

Research Paper

Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

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ABSTRACT

Background: Paruresis, is a condition which lie in the spectrum of anxiety disorder which can cause functional disability in the patient. **Aim:** The purpose of our case study is to investigate how CBT-based idiosyncratic psychotherapy can be used in conjunction with treatment as usual **Method:** A male patient (RY) who had 18 sessions of cognitive behavioral therapy (CBT) was the subject of this case-experimental investigation. Additionally, two follow-up were conducted over the phone. **Results:** Based on RY's Subjective & objective assessment, a decrease in his functional impairment and symptomatology were observed. **Conclusions:** This report indicates good applicability of CBT on paruresis patients. The limitation of the treatment should be catered to in the future research.

Keywords: *Paruresis, shy bladder syndrome, cognitive behavioral therapy*

Paruresis, also known as “shy bladder syndrome,” is defined by Vythilingum et al. (2002) as “fear of not being able to urinate in public bathrooms or in situations in which others may be aware that the subject is urinating” (p. 84). This condition is not diagnosed as a specific category but is categorized under social anxiety disorder as per DSM V and classified under specific (isolated) phobias as per ICD 10, characterized by inappropriate fear of urinating in the presence of others stemming from fear of being judged, embarrassed, or humiliated, which sometimes even makes it difficult for the person to urinate in their own home in the presence of others (Soifer et al., 2001). Like any other phobia disorder, patients experience subjective anxiety in correspondence to fear upon (actual or potential) exposure to specific stimuli. It is frequently physiologically difficult or impossible for people with paruresis to actually start or continue urinating in frightening scenarios. It impaired the functioning of the individual and sometimes caused depressive symptoms secondary to this impairment.

As per the International Paruresis Association (IPA), the prevalence of paruresis is around 7% and reported higher in males (Hutchings & Kehinde, 2024). No specific data was found

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Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

on the prevalence of paruresis in India. But as per the National Mental Health Survey (2016), a 0.47% prevalence rate is reported for social anxiety disorder in the general population with onset in adolescence.

Cognitive and behaviour therapy was found to be effective in the treatment of social anxiety disorder in researchers like Boschen (2008) and Zgourides (1987), while Jasper (1998) reported on the efficacy of combined cognitive and behavior therapy with the patient with paruresis.

Rational

There is a lack of reporting for psychogenic paruresis as a primary symptom in the Indian context. Only one Indian study was found for treatment of paruresis with yoga technique (Javed & Mishra, 2022). Hence, the reporting is found to be necessary to create an evidence-based approach for psychotherapeutic management of paruresis in the Indian context.

METHOD

The present study uses single case experimental design to explore the application of CBT along with treatment as usual in patient with paruresis as a primary complaint. An idiosyncratic case conceptualization was developed for the patient using Clark & Wells (1995) model of social phobia, alongside Boschen (2008) cognitive behavioural model of anxiety. To assess the client's illness progression, objective tools like the Shy Bladder Syndrome Scale and Depression Inventory were used.

Patient Profile:

Index patient, Mr. R.Y., 25 years old, male, Hindu, Hindi-speaking, belongs to a suburban area, Jharkhand, graduated in economics, working as a clerk, unmarried, visited RINPAS, Ranchi OPD with chief complaints of "not able to urinate or sustain urination in perception of real or potential presence of others along with the excessive worry while using a toilet in different social situations like office, ground, public toilets, even at home." Further, he mentioned excessive sensation in his penis due to preoccupation with fear to urinate. Gradually, it leads to avoiding social situations and a reduction in concentration. This further leads to avoidance of social situation and caused isolation, constant worry, disturbed sleep, palpitation, which in turn contributed to low mood, weight loss, reduced appetite, and hopelessness. This constant anxiety triggered his previous condition of fatty liver II and increased his bilirubin at significant level that forced him to take medical leave from the office. He consulted to multiple specialists majorly included urologist and gastrologist where his urologist further ordered a urodynamic test to check for the pathology related to the urinary tract, but no significant positive findings were reported on his test. With the above consultations he got improved with his liver functioning with medications and improved diet but still his urine issue was unresolved. Hence, he was referred for seeking psychological services in the view of psychogenic origin.

The Psychopathology formulation:

The therapy session started with the history exploration of the symptoms to understand the manifestation of the disorder. The individual reported being unable to urinate in the situations involving an attached bathroom or the presence of others in the same toilet, even at home. This stems from the catastrophic thinking that "everyone will judge me if I take too long"; the specific cognitive distortion he reported was "the sound of my urination will be heard by others, and they will judge me for my urination activity," inducing a feeling of

Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

embarrassment. He reported the experience of anxiety presenting as physiological symptoms like palpitation, tension in the body, and trembling (in extreme scenarios) which occurred in anticipation of either the patient experiencing failure to urinate, taking more time than usual in the process when attempting to urinate, or exiting the toilet without attempting to urinate whenever he felt the urge to urinate. During the inquiry, he disclosed that it started during adolescence, when he first had a thought about his size compared to his peers while urinating adjustment to his peers, and he was unable to urinate on that day and had to distance himself to do so. Following this progressively his conditions was deteriorating but he was able to maintain himself by taking precautionary steps, like performing urination in private space only. It was workable for him as he used to be at home and preparing for competitive exams for 3 years. However, one year ago, when he joined his job and had to urinate in the attached washroom of the staff office, his condition worsened and he started to have difficulty urinating in the office washroom, and began to go outside the office. But one day, one of his female colleagues pointed out this behaviour, his condition deteriorated further. Gradually he started to hold his urine to avoid the office washroom altogether. This situation gradually started to impact his mental health, and he began to experience the symptoms of constant low mood sadness, disturbed sleep and reduced appetite along with the hopelessness.

This Chronic stress caused persistent increased production of cortisol which caused the hormonal imbalance and triggered his preexisting condition of fatty liver grade 2. This led to his severe health deterioration, forced him to take medical leave from his office. He started to experience bloating, stomach pain, loose motion, and yellowness in the skin caused by grade 2 fatty liver, which forced him to take medical leave from the office and went back to his sister's house, where he consulted multiple specialized doctors and underwent pharmacological treatment for 2 months and got improved with his physical health. But this urination problem persisted, so he took a urodynamic test, advised by urologist, to check for the pathology related to the urinary tract, but no significant positive findings were reported on his test. Hence, in last the doctor referred him to RINPAS for the psychological management.

Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

Psycho-therapeutic Formulation:

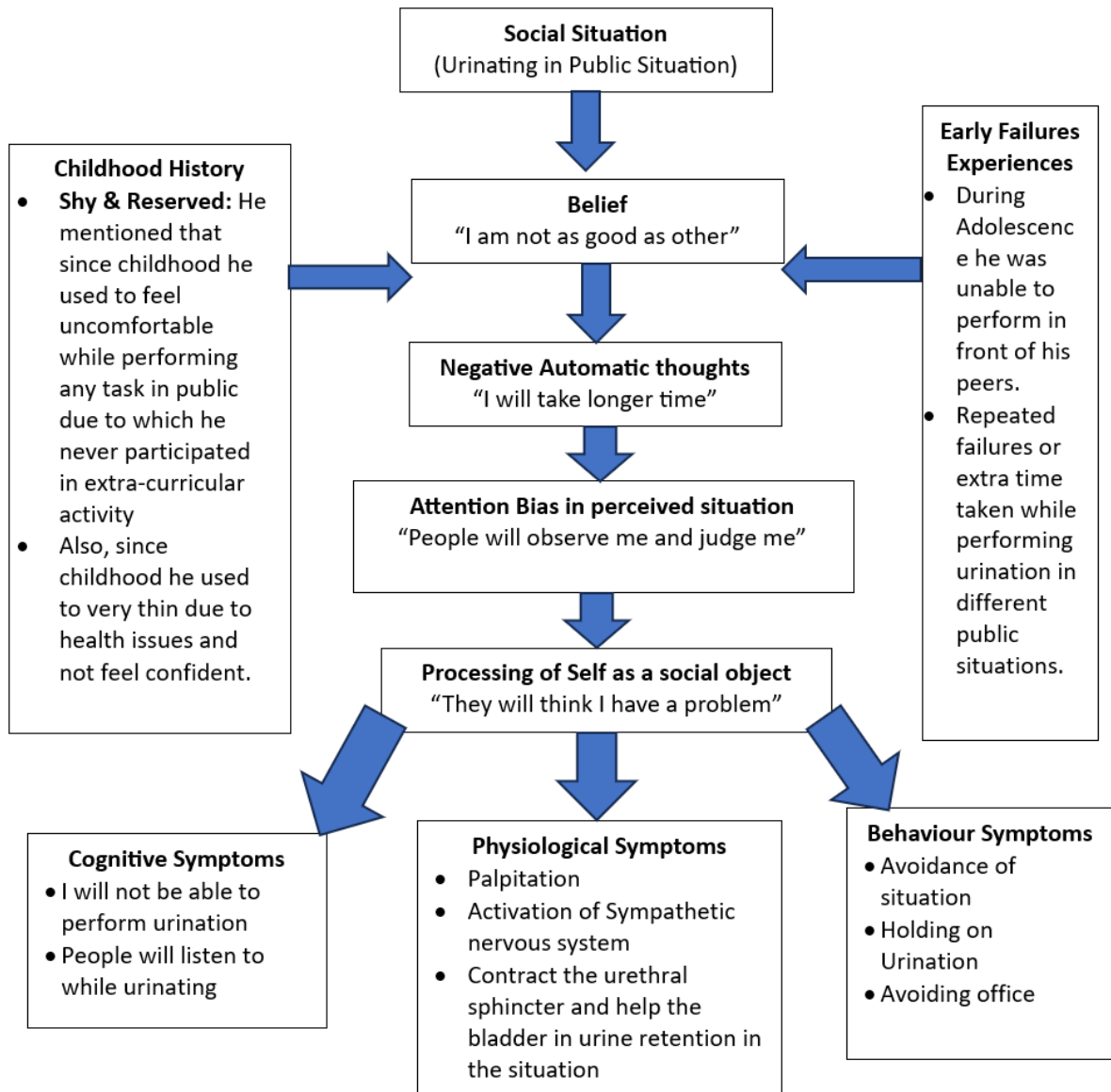


Figure 1: Formulation of Paruresis from Boschen (2008).

Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

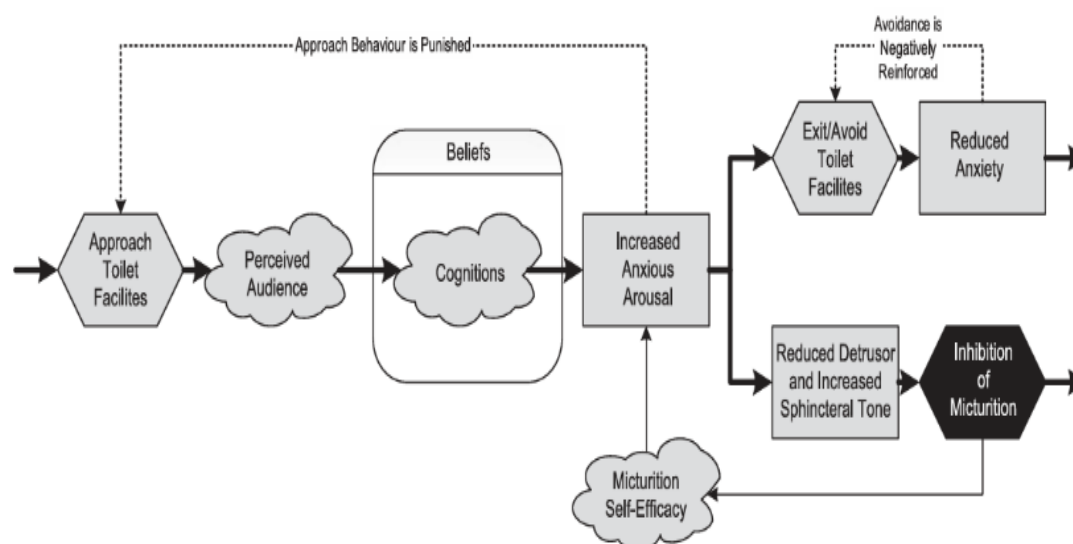


Figure 2: As per Clarks & Well (1995):

Treatment Process:

In initial two sessions case history was taken. Patient reported the chief complaints of low mood, perceived lack of control, sleep disturbances, underline anxiety, hopelessness related to not able to recover etc. The patient was assessed on Shy Bladder and Bowel Syndrome Scale (Knowles & Skues, 2016) where he scored 25 out of 32, indicating sever anxiety, and Beck Depression Inventory (Beck et al., 1961), on which he gained a score of 15, indicating mild mood disturbance.

The case was formulated by using Clarks & Well (1995) Model of social phobia and Boschen (2008) cognitive behavioural formulation for anxiety. Consequently, a cognitive behaviour therapeutic modules was applied along with the treatment as usual to address his anxiety, thoughts (fear of judgment), avoidance behaviour, and physiological symptoms. Based on these symptoms, the treatment consisted of 18 sessions with the frequency of 2 session per week. After taking the comprehensive case history, treatment started with identifying the triggers and making a hierarchy of the subjective unit of distress in collaboration with the patient. At first 2 sessions the patient taught progressive muscle relaxation with the purpose of reducing stress and thereby getting trained on deep breathing so that the patient can self-induce the relaxation during the instances of distressed situations. In the subsequent 6 sessions, the distress situations were exposed in the patient through in vitro imagination techniques to induce the anxiety in the patient and ask the patients to experience it till the time it will settle automatically or by practicing the taught relaxation techniques. After the graded exposure exercise, the patient's experiences and thoughts were discussed and helped him to identify cognitive distortions like mind reading, catastrophizing, overgeneralizing, and fear of judgment. And tried to challenge those with reality testing, asking for alternative explanations for the situation. Since the patient used to practice yoga and in the literature the effect of yoga has been found significant, he was asked to restart his yoga routine again to develop more physiological control under distress situations. After 7-8 sessions, the patient was asked to increase his intake of water and practice the same exposure in the public toilet in different settings like a hospital washroom, shopping mall, etc. Along with this, the patient has also been introduced to focusing on his hobbies or new skill development as a part of behavioural activation.

Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

After 3 months, the patient was reassessed on Shy Bladder and Bowel Syndrome Scale (Knowles & Skues, 2016) where he scored 11 out of 32, indicating significant improvement in anxiety, and Beck Depression Inventory (Beck et al., 1961), where he scored 5 indicating no depressive symptoms. Subsequently, the patient was asked to join his office again, as he subjectively reported that now he can perform urination in a public toilet in a locked bathroom. The patient was asked to report in case of increasing the distress

DISCUSSION

This case report illustrates the effectiveness of tailored sessions using an idiosyncratic approach based on CBT formulation where the graded exposure technique was used, drawing on principle of classical conditioning (Pavlov, 1927), to neutralize the patient's trigger situations. Along with these techniques, cognitive restructuring was employed to alter the negative belief system underlying his anxiety. Behavioural activation strategies, like yoga and educational video-making were used to induce a sense of autonomy and competence.

The patient demonstrated improvement by 56% in his urination-related anxiety, Shy Bladder and Bowel Syndrome Scale scores decreasing from 25 (pre-treatment) to 11 (post-treatment). However, the patient continues to experience difficulty when required to urinate in close physical proximity to others — for instance, at adjacent urinals in a public restroom. These results align with the Hambrook et al. (2016) report of the similar case. Additionally, the patient's mood improved significantly as his score on the BDI reduced to 5 (post-treatment) from 15 (pre-treatment), indicating remission of depressive symptoms.

Although these findings are meaningful, several limitations should be acknowledged. Since this is a single case study, generalization is limited, and the absence of a control condition and reliance on self-report measures further constrain the strength of the conclusions. Further research is needed to explore the additional psychological parameters associated with paruresis. Also, a large sample size is needed to empirically establish this approach as effective for the Indian population. But based on this research, it was concluded that the CBT approach can be used for the patient with paruresis, integrating more exposure-based techniques for improved results. In future research, the integration of other approaches like mindfulness and exploring of personality factors can be considered. Since the patient was hailing from a significantly long distance, due to which the follow-up was logistically difficult, hence, its applicability in an online mode can also be an area to explore in the present digital world.

Overall, this case supports the feasibility of an integrated CBT–yoga approach for paruresis in a real-world clinical setting, while highlighting the need for larger, controlled studies to confirm its efficacy.

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Application of Cognitive Behaviour Therapy on a Classic Case of Paruresis

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Conflict of Interest

The author(s) declared no conflict of interest.

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