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Brief Cognitive Behaviour Therapy in a Case of Depression in India

Abstract

Beck's model of Cognitive Behaviour Therapy (CBT) has been successfully used for the treatment of depression. Brief versions of CBT are now being increasingly applied in the treatment of depressive disorders. The case of Ms. A is presented to highlight the effectiveness of a brief intervention conducted across 7 sessions to ameliorate the debilitating effects of the disorder which was diagnosed post the traumatic loss of her brother 2 years ago to suicide. The rationale for the choice of a brief intervention, its application and a session wise discussion of the treatment and its planning are discussed to provide an insight into the varied applicability and utility of brief interventions.

Keywords: Depression; Brief cognitive behaviour therapy; Interpersonal relationships; Suicide

Case Report

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Introduction

Reviews of literature have demonstrated Cognitive Behaviour Therapy to be an established paradigm for the treatment of depression [1-4]. Research has also shown that it is the distortions in the processing of information from the environment and about the self that tend to be integral to the development and maintenance of many psychological and psychiatric problems. Depression is also seen to be impacted by the memories that are formed in relation to negative or distressing events in an individual's life. Behavior is thus seen as a function of the specific environmental and internal conditions surrounding it [5,6]. CBT requires learning to shift appraisals, core beliefs and associated biases in attention and memory [7,8]. It works through targeting symptoms that are observable and are identified as part of the presenting problem. An attempt is made to elicit the core thoughts or beliefs that are seen as the root cause of the maladaptive thoughts and behaviours. Working through a CBT framework requires a change process in these core assumptions that an individual has to effect a long lasting change. An attempt is also made to provide new learning experiences and teaching new coping skills. Brief CBT is utilized in situations where there is a paucity of time on account of the client needing to shift or due to financial constraints or any other constraints that may make it difficult for long-term therapy to be engaged with. Research has provided evidence in support of the utilization of brief therapy where it is warranted on account of factors similar to the ones mentioned above. Beek et al. [9] in a 24 week randomised controlled trial found that brief CBT significantly reduces anxiety and depressive symptoms in patients with non-cardiac chest pain who are diagnosed with panic and/or depressive disorders.

Clinically identifiable depressive disorders have been found to be as common in India as in the west [10]. CBT has been found to be effective for patients with depression in India [11], though limited evidence pointing to the efficacy of brief CBT is available. Nalini et al. [12] examined the efficacy of Beck's CBT in reducing depression and negative thoughts in 25 patients identified with depressive disorder in India. Therapy resulted in a reduction in depressive features as well as negative thoughts from the pre- to the post-assessment period. The comparative efficacy of CBT and pharmacotherapy was assessed by Dixit et al. [13] in a sample of 330 depressed patients. Their research revealed that both treatments were effective and more patients relapsed once their medication was stopped, indicating that CBT was effective in maintaining treatment gains. The impact of brief cognitive therapy on mild depression associated with gynaecological problems in women was examined by Dixit et al. [14]. In four groups comprising women with a diagnosis of chronic pelvic pain, infertility, menopause and delivery problems and having mild depression, it was found that post a brief CBT intervention there was significant improvement. However, the study did not look at the long-term gains post intervention through follow-up over a longer period of time.

In the case highlighted in this article, the client's description of the events in her life, over the last two years in particular, and the quality of her thinking style were found to have significant cognitive distortions. Her thinking style indicated that Cognitive Behaviour Therapy would be a reasonable treatment for her presenting problems. The brief version of the therapy had to be utilized as the client was available for a period of 6 weeks post which she had to return to the city where she was pursuing her education. She had at present come for an internship program. This coupled with financial constraints did not permit the conduction of frequent sessions.

Case Presentation

Ms. A, a 22 year old, female, is currently a student pursuing the fourth and final year of her graduate degree course. She had come to the first author's city for an internship for a period of 6 weeks. She presented with complaints of severely low moods, with

frequent crying spells. She was experiencing moderate to severe impairment in interpersonal functioning and in the pursuit of her academic curriculum. Her moods would dip severely which would also result in thoughts of self-harm and she frequently felt unable to cope with her current personal situation, describing having no faith in her own self or her abilities to deal with problems. Ms. A had previously undergone 4 sessions of therapy with the first author - 2 each, two years and one year ago, respectively - following her brother's suicide. Due to her unavailability for therapy on account of the pursuit of her academic degree in another city, an elaborate form of therapy could not be indulged in previously. To protect confidentiality, the client described is referred to as "Ms. A", and all other identifying information has been changed.

Presenting Complaints

Sessions conducted previously with Ms. A had helped her understand the need to remain focused on her education, while also attempting to take care of her mother, who was struggling with the loss of her son. The sessions had been brief and far in between to bring about any significant insight in relation to her thought processes or to work upon identified distortions about the self, the world and the future. She strongly believed that "People cannot be trusted", "Everything that can go wrong would go wrong with me", "People do not like me because I am bad", "It's my fault and I am to blame", and "I'm not good enough".

When Ms. A reinitiated sessions after one year, the problems identified earlier remained unresolved and she was struggling. She was having significant interpersonal difficulties and her grades at university were dropping as well. She was finding it difficult to cope with the pressure of her academic curriculum and she constantly felt let down by people. She felt increasingly uncertain about the future, as previously she had been an accomplished student and she had a plan for herself then. She felt less confident in her own self and did not trust that anyone or she herself would be able to help make things better. Her mother, who accompanied her, corroborated the information she had provided.

History

As a young girl, Ms. A's parents separated from each other when she was 12 years old and her brother were 15 years old. She recalled incidents at home when there would be a lot of screaming and fighting between her parents, which sometimes also involved hitting her mother. The abuse eventually led to a separation between her parents when her father was having multiple relationships outside of the marriage. Post the separation her mother experienced significant challenges due to lack of support from Ms. A's maternal grandparents and also because her mother was not employed at the time. Through their struggles at home, her brother had been diagnosed with a severe Learning Disability at the age of 11 years. He did not receive adequate help for the disability and was sent to a residential boarding school at the age of 15 where he experienced several incidents of severe bullying. Concurrently, Ms. A was going through instances of bullying and harassment at her own school, where her friends distanced themselves from her and became increasingly insensitive to the struggles she, her brother and mother faced on account of her parents' separation.

She witnessed several incidents of ridicule by members of the community where they resided. People made negative comments and frequently questioned her on what had happened between her parents, insinuating some wrong doing on the part of her mother. Despite the challenges at home, with friends and at school, she kept her focus on her education and procured good grades. At the age of 18, she shifted to a different city to pursue a graduate course in law. At the time, her relationship with both her brother and mother had become distant, as she would find it difficult to keep revisiting incidents from the past and problems in the present which were brought up in almost every conversation she had with them.

Her academic life at the university was calm and gave her a sense of stability. She was able to make a few new friends and was being able to put behind incidents from her school life which had made her wary and mistrusting of people. Small points of discussion would at times leave her feeling dejected as she had a strong need to have close to perfect relationships with all those she was interacting with. Two years into her studies at the university, her brother committed suicide, leaving no note and not having communicated with the family for two weeks prior to the incident. Eight weeks after the religious ceremonies Ms. A underwent two therapy sessions, both of which were aimed at helping her make sense of what had happened so that she would be able to continue with her life and resolve her grief. At the same time, she was put on anti-depressant medications by the second author (psychiatrist) who had evaluated her initially.

However, post the incident she became extremely critical of her own self. She blamed herself for not being there for her brother and having distanced herself from her family. She experienced significant guilt which was accompanied by feelings of not wanting to live herself. Her grades at the university she was attending began to drop. At the same time, she had an over-powering need to be with people. However, she was also very critical of them, their intent, and felt that they would be unavailable and were not responding to her needs adequately. Her mother also accompanied her and shifted to the city where she was pursuing her education. However, due to a problem with language and culture her mother was not being able to engage herself with a job or any volunteer work. Her mother too was taking treatment for depression and her mood states were only worsening with time as she too felt a lack of social support and non-responsiveness from her friends over the period of two years since her son's demise.

At the time of the intake, Ms. A was increasingly feeling disconnected from her friends. She was finding it difficult to trust people and was feeling more hopeless about the future and helpless in bringing about a change. Her thoughts of not wanting to live have increased and the counter for her doing anything was her mother. She felt anger and that anger would get internalised towards her own self, making her think of self-harm. She did not feel she would be able to create a future for herself and that nothing would ever be good in her life again. Her father had continued to be involved in their lives and was providing financial support post the separation from her mother. Her thoughts would continuously get redirected to determining the reasons for her brother's suicide. In this process of trying to understand what

would have made her brother commit suicide, she was beginning to blame her father as well as she felt his lack of support, presence and involvement might have been a significant part of the reason for her brother's decision.

Assessment

Ms. A was evaluated using an intake interview and behavioural observations were made to aid in diagnostic formulation and for the development of an effective treatment plan. She was informally dressed and came appropriately groomed for the session. She was alert and oriented and responded appropriately. Her reality testing appeared to be intact. Her speech was somewhat slow and she would display hesitation in responding to questions initially. Her mood was severely depressed and the affect was congruent with thought content. Her thinking was clear, showing adequate judgment and her intelligence was judged to be above average based on her academic background and the use of language and vocabulary in the interview. She would get upset while talking about her brother and would display some amount of anger towards her father and her friends. She displayed no overt signs of hallucinations, delusions and any other form of psychotic behaviour. She stated having thoughts of self-harm and wanting to end her life but reported not having indulged in them for long and there was no active planning around this. There was no impairment in memory.

Case Conceptualization

Ms. A's case can be conceptualised from both a psychodynamic and a CBT perspective. Given the brief version of the therapy used and the strong need to restore her functionality at the earliest, a CBT formulation was created to guide therapy. As was evident from the history gathered from Ms. A and her mother, her early childhood experiences of domestic violence within the home, the strained relationship between her parents, the lack of support from the extended family, her experiences with friends at school and the bullying that her brother underwent, had convinced her of the untrustworthiness of people around her.

These experiences had led her to formulate beliefs that resonated as "The world cannot be trusted", "Everything that can go wrong would go wrong with me", and "People do not like me because I am bad". Her situational experiences with peers which continue to the present day made the outside world threatening and unreliable for her. She held an underlying assumption that in any given situation the worst would always result and that she would not be helped by any individual. As a result, her help seeking behaviours were at a minimal and situations would get catastrophized with there being significant narrowing of perceptions and focusing on specific parts of a situation rather than looking at the whole of it. A lot of personalization was leading to a feeling of being crucified by people and not being supported by them.

These feelings were exaggerated in particular post the loss of her brother. Traumatic grief reactions can be complicated or complex in their form, lasting for several months or years even, and affecting various aspects of the individual's functioning. Freud [15] had identified the loss or disturbance of self-regard being an integral part of a complex grief reaction. This aspect though present in the case of Ms. A could not be addressed at the present time through in-depth therapeutic work. Her sense of self was impacted significantly and there was a lack of belief in her own self and her ability to change the situations of her life. This made her feel extremely helpless and strengthened her beliefs of "It's my fault and I am to blame", "Nothing and no one can help me" and "I'm not good enough".

It was also evident that Ms. A's mother had a significant influence upon her perceptions and thought processes. Given that her mother herself was depressed and found it difficult to cope with situations, perceiving a complete lack of support from the environment, her feedback to Ms. A about her own life situations would frequently be negative. This would create a negative cycle which both of them would not be able to break, feeding into each other's negative thought processes. It was clearly in evidence that the stressors in Ms. A's life were making it difficult for her to cope with them and were increasing her depressive symptoms. She was increasingly seeing herself as being inadequate and incapable of handling her problems and solving the situations of her life. She had developed a number of assumptions, life rules and behavioural strategies to cope with her situations which appeared to be maladaptive. At the same time, she viewed the people around her being unsupportive and complicating the situations of her life. She predicted a hopeless future with no potential for change and the vicious cycle of her negative mood, thoughts and behaviours which characterises depression found a stronghold. Once established, the attitudinal and memory biases were continuing to maintain them.

Course of Treatment and Assessment of Progress

Work in any therapeutic modality requires the establishment of trust, rapport and a collaborative therapeutic alliance. It is a collaborative approach which helps foster self-efficacy in the client and also helps in challenging their negative perceptions and beliefs about the self, the world and the future[2,6,16,17]. Furthermore, collaboration forms the basis of a cognitive intervention which ensures that the client is an active participant in the change process.

Building a rapport can be a challenge. However, given the previous sessions conducted with Ms. A over the course of two years, a rapport was present and there was an element of trust on her part which had ensured that despite the sessions being far apart she sought treatment again with the first author. She reported in the beginning of the current treatment that she had felt a sense of comfort and ease in communication which made it easy for her to take the decision of pursuing therapy with the author. She reported having felt being understood and that the structure provided previously had helped her ensure that she did not do anything to harm herself and continued to make efforts to carry on.

Therapy with Ms. A to tackle the problems she was experiencing was directed towards helping her identify and become more aware of the ways in which she was attributing meanings to situations, the memory biases that were confounding the process, along with the influence her mothers' thinking and state of mind were having as well, in an attempt to help her develop healthier and more effective ways of thinking, behaving and coping. Cognitive restructuring was utilised as a key process to help reduce the biases in her thinking and the corresponding feelings

that were being triggered on account of the automatic jumping to conclusions and misinterpretation of information. Through the sessions a collaborative effort was made to look at situations, identify meanings that were attributed to them, determine the thoughts and feelings triggered on account of them as well as developing more realistic ways of looking at situations and solving problems. Therapy with Ms. a following the brief CBT approach was conducted over 7 sessions of 60 minutes each. The goals for therapy included reducing the depressive symptoms through removal of thoughts of self-harm, communicating assertively and re-evaluating initial thought processes to reduce impulsivity and jumping to conclusions and realistically evaluating social interactions and relationships.

Session1 primarily involved gathering information about events and experiences which had been happening over the course of the previous two years. Given the intermittent nature of the sessions, continuity in terms of understanding life situations had not been there previously. The information provided by Ms. A was supplemented with her mother's narrative which further provided evidence of the deep depressive state that Ms. A was going through despite being on medications continuously. The goals highlighted above were decided upon collaboratively with Ms. A. It was decided that we must take a here-and-now approach to begin with in order to elicit automatic thoughts, identify the dysfunctional thought processes and use Socratic questioning to arrive at her core beliefs. The rationale for using a Cognitive Behavioural approach was explained to Ms. A in the first session itself. Session 2 and 3 focused upon the loss of her brother as being the central theme. Ms. A over the past two years had continuously been attempting to identify the reason why her brother committed suicide. The lack of a note or any communication two weeks prior to his demise left her with many questions. The experience of being alone and taking care of her mother while also trying to maintain her own life was proving to be too challenging a task. In her mind she needed to know the answer to the "Why" and the lack of one kept disturbing her, increasing her rumination around it. She talked about how she began to blame herself for not having had a better relationship with her brother. She developed a belief that the lack of a relationship with her was probably a primary reason for his act. What also came through during these sessions was that her mother during this period was also thinking along similar lines and experienced self-blame and criticalness towards herself and her actions. The vicious cycle which was being set between the two of them while being isolated from other social contact was ensuring that these thought processes and beliefs continued to persist in her mind.

During the course of these two sessions it was recognised that Ms. A's beliefs about her role and the catastrophizing of the situations through selective abstraction was making it impossible for her to break the vicious cycle of blame and guilt which had been set in her mind. The first step was to help her look at the broader themes that were related to the situation concerning her brother's demise and not just the significant role she presumed she had played. However, this required first and foremost that there should be willingness on her part to look at an alternate perspective. The reason Ms. a sought treatment was her need for change. Though there was some resistance on her part, her recognition of the paucity of time and the severe impact her thoughts were having on her in the form of depression and suicidality made it easier to help her look at an alternate perspective. An effort was made through the use of Socratic questioning and the downward arrow technique to help her recognise the dysfunctionality in her thought process and the manner in which she was jumping to conclusions about her role in her brother's decision to commit suicide. Encouraging her to look for evidence to support her assumptions helped her recognise the irrationality of her thinking patterns. She was able to understand the need to accept her brother's decision and respect it on account of the fact that she did not fully understand the situations of his individual life. She did express feeling disturbed about having to accept this reality but felt that if she wants her life to continue in a positive direction and to resume a normal life then she would need to at least put this aspect aside till the time she is in a situation where all aspects relating to it can be fully explored. This prompted her to decide that she would make proactive efforts to put aside the thought process if it would come to her in the future and that she would actively try to occupy herself in order to take care of her time and self.

Sessions 4 and 5 focused on her interpersonal relationships which Ms. A had brought up during the previous sessions as well. However, since we had limited time at hand an attempt was made to look at resolving one aspect at a time and a note was kept of other themes which may need attention in subsequent sessions. As noted by Beck [18] individuals with depression have a significant vulnerability to interpersonal events. The same was evident with Ms. A. She reported on numerous instances where she felt let down by her friends, believing that post her brothers' demise their attitude and interactions with her had been negatively altered. Probing into what made her experience things to be this way also highlighted that she had experienced these changes in her friends in the past when her parents had divorced and she had a very difficult time.

Upon reflection Ms. A was able to recognise that there was a part of her that would expect things to go wrong with people and in situations and another part of her would look for every small clue which would indicate that there was a change or a problem. For instance, if her friend responded to her in a slight sharp tone, Ms. A would attribute it to a change in attitude in her friends' thoughts and behaviour towards her on account of her brother committing suicide as there is a stigma attached to such an act in India. Her hyper vigilance made it difficult for her to be able to let go of small instances of differences and disagreements and she would frequently personalise these to be relating to her individual self. At this juncture she also pointed out to how her mother would frequently react very angrily and critically towards how her friends would be with her and it would at times validate and at times even exaggerate her thoughts about their unfairness towards her. Given that her mother too was struggling on account of her misperceptions of situations with her own friends, their joint belief system regarding the untrustworthiness of people would only get reaffirmed.

Ms. A also spoke of the existence of an in-group kind of behaviour in people who came from the same regional areas. Her tendency to see everyone from her own perspective made it difficult for her to be able to embrace the reality of the existence of cultural and regional identities in people. This made it difficult on occasions to be able to negotiate some situations in her

interpersonal interactions and she would want to avoid people altogether instead of accepting these parts of them. The sessions helped her recognise the need to accept the individual, cultural and regional identities that people have and to be ok with these aspects of their individual selves, which were divergent from her own self. Session 6 focused on helping Ms. A devise some very clear, direct methods of ensuring that she is able to complete her education without too much struggle. Collaboratively it was decided that the aim would be to finish university education and seek longer therapeutic intervention post it. However, this needed the laying down of some basic rules as it would have been rather easy for her to fall back into her old ways of being, thinking, and believing. One of the steps suggested by Ms. A herself was to make a conscious effort to not discuss some of her interpersonal problems with her mother as she was beginning to see the vicious cycle being set between them. It was also decided that she should focus on herself when at university and make a conscious effort of not personalising or catastrophizing a situation. She would need to remind herself that she has a tendency to ignore the whole situation and can get stuck to some narrow aspects of a situation. At the same time, she would also make a conscious effort to re-engage with her studies and learning while also integrating some physical activities into her routine.

Session 7 was primarily directed towards consolidating all that we had achieved over the course of the seven sessions. Ms. A had reported feeling increasingly better, having no suicidal thoughts and feeling more relaxed through the course of the therapy and it was reiterated that in order to maintain the gains that had been achieved it would be imperative to follow through on the things discussed in the previous sessions. At the same time, she was also encouraged to stay in touch with the first author given that a lot of intensive work still needed to be done once she would complete her education and to prevent the return of suicidal thoughts or a deepening of her depressive state.

Complicating Factors

Therapy with Ms. A was terminated at the end of 6 weeks which was scheduled prior to the initiation of treatment. Evaluation of her progress revealed that she felt more in control of her thoughts and feelings. Her suicidal thoughts had all but disappeared and she was cognizant of the irrationalities and dysfunctional tendencies that her thinking was prone to. She could recognise the vicious cycle she and her mother would get into and began to value the need to develop good relationships with others which are free from judgement and biases. She reported that she was able to do more work, could focus and take care of her responsibilities towards her education and internship related work. Through the course of the therapy numerous gains were incurred by Ms. A, though there is no doubt that a longer course of treatment, particularly one which would have used a psychodynamic orientation would have benefitted her the most. Also a greater frequency of sessions, twice or thrice a week may have provided better gains as well. However, the restrictions placed in terms of the limited time that was available in addition to the financial constraints that were there made it impossible to extend the treatment.

Access and Barriers to Care

Ms. A was restricted on account of her internship program which had strenuous work hours during weekdays and the financial constraints that the family had been experiencing for some time. In India, therapy is not covered through insurance which makes it pertinent that an individual seeking therapy needs to have enough financial resources to bear the financial burden that the treatment places. There were no other apparent access issues or barriers to care considerations as Ms. A and her mother ensured that all sessions took place as per schedule.

Follow-up

Ms. A has continued to stay in touch with the first author once a week through the medium of tele-consultations. The aim of these sessions has been to ensure that the treatment gains incurred during the course of the 6 weeks are maintained. Ms. A Plans to seek longer therapeutic intervention post the completion of her graduate studies. She appears to be more secure in her self-appraisal, self-esteem and in her evaluations of others and their intents. She looks forward to having a good life ahead and is making efforts to improve her academics.

Discussion

The treatment highlighted the role that the therapist-client rapport plays in bringing about change. The therapists' trustworthiness, reliability and consistency were factors which ensured that therapy could follow the course which had been decided upon collaboratively with the client. The rapport ensured that difficult issues could be looked at through a distant lens which permitted for the resolution of some aspects associated with them such as those relating to her brothers' demise. Through the treatment Ms. A was able to accept and adopt cognitive skills which required her to monitor her thoughts and replace them with realistic ways of appraising situations. She understood the importance of evaluating evidence in favour of her assumptions to be able to discredit them in situations where they came across as being faulty or having cognitive distortions associated with them. Bringing a control of her impulses of self-harm was a significant achievement, which also helped uplift her moods and enabled her to engage in her everyday activities with a sense of goal-directedness towards a better future characterised by good interpersonal relationships and a healthy professional life.

The treatment highlighted the possibility of short, brief therapies resulting in significant changes even in a case of severe depression which had an onset in grief associated with loss. This provides for more evidence supporting the efficacy and effectiveness of brief psychotherapies which must be explored specifically in situations where there are significant limitations on account of contingency factors like time and finance.

The article highlights the key role that having a good therapeutic relationship has on treatment outcomes. Client experiences which have been especially difficult would require a strong empathic stance from the therapist with genuineness and unconditional positive regard to create a strong rapport which would facilitate therapy. Brief interventions can and do result in good treatment outcomes and practitioners should look at utilising these approaches to counter client experiences of mental health related challenges. Long term therapeutic work would be ideal in a case like Ms. A's, however alternate modalities can and should be considered when there are significant constraints on account of the prevailing situations of an individual's life [19-21].

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