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Effect of Cognitive Behaviour Therapy on Depression: A Case Study

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Abstract: The present study is mainly oriented to examine the effect of cognitive behaviour therapy on the depressive patient..Pt. R 18 years old unmarried female, 11th pass, student belongs to middle socio economic status of rural background, presented with complaints of become unconscious and low mood last one year, course episodic, acute onset, with well-adjusted premorbid personality. On mental status examination pt. was co-operative and rapport was established. Pt. was oriented toward time, place and person. Attention was aroused and sustained; memory was intact, average level of intelligence and having abstract thinking and intact personal, social and test judgment, Insight 3/5.

Keyword: cognitive behaviour therapy, depression, premorbid personality**.**

PSYCHOTHERAPY CASE REPORT

Name : R

Age : 19 years

Sex : Female

Education : 12th

Marital status : Unmarried

Socio economic status : Middle

Informant: Self

Mother – 45 years old illiterate, labor

Chief complaints – According to patient –Udaasi rahti h
Kisi kaam ko krne ka man nhikrta
Kisi se baatkrne ka man nhikrta } 3months

According to mother – Rone lagti hai
Baat chit kam krti hai } 1 month

Onset: Insidious

Course: Continuous

Total duration of illness: 3 months

Precipitating factor: Breakup with her boy friend

History of present illness: 6 month back she came to contact with a boy from her friend. During these months they talk to each other continuously on phone and meet daily. They remained very close to each other. She told about this relationship to her mother. Her mother does not accept it and bit her. Her mother said that boy was not good for her. When she told it to her boyfriend he also denial for continue the relationship. After 6 months of the relationship suddenly broke the relationship. After relationship break up with her boyfriend she started remaining sad most of the time of the day she would remain sad. She would think only about her boyfriend. She would think that why he broke the relationship. She lost interest in everything and most of the time she would spend in room. She has stooped recreational activities that she was doing earlier like, going for shopping with friends. Parents found her irritable, but previously she was very calm in nature. She would become angry very easily with her mother. She stopped interact with her friends neighbours and family members. Her confidence was very low. She use to complaining that she cannot do anything. When the family member asked her about this behaviour she did not reply. Continuously saw this type of behaviour her family members brought her psychiatry OPD, PGIMS Rohtak. No history of psychiatric illness in the past.

Negative History: No history of head injury, seizure & trauma.

No history of muttering to self

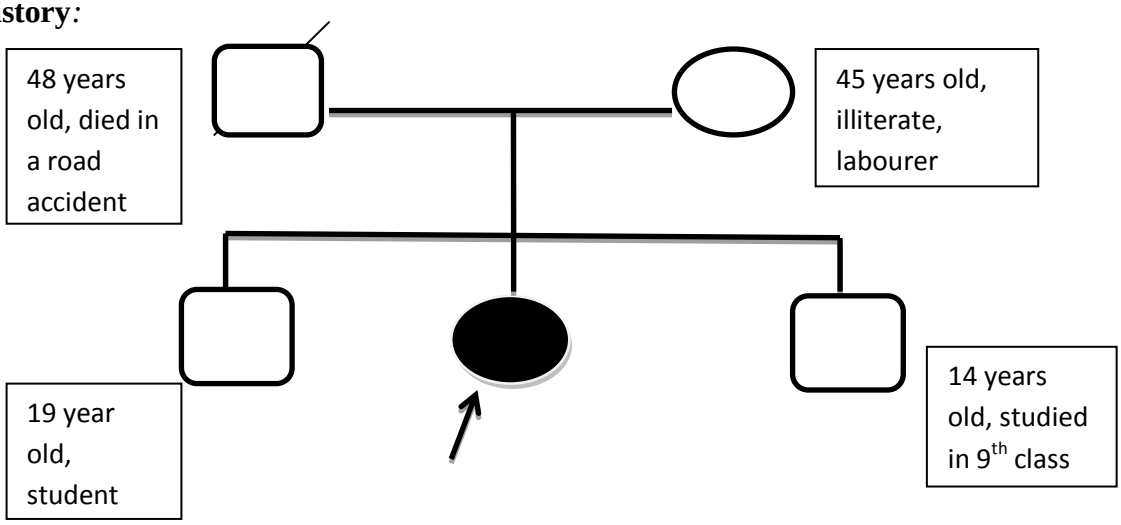
No history of seeing images and hearing voices in clear consciousness which was not heard or seen by others.

No history of persistent, pervasive elevated mood and over grooming, big talks.

No history of persistent, pervasive sad mood, and suicidal ideation.

No h/o intrusive thoughts and compulsive acts.

Family History*:*



Family had cordial relationship with each other. Her mother was the nominal and functional head of the family. No history of psychiatric illness and suicidal attempt in the family.

Personal History: Full term normal delivery at home. Milestones achieved at normal times. She started her schooling at the age of 5 years. She was average in studies. She was well adjusted with peer group. She studied up to 11th class. She was less social able and less participation in extracurricular activities. Currently she is perusing BA 1st year. She was unmarried. She achieved menarche at the age of 14 years. Her menstrual cycle was regular. Her last menstrual 4 days back.

Premorbid personality: She had cordial relationship with her family members and neighbour.She used to euthymic mood and optimistic view about future. She spent her leisure time with her family members**.**She is religious in nature.

Impression: Well-adjusted premorbid temperament

Mental Status examination:

Pt. entered the interview room in a normal gait and sat on offered chair. Pt. looking of stated age. Pt. has adequate level of grooming and cleanliness. He was conscious and alert. He was cooperative and rapport was established. Eye to eye contact was made and maintained. Reaction time and psychomotor activity was in normal limit. Her speech was normal in tone, volume and flow. Her mood was to be depressed. In thought and perception no abnormality detected. She was oriented to time, place and person. Her attention and concentration aroused

and sustained. Her immediate, recent and remote memory was intact. She has average intelligence. Her abstract thinking and judgment was intact and insight 4/5

Diagnostic Formulation*:* Pt. R 19 years old female, study in BA Ist, belongs to middle socio economic status of rural background, presented with complaints low mood, anhedonia, restlessness, with well-adjusted premorbid temperament. On mental status examination pt. was co-operative and rapport was established. Pt. was oriented toward time, place and person. Attention was aroused and sustained; memory was intact, average level of intelligence. Pt. having abstract thinking and personal, social and test judgment was intact, Insight 4/5.

Diagnosis: Moderate Depression without somatic symptoms

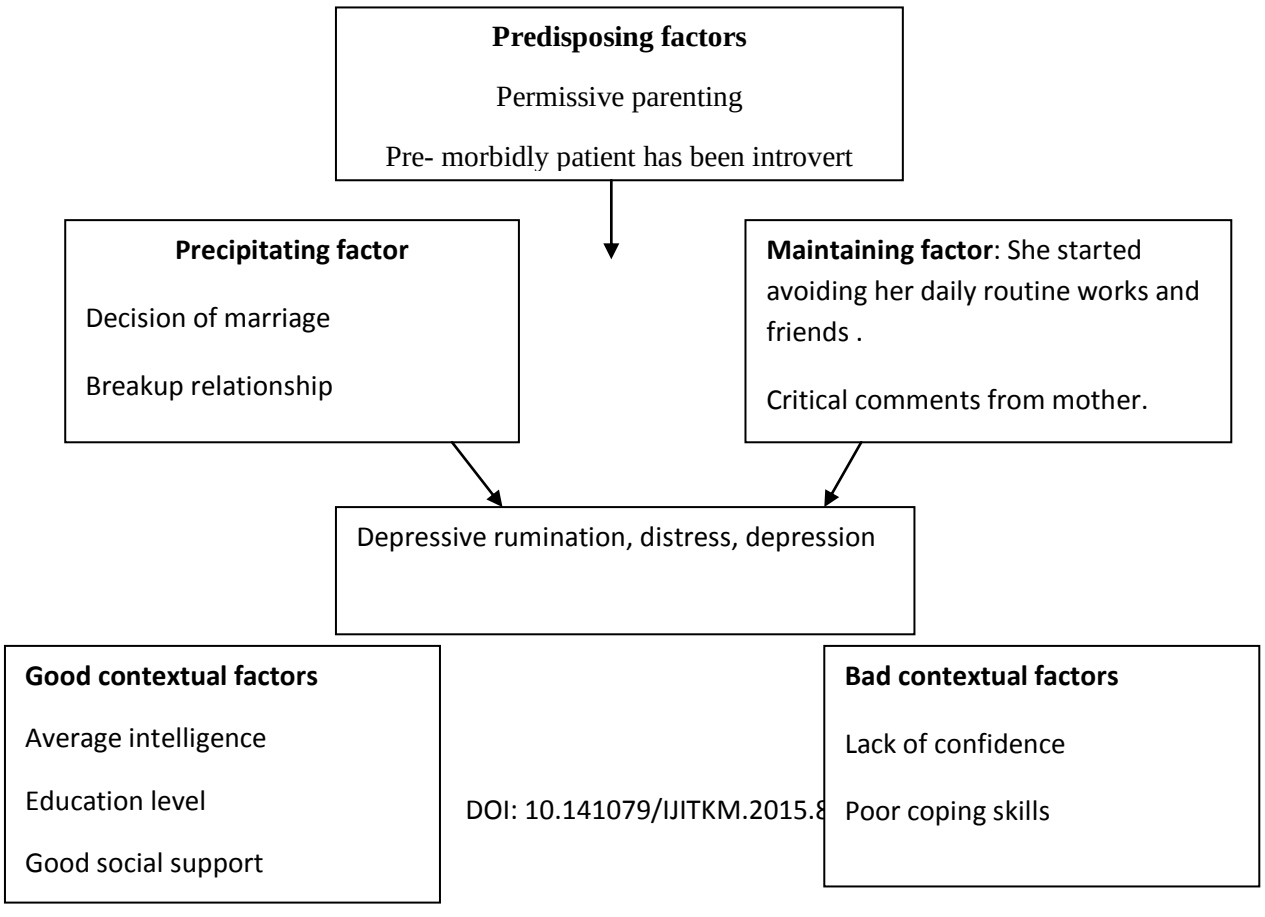
Rational for Intervention: Patient has significant depressive rumination and sad mood due to relation break up. So she was referred to change maladaptive thinking, decreasing distress from cognitive intrusions and improving coping strategies.

Assessment: 1) Beck Depression Inventory-II – To check the level of severity.

2) Self-Monitoring Diary

On BDI he had moderate level of depressive future in these domains, mood, pessimism, indecisiveness, sleep disturbance, work inhibition.

Clinical formulation



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Plan for treatment – Plan was to improve her sad mood, decreased her unwanted cognition intrusion and to develop healthy coping to deal with stressor. It was decided to have session with mother to understand their concerns and let her ventilate. In addition, the goal was to psycho educating the mother about illness.

Goal of therapy

Immediate goals

- Establishment of rapport
- Psycho education regarding nature and treatment of the illness
- To explore her past experiences and interpersonal experiences
- Explaining therapeutic goal and rationale

Short term goal

- Improve her level of confidence and self esteem
- To promote better emotional regulation
- To improve her psychosocial functioning

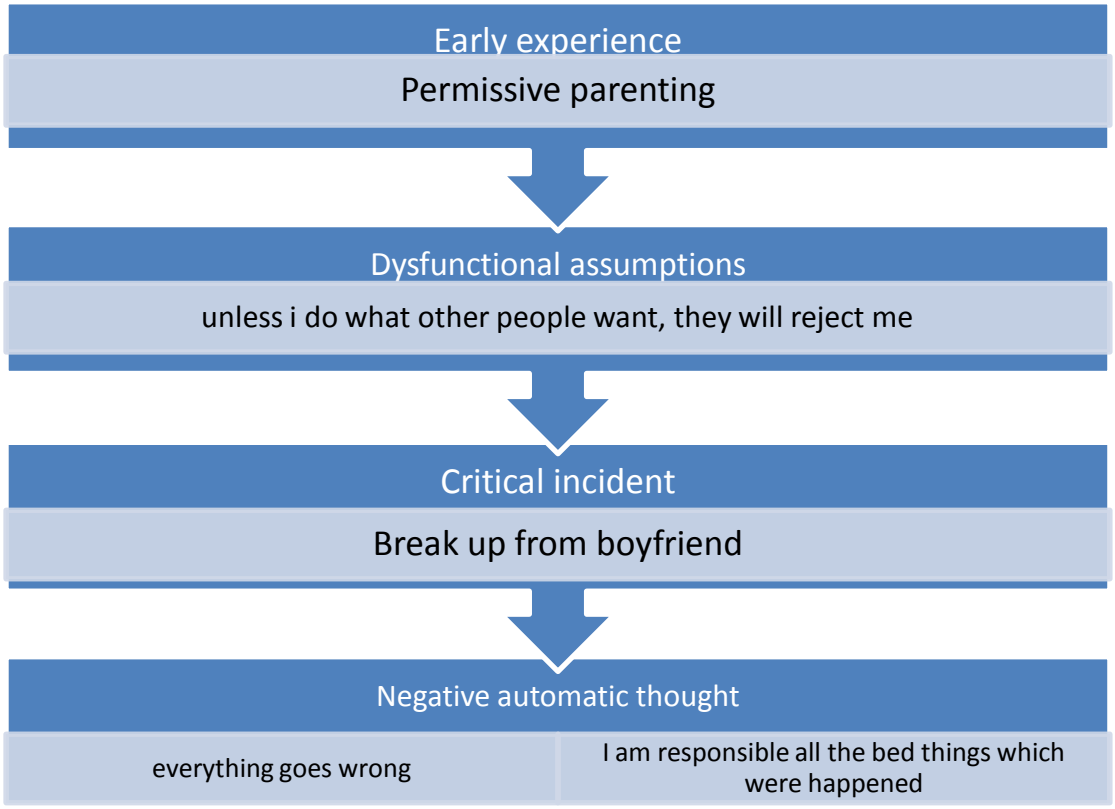
Long term goals

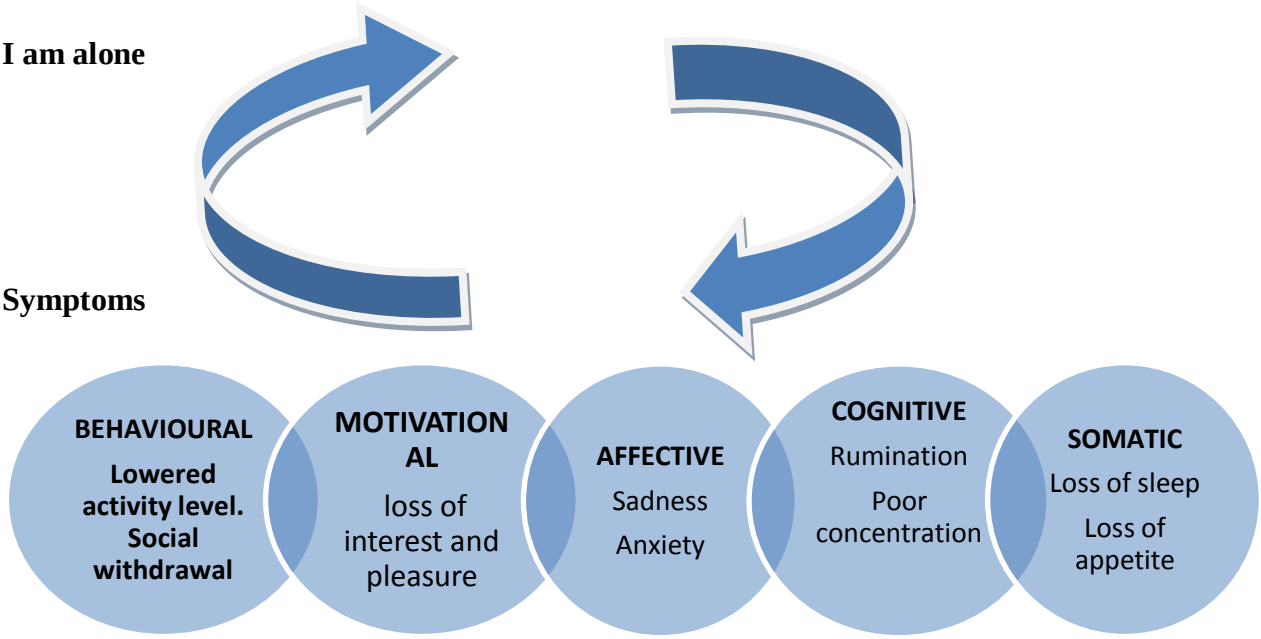
- To learn better copings with interpersonal stressor.
- To make realistic plan for future

Initial Phase (session 1-3)

Patient was well built and adequately dressed. She entered the therapy room with a gloomy face and with slow movement. The therapy of the patient was started with building a therapeutic alliance with her and made her comfortable. In the process rapport development her problem was empathized by saying that she had been attach very much to the boy and the way she has broken the relationship was shocking for her. At the same time, she was provided with a cognitive behavioral formulation of the link between cognitions and emotions and the chain reaction triggered by certain automatic thoughts arising out of distorted perception of experiences.

CBT model of depression has been explained.





She was asked to keep a thought diary, but he found it difficult to do the same, and it was mostly through the narration of his experiences in the therapy session to identify certain cognitive distortions such as personalization, polarized thinking and selective abstraction. When she thinks more about this matter she feels more sad and angry and the end of session rational for therapy was developed and she seemed more receptive. Initial task of learning emotional regulation was to develop her capacity to view experiences from an observing position instead of less rational. Therapy focused on acceptance of emotions and recognition of vulnerability to intense emotions, while at the same time, delaying reactions such as impulsive outbursts in interpersonal situation and learning to cope with the subjective distress caused by the emotions. An activity scheduling was carried out by the patient and the therapist together. The schedule included work at the home, talking to family members and taking care of them, reading newspaper and watching television etc. Coping strategies such as listening to music, relaxation and deep breathing and taking a walk, were identified by the patient as activities that help him reduce stress.

One 40 mints session was taken with mother; she told that she had been very honest person in relationship. Though she had few friends but she was devoted to them completely and saying she accepted from other side also.

MIDDEL PHASE (4-7)

In this phase goals of the therapy were made:

- Engaging her in work and help her to follow a structured routine.
- To Identify and then to modify negative thoughts and beliefs using cognitive restructuring.
- Enhancing her problems solving ability using the problems solving technique.

The Patient's negative thoughts which were causing her tremendous distress hence the patient was taught some distraction techniques to give her temporary relief. If was explained to her, however, that these techniques were only to give her relief only for some time. The patient's pleasant memories and incidents were selected by talking to her and listed for her. She was then advised to imagine those memories and to think of those pleasant memories as vividly as possible whenever her negative thoughts arouse.

The next step in the therapy was the maintenance of a dysfunctional thought record. This included columns for situation, negative thought and emotion. The relationship between

thought emotion and behaviour was explained to patient. It was explained to the patient that when a person feels a negative emotion like anger, sadness, guilt etc, there is always a thought behind it and that the key element of this therapy was to identify those thoughts so that they could be changed thereby changing the emotion that was attached to that thought. Homework assignment and self-monitoring was given to the patient.

After identifying the problematic situation in which the emotion occurred, patient had managed to identify a number of negative thoughts she was helped to challenge them one by one. This was done by the use of questions like-Is there and alternative way to think that might be somewhat more positive? If this thought were to be true then what was the worst thing that could happen? What could be a more rational way to think about the situation? Supposing a friend came to the patient and said that this thought had been causing the former distress, what advice would the patient give him or her? The alternative positive thought was to be written in an additional column.

The patient managed to identify many thoughts such as what would be happen in future. I will always be unsuccessful in dealing with any relationship, nobody listens to what I say, I want to forget everything but I failed to do so I have gone mad and will never get alright.

Often the positive thought would be followed by a 'yes, but' in such situations the negative thought following the positive one would be recorded again in the negative thought column and the patient would be required to come up with another positive counter thought. The patient was asked to make sure that she ended in the positive thought column which meant that all his subsequent negative thoughts would have been countered by a positive one.

After the patient was able to skilfully identify and challenge her negative thoughts the focus of the therapy turned to dealing with the dysfunctional assumptions that underlay them. It was explained to the patient, how her early experiences, led to dysfunctional assumptions which were then further strengthened through critical incidents, which later gives rise to negative automatic thoughts about herself, her surroundings and about her future. On analyzing it was found that she was employing the following cognitive distortions.

Overgeneralization: everything goes wrong.

Selective abstraction: I have not done anything good today. I have not had even a moment's pleasure today etc.

Arbitrary inference: I will never be able to do anything well in future for my family.

Personalization: I am responsible all the bed things which were happened.

The Socratic questioning was applied which patient was asked number of questions to be able to find the core belief of the patient that was giving rise to a number of her negative thoughts. Later on with the help of guided discovery (which refers to the process, through which leading questions are asked to help the patient to arrive at new perspectives that would challenge his faulty cognitions) the patient was enabled to alter her faulty cognitions.

The last few sessions of the middle phase were devoted to providing the patient with information regarding sleep hygiene and teaching her the technique for problem solving.

As patient reported sleep disturbances in initiation phase, sleep hygiene was explained like took food 2 hour before going to sleep, did not drink tea in night, less disturbances in environment, turn off the light before going to sleep and did not think about anything which made distress to her.

The step for problem solving were taught to her that were : Definition of the problems in concrete behavioral terms, Brainstorming regarding all possible solutions, Rating each solution on a scale of 1-5 based on its positives and negative attributes. After each solution is rated, its pros and cons are calculated separately. The solution with the highest number of pros is chosen. This solution is then applied in real life. If the solution works then the process of problem solving ends else the patient has to go the 3rd step and chose the next best option.

During this phase the patient was prepared for the termination of sessions. So that, she can prepares herself for termination of sessions.

Terminal phase:

In the terminal phase she and her mother were spoken to in detail and mother was educated regarding her problems. It was explained to her mother is need to be supportive and caring and advise to avoid arguments with her.

It has been seen that she improved significantly and was able to deal with the situation and cope up. She said that she can handle the crises and also trying to go her studies. BDI was again administered and she scored 4 indicative of minimal depression. There was significantly improvement was reported. She was assured that she was not alone; she had to

practice all these techniques whenever she faced problems and if she not able to solve the problem, whenever she need for treatment she can come again for resolving her problems.

Future plans:

Follow up sessions after two month and whenever she will notice the sign and symptoms of illness then she will try to use the strategies that she had learnt in the life therapy process.

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