Caroline Anne Williams

**This case has been de-identified.

My theoretical orientation is integrative, rooted in relational psychodynamic theory and feminist conceptualization while utilizing interventions from Compassion-Focused Therapy (CFT). I seek to understand my clients' attachment patterns and use countertransference to bring insight into their relational interactions and view of self. Concurrently, I assess how intersectionality and systems of power are impacting the clients' sense of self, other, and the dynamic in the therapy room.

Relational psychodynamic theory guides my approach, with insight and corrective experience acting as the mechanism of change. I target these mechanisms through relational reflections, experiential exercises, feminist considerations, and CBT (including CFT) interventions. This process is facilitated by an authentic connection with the client. I approach treatment planning from a feminist perspective by collaborating with clients on culturally appropriate and obtainable goals. My approach is flexible—as I gain new insight, I proactively shift. In treatment planning, I consider symptoms and resulting diagnoses, but only discuss diagnosis with the client if beneficial to treatment.

Case Study:

Molly, a 19-year-old, cisgender, heterosexual, White woman, presented for short-term counseling at a university clinic. She reported years-long symptoms of rumination, worry, restlessness, fatigue, and irritability, consistent with a diagnosis of generalized anxiety disorder. She noted these were exacerbated by her daily chronic pain. Molly experiences frequent migraines and has daily nerve pain in her arms, varying in intensity. She noted she was a member of the Church of Jesus Christ of Latter-Day Saints and engaged to be married in the near future.

At session four, I noticed feeling unease when I was anticipating a session with her (a countertransference). Informed by a feminist lens, I considered if she may be distrusting of health services due to potential provider bias regarding chronic pain, age, and gender. In session, wondering if a more avoidant attachment pattern was being activated, I reflected that I felt distant from Molly in that moment. Molly disclosed she viewed therapy as transactional; we considered this happening in other relationships as well. Molly connected that she can worry that others may devalue her because of her chronic pain. As an able-bodied person, I wondered aloud about our intersectional interaction of disability status. We reviewed our interactions for microaggressions against her, which she denied; however, she noted her frustration with therapy not helping her enough. To incorporate her feedback and work towards her treatment goals, we agreed to try more guided experiential interventions and used a two-chair technique from CFT to cultivate compassion. This shift resulted in Molly understanding her critical self, developing a compassionate inner being, and having a corrective humanizing experience. When treatment was completed, Molly shared she felt less anxious, had become more comfortable with showing affect, and no longer felt like a "robot." This led to her making significant changes to accommodate her disability needs while pursuing her passions.