

Cognitive Behavior Therapy for Depression: A Case Report

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Abstract

Depression is expected to become the most common psychiatric disorder and cognitive Behaviour Therapy (CBT) is recommended for treating depression as an effective treatment. Mental health issues in developing countries are difficult and challenging. It is suggested in many ways that intervention developed in western countries may not be effective for developing countries. Moreover, the findings of the study will help the mental health professional to reduce these symptoms and help them to make better adjustment.

Keywords: Cognitive behavior therapy; Depression; Psychiatric disorder; Mental health

Introduction

Depression is expected to become the most common psychiatric disorder, and one of the leading causes of disease burden in developing countries. It is an important global public-health issue, among various other mental health problems that affect 1 in 20 people in every year [1]. Prevalence of depressive disorders in Bangladesh is 4.6% [2]. Although these seem small but already the ultimate consequence of depression is suicide [3]. Depression is more common in women and it is the main cause of disease burden in Bangladesh [4]. Cognitive Behaviour Therapy (CBT) is recommended for treating depression as an effective treatment modality for a long time in developed world [5]. Recent findings suggest that CBT might be as effective as medication in treating moderate to severe depressive illness, especially in the initial phases of depressive illness and CBT has been shown to be effective treatment for depressive illness [6].

Case Description

Ms. A, a 22-year-old unmarried female Muslim client was referred for psychological intervention in the Psychiatry Outpatient Department (OPD) of National Institute of Mental Health (NIMH), Bangladesh. She was assigned to the present therapist and was diagnosed as depression by the psychiatrist. In the assessment sessions she presented her problems along with history. Her problems are presented in the following in clustered fashion according to different areas of functioning. The client believed that she was suffering from psychological illness [7,8]. The client complained lack of concentration, lack of self-confidence, and indecisiveness. She also complained of depressed mood, feeling of guilt, lack of pleasure, anger and hopelessness. She felt irritability and fear. She avoids social gathering, friends and sometimes occasionally she used to cry. The client complained of headache, palpitation. She also complained that family members usually irritate her especially eldest brother. Her dress up, appearance and behavior appeared to be culturally appropriate. At the initial interview she spoke willingly about her problems. She was well motivated and interested to work collaboratively with therapist.

Exploration of history revealed that the client was in a middle-class family of a rural area with two brothers and three sisters. Her father was 55 years old and he was a small business man. Her mother was a 45 years old house wife. From her childhood she experienced that the relationship between her parents was not good. The eldest son of their family maintains everything of the whole family. Her eldest brother was very dominating. She had to lead her life as to his liking. She was the last issue of her parents. Though she was meritorious student from

childhood she was always underestimated instead of being encouraged. The senior most brothers always used to apply pressure on her for studies. They were not happy with the results she obtained. During any bad occurrence in her family if she protested, she had been termed as "disobedient". She likes reading story, listening to music and reciting poetry which are not supported by her elder brother. Her brother doesn't even like her writing skills. She was physically tortured several times for doing these [9].

She was sexually abused for several times. At the age of five or six years old, some of her playmates abused her. When she was in class seven her cousin tried the same way. During college life one of her uncles tried to abuse her also. She couldn't tell these to her family with a fear of receiving disbelief of the family. When she was 15years, she had an affair with a boy. Then due to misunderstanding that broke up. When she was in college she again got involved with a boy only to pass time with that boy. Now she is having third affair. She is a graduate student. Since having all these she thinks that if she had got family support enough, there wouldn't be so many problems. There was no history of psychiatric problem in her childhood and adolescence.

Assessment

In clinical interview the client was asked the reason for referral, why she sought for help and how long the main complaint had persisted, when did the problem first occur, what was the subsequent development in her life (occupation, living with parents, at school), what were the impairments that have been produced by the her difficulties, how she and others coped with the problem, what her belief about the problem, what was the attitude to her difficulties, what was her cognitive functioning, what was her prevailing mood, what was her background history, early development history, occupational and educational history, sexual history and what previous psychiatric, psychological or medical help she had taken [10-12]. The client asked to find out and list up her main problems. Thought diary was applied to assess situation specific negative automatic thoughts (NATs) and corresponding emotion, physiological changes and behavior for the client. It was administered to identify the NATs about the social situation and the relation to changes in emotion, physical reaction, and behavior [13].

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Received July 19, 2018; Accepted July 30, 2018; Published July 31, 2018

Citation: Ara J (2018) Cognitive Behavior Therapy for Depression: A Case Report. J Clin Case Rep 8: 1151. doi: [10.4172/2165-7920.10001151](https://doi.org/10.4172/2165-7920.10001151)

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Measurement

Therapist conducted both type of measurement, subjective & objective measurement. In assessment session client mentioned her overall problems severity at '100' point on (0-100) rating scale. For objective measure Depression scale [14] was used to assess the severity of depression. The highest possible score of 30 items form of depression scale was 150 and the lowest possible score was 30. Higher score on the scale indicates high level of depression and lower score indicates low level of depression. Both the split-half reliability (Guttman split-half $r=0.7608$) and test-retest reliability ($r=0.599$) of this scale ensured that the scale is a reliable instrument. Estimation of concurrent Validity shows that, rating of depression by the psychiatrist ($r=0.377$) and self-rating of depression by the patients ($r=0.558$) were positively correlated with the obtained scores on the current depression scale ($p<0.01$). Discriminability ($F= 85.386$, $p<0.01$) concluded high concurrent validity of the scale. Construct validity were found satisfactory.

Anxiety scale [15] was developed in the cultural context of Bangladesh. It assesses the severity level of anxiety from the very beginning sessions. Score ranges for mild, moderate, severe and profound severity were 27-54, 55-66, 67-77, and 78-144 respectively. A higher score indicates a higher level of anxiety. The anxiety scale poses sound internal consistency (Cronbach's alpha = 0.9468) and temporal stability (test rest reliability = 0.688, $p<0.01$).

Procedure

Ms. A was assessed for eligibility for treatment with the Depression Scale and Anxiety scale. Following the initial assessment, the patient was assigned to treatment and evaluated psychologically regularly as detailed in Tables 1 and 2.

Case conceptualization

Ms. A 22-year-old unmarried female Muslim client was referred with the complain of depressed mood, lack of concentration, lack of self-confidence, indecisiveness, guilt feelings, anger, felt irritability, headache, and avoidance behavior. In-depth interview and the exploration of her thought revealed that she was suffering from depression. Based on information's collected from the client, her formulation was done in predisposing, precipitating and maintaining factors [16].

Sessions	Severity of the problem (0-100)
1 st Session	90
2 nd Session	90
3 rd Session	75
6 th Session	60
9 th Session	50
10 th Session	45
13 th Session	25

Table 1: Subjective report of the client.

No of sessions	Anxiety scale	Depression scale
1 st Session	62 (Moderate)	135 (Severe)
3 rd Session	54 (Mild)	120 (Moderate)
5 th Session	45 (Below cut off point)	113 (Mild)
7 th Session	38 (Below cut off point)	106 (Mild)
9 th Session	30 (Below cut off point)	92 (Below cut off point)
11 th Session	30 (Below cut off point)	72 (Below cut off point)
13 th Session	28 (Below cut off point)	63 (Below cut off point)

Table 2: Anxiety and depression scores.

According to the client though she was meritorious student in early age she was always underestimated in stead of being encouraged, she did not get any attention and care for doing good result or doing any thing good. In general, behavioral models claim that depression comes about because the person is receiving inadequate or insufficient positive reinforcement or reward from him or her environment [4]. According to the client the relationship between her parents was not so good. Her senior most brothers always used to apply pressure on her for studies. She likes reading story, listening to music and reciting poetry which are not supported by her elder brother. Even she was physically tortured several times for doing these. She was sexually abused for several times [8]. Propose that "Sometimes individual process traumatic information in a way that produces a sense of current threat, whether this is physical or psychological". Crittenden reported that a child exposed to repeated early traumatic experiences is likely to show a disruption in normal Personality development. Children who experience a trauma exhibit discernable long-term effect [1]. Since she had some difficulties in making close relationship and the entire incidence seemed to develop her problem gradually.

The client came from a restricted family. The relationship among parents was disharmonious which maintained her problem. Domination of elder brother and lack of support from family also maintained his problem. She was withdrawn from daily activities & social gathering. This avoidance was also acting as a maintaining factor for her current illness. She was passive and angry in nature and couldn't express her emotion in appropriate way. But after then when realized the mistake she was suffering from serious guilt feelings. The client had some NAT's which helped to maintain her problems, such as- "I am helpless", "I am not good enough", "I never get any good things in my life". She was sexually abused for several times, for these incidents she thinks herself as untouchable and feels guilty. She shows herself to be a rather introverted who had some difficulties in making close relation. She has difficulties in situations where she must assert herself and lacking in self confidence. She sets herself high standards in relation to work performance and in her role as a difficult daughter. The client also had some social skill deficit which helped to maintain her problems. All these lead to indecisiveness, lack of concentration, lack of self confidence and maintain his problem. After obtaining information on predisposing, precipitating and maintaining factors, client's problem was formulated based on the cognitive model described by Beck (Figure 1).

Course of treatment

The formulation of the client's problem was drawn based on cognitive model, cognitive behavior therapy was chosen for the client's problem. Formulation was shared with the client to make her prepared to follow psychological treatment. Goals of the treatment were set and defined collaboratively with Ms. A, which were as follows: 1) to reduce depressive symptoms 2) to terminate avoidance and 3) reduction of guilt feelings. Priorities were then set by negotiating to which problems were to be dealt with first. Following cognitive-behavior therapeutic techniques were followed in the sessions.

The client could not express her feelings and past experiences. In therapy session the first treatment session focused on establishing sufficient rapport, educating the patient about depression and psychotherapy in general, emphasizing the importance of homework, taking responsibility for change, empathy was given aiming to open her feelings and thoughts and adjusting her expectations about what can be gained through therapy.

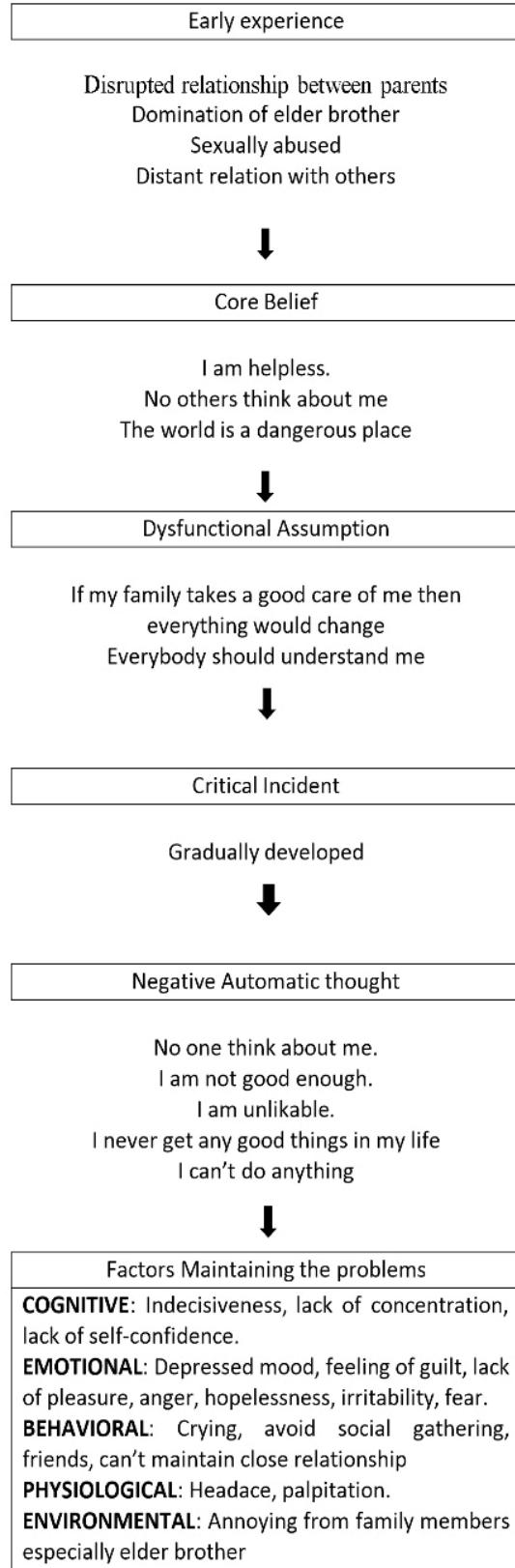


Figure 1: Information on predisposing, precipitating and maintaining factors, client's problem was formulated based on the cognitive model.

Thought Challenge technique was used to modify the client's NAT's by examining the evidence for against the NAT's of the client. Cognitive therapy was given to reduce her NAT's as NAT's maintaining her problem. The steps that were involved in challenging a thought were as follows-

- 1) What is the worst thing that, suggested by the perceived threat can happen?
- 2) What are the points that supports that the worst thing will happen?
- 3) What are the points that indicate the impossibility of the worst thing to happen?
- 4) What are the benefits of thinking about the worst?
- 5) What are the costs of thinking about the worst and finally?
- 6) Considering these points what should I do? i.e., what does all these points suggests.

Pie chart was used to reduce feelings of guilt (especially which was related to sexual abuse). It helped the client to determine her responsibility for an incident. Decision making problem is common problem of depressed client. If decision making is not appropriate that time person not feels comfort and self blame and guilt feeling come. There are some steps of decision making. These are isolating the problem, decide to act gather resource, plan, visualize your plan of action and act.

To make the client more assertive she was trained assertive training. This training helped her to communicate with her family members. Assertive training helps people to express how they feel without trampling on the rights of others in the process [15].

Muscular relaxation was to teach to reduce headache and tension. Evidence suggests that relaxation procedure have been effective for a vast array of problems including headache, insomnia, anxiety, temper outburst [12-16]. The client was taught how to express anger in a constructive way. These include defining the anger, being assertive and finding some mutual way of solving the problem.

The client often underestimated her positive qualities which maintained her problems. So, the client was asked to write down at least two good qualities every day. So that she could aware about her positive qualities, it would help her to perceive herself in another perspective. Sessions 8-13 focused on monitoring activities. The client complained of lack of pleasure, so a record-sheet was given to client to record what he did on an hour-by-hour basis, and to rate each activity out of 10 for pleasure (P) and for mastery (M). It was used to improve mood and to increase level of pleasurable activities.

Results

Subjective rating of the client's problem was taken intermittently in assessment and treatment sessions. Verbal rating of the clients' problem was taken in a 0 to 100-point scale, where 0 means lower level and 100 means high level of problem.

Table 1 indicates that client's subjective rating about the problem was reducing gradually. Standardized scale was applied in most of the session to get an objective measure of the improvement and to provide an objective feedback about improvement to the client and therapist. Anxiety and depression scale were used as objective measures of

improvement. Session wise scores of these scales are presented in following (Table 2).

The subjective and objective report of the result of intervention strongly suggests that improvement have occurred.

Discussion and Conclusion

The client was very much sensitive about her problem. When she got the impression that the therapist understood her problems she became very much motivated and showed high level of compliance with psychotherapy, it's helped the therapist to deal with her problem. She accepted psychotherapeutic formulation of her problems and she could internalize therapeutic technique and its rational. Her NAT's was reduced, and she started thinking positively. She could generalize psychotherapy and applied skills in different settings. So, it can be said that it will be disturb his improvement and chance to future relapse. The client was asked to practice all technique which he learnt. But if the she continued 2nd and 3rd follow up session the therapist could feel more confident about the client's improvement due to psychotherapy.

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