MedCrave
Step into the World of Research

Journal of Psychology & Clinical Psychiatry

Case Report

Open Access

CrossMark

Application of cognitive behavioral techniques in the treatment of depression in the context of school counseling: a case study example

Abstract

The effectiveness of Cognitive Behavioral Therapy has demonstrated success in the treatment of many disorders, amongst those in the domain of anxiety and depression. This article is based on a practical example of working with motivated adolescents, on the application of Cognitive Behavioral techniques which provided the basic necessary tools for active engagement on changing dysfunctional thoughts and behaviors whose impact is reflected in the decline in depressive symptoms, increasing self-confidence, and consequently a higher academic success. It certainly is an encouragement to therapists that dare to use even more of Cognitive- behavioral techniques in the school context, and to provide more research on their effectiveness.

Keywords: cognitive-behavioral therapy, adolescents, depression, anxiety, school context

Volume 3 Issue 6 - 2015

Maja Sedmak MA
Licenced School Psychologist and Counselour, School of Fashion and Design, Croatia

Correspondence: Maja Sedmak MA, Licenced School Psychologist and Counselour, School of Fashion and Design, Prilaz baruna Filipovica 30, 10000 Zagreb, Croatia, Email mojca.psy@gmail.com

Received: March 08, 2015 | **Published:** October 15, 2015

Introduction

The origins of Cognitive Behavioral Therapy (CBT) dates back to the Behavioral Therapies and their development in the early 20th century, and correlate with the development of Cognitive therapy in 1960, and consequently resulted in their fusion. Their effectiveness has been demonstrated by numerous clinical studies in the treatment of various psychiatric disorders. Aaron Beck is considered to be the father of Cognitive Therapy, and his focus was initially on targeted treatment of depression. He thought that in depression there is a distortion of thoughts that is mainly focused on the negative perception of themselves, negative interpretation of the environment and the negative expectations in the future.[1]

High efficacy of Cognitive Bihevioral Therapy is demostrated in the treatment of depression, generalized anxiety disorder, social phobia, posttraumatic stress disorder, and depressive and anxiety disorders in children. Generally, Meltzoff & Kornreich.[2] found 80% of positive outcome after psychotherapy (80% of behavioral therapy, and 70% of psychodynamic and phenomenological approach) while about 75% of patients progression is observed in the treatment (regardless of therapy approach), compared to patients outside the treatment. According to more recent meta-analyzes of Clark.[3] 74-94% of patients diagnosed with panic disorders, noticed improvement, while Tolin.[4] in a meta-analysis of 21 studies of anxiety and depressive disorders found slightly to moderately better outcomes of Cognitive Behavioral Therapy in comparison to other forms of treatment and taken the conclusion that the effects of psychotherapy is visible after 6-8 sessions in 50% of clients, while 75% showed improvement up to 26 sessions. Range effects have been confirmed in the treatment of partner problems, anger control, child physical disorders, chronic pain, obsessive-compulsive disorder and bulimia nervosa. American Psychiatric Association in recommendations for treatment suggests use of cognitive-behavioral techniques in 80% of a variety of disorders, which represents the most recommended psychotherapeutic approach.[5] Although it is often disputed that this approach ignores the therapeutic relationship, Cognitive Behavioral Therapy is well accepted among patients, it is seeking to establish cooperative relations based on trust and consensus on issues on which we want to work on, it questions the patient's expectations and set goals. Patient is taught to work actively during therapy, and after therapy, in order to become independent and to prevent recurrence of symptoms.

Basic principles of Cognitive Behavioral Therapy include cognitive restructuring, in which therapist and patient work together to change disruptive thinking patterns. It includes behavioral activation, in which patients learn to overcome obstacles to participating in enjoyable activities. Also, it focuses on specific, present problems and it is time-limited, economic and goal oriented. In individual or group sessions, problems (in terms of behaviors, emotions and thinking) are identified. Approach is educational. The therapist uses structured learning experiences that teach patients to monitor and write down their negative thoughts and mental images. The goal is to recognize how those ideas affect their mood, behavior, and physical condition. Therapists also teach important coping skills, such as problem solving and scheduling pleasurable experiences. Patients are expected to take an active role in their learning, and that is why they are given homework assignments at each session which is one of the main basics in cognitive-bihevioral therapy. If you had learned in school multiplication table for only an hour a week, you would probably still wondering how much is 6x7. Same is with psychotherapy; achieving the goal would take a very long time if all what person is doing is thinking about techniques and topics taught only one hour a week. Therefore, Cognitive Behavioral therapists assign patients homework and encourage them to practice techniques that they are taught.

Working in the school context

School of Fashion and Design in which I work as School Psychologist and Counselor, has 520 students, mostly female. Difficulties of 56 students who came for an advice in the first term in the last school year, and to whome I provided counseling sessions, can be grouped into several categories. 74% of them manifest symptoms from spectrum of anxiety and depressive disorders (measured by questionnaires BYI-II* and BDI**). 28 students are provided with regular treatment by a psychiatrist, and take medications, while 6 adolescent girls have history of suicide attempts. 92% of students in regular counseling suffer from low self-esteem, lack of adequate working habits and they are constantly faced with academic failure. Only 7% of the students with whom I work regularly live in families with both parents.

Represented data speak in favor of the Croatian Institute for Public Health according to which depression is a third mental illness (behind alcoholism and schizophrenia) being treated in the hospital, where the number of hospitalizations due to depressive disorders has almost doubled from 1995 to 2013. Approximately 3-5% of children and adolescents have had a depressive episode in their medical history, but the worrying fact is that a growing number of young people report on depressive symptoms, while girls are an especially vulnerable group.[6] Although adolescent depression is similar to adults, some differences lie in the range, the severity and impact of symptoms. For example, depressed adolescents, unlike adults, can enjoy some activities that represents satisfaction to them. Behavior will be depressed or irritable most of the day, with considerable difficulties in family, peer and academic functioning. Additional symptoms that indicate that it is a depressive disorder may include subjective feelings of sadness or emptiness, loss of interest or pleasure in all, or certain activities, change in appetite and weight gain, insomnia or too much sleep, fatigue and loss of energy, difficulty while concentration, feelings of worthlessness, guilt, low self-esteem, feelings of hopelessness, suicidal ideation, and perceptions of the environment on behavior change of adolescents with primary sad mood and loss of interest in usual activities. Since I am attending second degree education in Cognitive Behavioral Therapy, which has proved very effective in the treatment of adolescent anxiety and depression, I decided to represent therapeutic work with one young girl of enviable motivation.

Disscusion: A case study example

Ana is 16 year old girl, attending the second class in the School of Fashion and Design in Zagreb, for the profession of clothes designer. She is very good student, and occurs due to difficulties with motivation for learning. There are a lot of problems with concentration and attention retention during classes, and according to her testimony: *"for 2 or 3 months I have no will to do anything and feel so miserable* ". At the first meeting she estimated her mood on a scale of 0-10 (where 0 is a total despair, and where 10 represents excellent mood) with 4. On a scale of self-esteem (RSE***) she achieves low result of just 10 points.

She is burdened with difficult family situation, namely by living with her sister and mother in the household. In the apartment above their live her grandparents. She has rare contacts with her father, since her parents divorced a few years ago, and he moved away from Zagreb.[7] Communication with her mother is dysfuncional, and she assesses her mother as nervous, intrusive, intolerant and mentally tensed woman. *(BYI-II) Beck Youth Inventories™ – consist of five inventories of 20 questions each to evaluate children's and adolescents' emotional and social impairment in the area of depression, anxiety, anger, disruptive behavior and self-concept.

**(BDI) The Beck Depression Inventory™ is a 21-question multiple-choice self-report inventory, one of the most widely used instruments for measuring the severity of depression. The scale score ranges from 0- 63, where higher total scores (above 30) indicate severe depression.

***(RSE) The Rosenberg self-esteem scale , is a self-esteem measure widely used in social-science research. The scale score ranges from 0-30, a higher score denotes higher self-esteem. They even had a physical fight after whom Ana was hospitalized in the Psychiatric Hospital For Children And Youth in Zagreb. She was there diagnosed with depression and is on medical therapy treatment of child psychiatrist (with antidepressants and anxiolytics, that is, prefluvoxamine and benzodiazepine). She believes that her treatment provided little help and that her medications mainly just make her sleepy. She had had no suicidal thoughts. At the present time she was listless, apathetic, with difficulties in directing and maintaining attention to her school assignments. She avoided arrivals to school when tests and oral examinations were expected. Among other symptoms were: insomnia, anhedonia, negative thoughts, lack of appetite. Genetic dispositions show that Ana's mother was also constantly prone to worries and anxiety fears, and allegedly grandmother. My implicit assumption was that apparently there is a genetic predisposition to anxiety sensitivity, which is combined with unstable environmental factors (like academic failure and social isolation), dysfunctional family situation and personality traits (sensitivity and perfectionism) which had led her to depression. Principles of work according to Cognitive Behavioral Therapy model, have been explained to her, as well as her need to be active in writing homework, as well as the position of our partnership in which we are two equal parties who arrange everything according to the agenda.

She has adopted principles and promised to work, and when I asked her what problems would she wanted to deal with, she ranged gaining better marks as her primary goal, second was problem of social isolation (she is not socialized with almost anyone in the class, but maintained contact with just only one friend from the neighborhood). Third problem was poor communication with her mother, and low self-esteem at the final. We ended up our first session by defining the objectives Ana decided to work on, and these were: getting better grades (at C, B and A level) and pass the second grade with very good success, become more physically active, to socialize more with her peers, to become pleased with herself (or to strengthen up self-esteem) and to improve communication with her mother.

How did we accomplish objectives

First we have established a relationship of trust, empathy and understanding. Through the next few weeks, Ana kept a self-monitoring diary with her own activities, related thoughts and degree of anxiety. At the same time we started with behavioral activation where we held several sessions in the schoolyard, in order to make Ana physically more active. After three weeks, she felt already more satisfied (estimated mood with 6) and by our mutual agreement she decided to go to the gym for two times a week. In order to improve her social skills, she decided to invite classmate to join her in that activity. Since Ana lacked communication skills, we went through some assertiveness training. Through role-play activities she practiced to call her colleague in the gym. Afterwords we trained and improved her social skills in order to make her birthday party come true.

Since Ana expressed negative thoughts with catastrophic, selective memory and other cognitive distortions, through the application of Cognitive Behavioral techniques we wanted to teach the patient more realistic and positive thoughts. Self-monitoring on the third meeting included replacing negative thoughts with more positive ones, and the assessment of the level of anxiety. Although Ana was here in the resistance and scratched herself as "not believing these good thoughts," we managed to trivialize those negative thoughts by Socratic dialog. Here are some examples of her thoughts: Through next several sessions of working on negative thoughts, we discovered Ana's dysfunctional basic belief that she is stupid and unworthy. The supporting thought of that dysfuncional belief was that if she is always beautiful, smart and successful, she will earn love and respect from the social surrounding, but also from her mother. Therefore, she always aims to be perfect, which in relation to her perfectionism consequently evokes feelings of anxiety, tension, worry, and in case of current academic failure - depression.

The increasing awareness of the negative basic beliefs has helped Ana to detect origins of its creation in early childhood, from the time when she and her sister were left alone with a mother who has been constantly frightened for their future. She was probably well-intentioned in order to protect them, but unfortunately has sent them wrong and completely discouraging messages. Topic of dysfuncional relationship with her mother remained opened during the sessions, while Ana has described her as cold, dominant woman, eternally unsatisfied with her achievement ("*Whatever I do, it's never good enough for my mother*"). In the middle of treatment, mother was included in three counseling sessions to provide adequate support for her daughter.

Although she was initially distrustful, and overloaded with existential problems and the fact that she is carrying as single parent for more than 10 years over her daughters, during the second meeting she broke down in tears as she admitted her dysfuncional thoughts and feelings of failure in a role of mother (*"I know I'm a bad mother*"). Since she has had a tendency of resorting those negative thoughts, I explained briefly what feelings and behaviors they cause, as well as a model to change them in the context of Cognitive Behavioral Therapy. She was strengthened and given support, as well as instructions by which she can alone question the soundness of negative thoughts when they occur. Soon she realized their irrationality, and was looking forward, just like her daughter, the possibility of their conscious control through active exercise. She was also, together with Ana, instructed on peaceful conflict resolution. What was more important is that she was advised to decrease high expectations regarding the academic success of Ana, and to reward her for every effort invested in learning, and not only the final achievement.

After the twelfth session Ana has already improved her learning skills; she was instructed with appropriate time management techniques and corrected two of the four negative marks. Mother bought her a rabbit as a reward, and playing with him was one of her top relaxation techniques (Table 1). She went regularly to the gym, even if her friend was prevented; slowly she began to accept invitations to go to the cinema, in the club, etc. I've been contacting her psychiatrist who assessed her condition as getting better and more functional. As she was in the obvious progress, medical therapy was reduced to the minimum, and later terminated. While there have been periods of difficulty and hesitation, for which she was prepared to come, she remained armed with patience and a high levels of motivation as predictors of success. Through those hard days I tried to be supportive and understanding. She was really a fighter. By the end of the school year, and at our 19th meeting, with the help and understanding of teachers in the school, she managed to correct four final marks, and passed second grade with very good B score.

Table 1 Thoughts

Negative thought	Level of anxiety	Positive thought	Level of anxiety
„I can not."	8	*„I can try."*	5
„I know nothing."	9	*„I know something, I was studying."*	6
„I'm ugly."	7	*„I'm unsatisfied with my weight and that is why I go to the gym. The rest is ok."*	4
„There will be nothing out of me!"	10	*„These are my mothers words and they are not true. I accept my disadvantages. There are no perfect people. And it's okay that I'm not perfect."*	5

Conclusion

In addition to experiencing academic success, Ana has achieved a higher level of behavioral activation; she goes to the gym two times a week and has a social network of peers with whom she regularly socializes with. The relationship with her mother has improved and she described it to be: "*much better than before, we talk more, hang out and even laugh*". Ana has learned how to be independent and active in changing her negative thoughts, which ultimately strengthened her self-esteem. At the final meeting she estimated her mood with 8, and on The Rosenberg self-esteem scale she has achieved 21 points. Her final words were: "*I do not think I'm as bad as before, now I know that these are the only bad thoughts. I'm okay with myself!* ". In order to prevent recurrence of symptoms, we heard each other couple of times via e-mail where Ana said she is well, and described her activities during summer holidays. This school year, we have had only two maintenance sessions where she was boasted for her good marks and the dance course which she started to attend.

At the final I can say that although I am a young practitioner in Cognitive Behavioral Therapy, during my work in the school context with population of adolescents, they are shown to be very effective because they are short-term, oriented on problem solving, achieving of independence, and what is important to point out in the teaching domain – they are educational are collaborative. Whereas they require active involvement of patients, ie. clients, an increase of activity in the therapeutic relationship through work and homework, while respecting the agreed rules and agenda, young people are given structure and tools to strengthen themselves, and consequently to increase engagement in therapy may overflow in the context of a more active performing of school obligations. Subsequently, this will lead to greater academic achievement. According to my humble experience let us not forget two key predictors of successful therapeutic process; a relationship established on mutual understanding and respect and motivation for change of the client.

As the Aaron Ellis said: "I think the future of psychotherapy and psychology is in the school system. We need to teach every child how to rarely seriously disturb himself or herself and how to overcome disturbance when it occurs.

Acknowledgments

None.

Conflicts of interest

The authors declare that there is no conflict of interest.

References

1. Beck J. Cognitive behavior therapy: basics and beyond. 2nd ed. The Gilford Press, New York, USA; 2011. 386 p.
2. Meltzoff J, Kornreich M. Research in psychotherapy. Atherton, New York, USA; 1970.
3. Butler AC, Beck JS. Cognitive therapy outcomes: A review of meta-analyses. *Journal of the Norwegian Psychological Association.* 2000;37:1−9.

4. Tolin DF. Is Cognitive-behavior therapy more effective than other therapies? A meta analytic review. *Clinical Psychology Review.* 2010;30(6):710−720.

5. Živčić-Bećirević I. Cognitive-behavioral therapy: What it is and how it works? First Croatian Congress in Psychotherapy. Zagreb: *Department of Psychological Medicine.* 29−30.

6. Vulić-Prtorić A. Depression in children and adolescents. Jastrebarsko: Naklada Slap. 2004.

7. Anić N. Cognitive behavioral practicum III Zagreb: *Croatian Psychological Society.* 1990.

Citation: Maja SMA. Application of cognitive behavioral techniques in the treatment of depression in the context of school counseling: a case study example. *J Psychol Clin Psychiatry.* 2015;3(6):1–6. DOI: 10.15406/jpcpy.2015.03.00175