Benet-Martínez, V., Lorenzo-Blanco, E. I., Sznitman, G. A., Cobb, C. L., Szapocznik, J., Unger, J. B., Cano, M. Á., Stuart, J., & Zamboanga, B. L. (2019). Biculturalism dynamics: A daily diary study of bicultural identity and psychosocial functioning. *Journal of Applied Developmental Psychology*, *62*, 26–37. https://doi.org/10.1016/j.appdev.2018.12.007

Shamsaee, M., Hossienimajd, H. S., Brojeni, A. P., Tousi, D. G., & Ghasemzadeh, A. (2024). The Psychological Effects of Parentification in Girls within Single-Parent Families. *Psychology of Woman Journal*, *5*(2), 19–24. https://doi.org/10.61838/kman.pwj.5.2.4

Solobutina, M. M., & Miyassarova, L. R. (2019). Dynamics of existential personality fulfillment in the course of psychotherapy. *Behavioral Sciences*, *10*(1), 21. https://doi.org/10.3390/bs10010021

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of internal medicine, 166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Stålsett, G., Gude, T., Rønnestad, M. H., & Monsen, J. T. (2012). Existential dynamic therapy ("VITA") for treatment-resistant depression with Cluster C disorder: Matched comparison to treatment as usual. *Psychotherapy Research*, *22*(5), 579–591. https://doi.org/10.1080/10503307.2012.692214

Stutts, L. (2022). Increasing Self-Compassion: Review of the literature and recommendations. *PubMed*, *20*(2), A115–A119. https://doi.org/10.59390/wszk3327

Taghizadeh, M. (2023). Investigating the effect of existential therapy on feelings of helplessness and failure, feelings of old age and emptiness, and feelings of confusion and conflict in retired teachers. *Novelty in Clinical Medicine*, *2*(1), 56–61. https://www.jpcmed.com/article_166533_f4ce01beb00df807b9a2e2ec636cc4b7.pdf

The Wiley World Handbook of Existential Therapy. (2019). In *Wiley eBooks*. https://doi.org/10.1002/9781119167198

Tolmacz, R., Hasson, S., Cohen, M., & Mikulincer, M. (2024). Parentification and satisfaction of psychological needs in romantic relationships: The mediating role of relational attitudes. *Family Relations*, *74*(1), 308–322. https://doi.org/10.1111/fare.13094

Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 well-being index: A systematic review of the literature. *Psychotherapy and Psychosomatics, 84*(3), 167–176. https://doi.org/10.1159/000376585

Vanhooren, S. (2019). Struggling with meaninglessness: a case study from an experiential–existential perspective. *Person-Centered & Experiential Psychotherapies*, *18*(1), 1–21. https://doi.org/10.1080/14779757.2019.1572029

Van Der Mijl, R. C., & Vingerhoets, A. J. (2017). The positive effects of parentification. *Psihologijske Teme*, *26*(2), 417–430. https://doi.org/10.31820/pt.26.2.8

Van Parys, H., Bonnewyn, A., Hooghe, A., De Mol, J., & Rober, P. (2014). Toward Understanding the Child's Experience in the Process of Parentification: Young Adults' Reflections on Growing up With a Depressed Parent. *Journal of Marital and Family Therapy*, *41*(4), 522–536. https://doi.org/10.1111/jmft.12087

Vos, J., Craig, M., & Cooper, M. (2014). Existential therapies: A meta-analysis of their effects on psychological outcomes. *Journal of Consulting and Clinical Psychology*, *83*(1), 115–128. https://doi.org/10.1037/a0037167

Vulliez-Coady, L., Obsuth, I., Torreiro-Casal, M., Ellertsdottir, L., & Lyons-Ruth, K. (2013). Maternal Role Confusion: Relations to Maternal Attachment and Mother–Child Interaction from Infancy to Adolescence. *Infant Mental Health Journal*, *34*(2), 117–131. https://doi.org/10.1002/imhj.21379

Winston, C. N. (2016). An existential-humanistic-positive theory of human motivation. *The Humanistic Psychologist*, *44*(2), 142–163. https://doi.org/10.1037/hum0000028

World Health Organization. (2024). The World Health Organization-Five Well-Being Index (WHO-5) (WHO/UCN/MSD/MHE/2024.1). World Health Organization. https://cdn.who.int/media/docs/default-source/mental-health/who-5_english-original4da539d6ed4b49389e3afe47cda2326a.pdf

Yablonska, T. (2013). Family factors of person's identity development during adolescence and early adulthood. *Social Welfare Interdisciplinary Approach*, *3*(2), 30–40. https://doi.org/10.15388/sw.2013.28230

Zhou, X., Huang, J., Qin, S., Tao, K., & Ning, Y. (2023). Family intimacy and adolescent peer relationships: investigating the mediating role of psychological capital and the moderating role of self-identity. *Frontiers in Psychology*, *14*. https://doi.org/10.3389/fpsyg.2023.1165830

Zimmerman, M. (2013). *Interview guide for evaluating DSM-5 psychiatric disorders and the mental status examination* (2nd ed.). Psych Products Press.