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Case Study
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# Cognitive Behavioral Management of Depression: A Clinical Case Study

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## Abstract

This case study illustrates the effectiveness of Cognitive Behavior Therapy (CBT) in the management of depression in 15 years old boy. M.F. presented with complaints of social withdrawal, low mood, loss of interest, decreased appetite, and weight loss and decreased sleep from last one year. He was assessed using HTP and Beck Depression Inventory-II and subjective ratings were also taken. Assessment leaded to the diagnosis of Persistent Depressive disorder, moderate, early onset. A management plan was devised on the basis of Cognitive and Behavior techniques to identify negative thoughts and cognitive biases and modifying them along with Assertiveness training and Problem solving skills. It helped in reducing client's depressive symptoms and increasing his functioning which was evident from post assessment on BDI-II. From this case study it can be concluded that cognitive behavior therapy is effective for the management of depression in adolescence as well.

**Keywords: BDI-II; Depression; Cognitive behavior therapy**

## Introduction

Depression is mood disorder which affects your feelings, your thinking ability and your actions. It also affects individual's level of functioning because individual loss interest in activities, which he previously liked to do. According to DSM-5, Individuals with depression persistently have low mood, feelings of helplessness and hopelessness or loss of interest in activities. Other than emotional problems individuals also report physical symptoms i.e. chronic body pains and digestive issues [1,2].

According to Diagnostic and Statistical Manual-5 (DSM-5), to meet the criteria for depression there must be 5 symptoms present for at least two weeks and one symptom should be either depressed mood or loss of interest. Other symptoms includes significant weight loss, fatigue or loss of energy, feelings of worthlessness, diminished ability to think and concentrate or indecisiveness and recurrent thoughts of death or suicidal ideations [2].

According to studies genetics, biochemicals, brain anatomy and brain circuits, immune system have rule in the development of depression [3]. Psychological theories also give explanation for development of depression. Psychodynamic view states that individual equate loss or failure with the symbolic or imagined loss of a loved one which leads to the feelings of depression [3]. Change in the patterns of reinforcement and punishment are held responsible for the depression by behavior point of view. Cognitive theorist believes that individuals with depression have negative thinking and they interpret events negatively [4].

## Case Study

### Participant

History of present illness started 1 year back. Client was studying in Madrasa from last 3 years; he was an average student and found it difficult to learn his lessons. His Qari used to beat him each time he couldn't recall his lesson, but things were going normal. One year back client's family noticed changes in his behavior. He started staying quiet, not took part in activities he liked to do before i.e. cricket or meeting his friends. His brother reported that he didn't like to talk and interact or sit with others and spend most of his time sitting alone and remains mute most of the time. Client's brother reported that client used to have low mood throughout the day. His sleep decreased, he used to go to bed on time but lay there for hours staring the walls that's why he didn't feel fresh in the morning. Client also reported that he used to have nightmares.

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When client opened up he revealed that one year back his old schoolmate took admission in the same Madrasa and he used to harass the client. On further probing it was revealed that client was a victim of harassment and sexual abuse in the school. His schoolmate who took the admission in the same Madrasa was one of the students who harass him in the school. When he came to Madrasa, he made group with other senior students studying there and they started to harass him also. As reported by the client: "they persuade me to involve in physical relationship with them" and "they asked me to do wrong things" (which was physical involvement on further probing).

Client reported to the Nazim (head) there and according to the client he took action and scolded those students, but they didn't notice that. Client started to be fearful of people and he used to stay alone and felt sad. About people he said that: "Everyone is bad".

He started experiencing decreased sleep, loss of appetite and his interest in daily activities also reduced. When his symptoms sustained for longer time his family brought him to spiritual healer in Multan about him they had heard a lot. When symptoms didn't improve and got worsened because continuous stress was there, they decided to take him to the doctor for his weight loss or disturbed sleep. Doctor referred the client to psychiatry department of a government hospital, and client was referred to clinical psychologist for detailed assessment and management of his symptoms.

## Background information

Client's father was 50 years old, had primary education and was a teacher in Madrasa. He was very strict and had authoritative nature. Client was very fearful of his father. He had uncongenial relationship with the Client. Client's mother was 45 years old, housewife, who had primary education. She had submissive personality. She used to take-care the client but client didn't have sharing relationship with his mother. Client had satisfactory relationship with his mother.

Client had 7 siblings including 5 brothers and 2 sisters. Client's eldest brother was 21 years old. He had completed his education till primary and he was hafiz a Quran and was living out of city to complete his course. He had aggressive nature. He was the one who brought the client to the hospital for sessions. Client had satisfactory relationship with his brother.

Second born was client's sister. She was 19 years old and was educated up to 8$^{th}$ class. She used to stitch cloths for others and do household chores with her mother. Client was very much attached to his sister and used to share with his sister. Client had congenial relationship with his sister. Third born was client's brother who was 17 years old and left his education after primary. He was working at shop. He had aggressive nature. Client didn't like his brother because he was always angry and rude towards everyone. Client had conflictual relationship with his brother.

Fourth born was client himself. One sister and three brothers were younger than the client, 15, 12, 11 and seven years old respectively. They were studying in school and client had congenial relationship with his younger siblings.

Client belonged to nuclear family system. They were total ten family members including his mother, father and seven siblings. Father was the authoritative figure at home and he used to take decision of all the matters by himself. General home atmosphere was stressed because of fathers and third born brother's aggressive nature. Third born brother used to fight with his elder sister and yell at younger siblings and mother, father also shout at children and wife which made the home atmosphere tensed.

## Psychological assessment

Assessment was done in order to gather information regarding the symptoms, severity, and also to assess the etiological, maintaining i.e. perpetuating, and protective factors that are contributing to the diagnosis and possibly affected the prognosis. Clinical interview, behavioral observations and Mental Status Examination (MSE) was used for informal assessment. Subjective ratings of symptoms were also taken from the informant as well as from the client. HTP and Beck depression Inventory-II were also used for formal assessment.

## Subjective ratings of symptoms

On the scale of 0-10, subjective rating was taken by the client, brother of the client and by the therapist regarding the problems presented by him, where 0 indicated no problem, 5 meant average level of problem and 10 reflected extreme severity of the problem. These ratings were taken in order to evaluate the efficacy of the treatment and change that would take place which was assessed through post-treatment (Table 1).

## House-Tree-Person (HTP)

Qualitative interpretation of house tree person revealed severe emotional disturbances, depressive, and withdrawal tendencies. It also revealed that M.F. lacked warmth in the home environment, reluctant to make contact with others, or difficulty in interpersonal relationships. It showed that M.F. was insecure, dissatisfied from life, lacked self-confidence and had greater dependency [5].

## Beck depression inventory-II

Beck Depression Inventory-II is a 21-item diagnostic measure for assessing depression. It is the inventory that finds out the intensity of depression and gives ranges [6]. Each item further consisted of four statements and the client was asked to select the most relevant according to her symptom severity.

## Quantitative analysis of BDI–II

**Qualitative interpretation:** The score of 27 on BDI-II corresponds to the moderate category of depression in BDI-II. Most problematic areas were problems related to mood, worthlessness, lack of decision making ability and sleep. Client also reported loss of interest and anhedonia which was also congruent to the child's apparent mood as

**Table 1:** Problematic areas and pre-treatment rating by the client, client's brother and therapist (0-10) scale.

| | Pre-treatment Ratings (0-10) | | |
|---|---|---|---|
| **Problematic Areas** | **Client** | **Brother** | **Therapist** |
| **Mood Related Symptoms** | | | |
| Sad/depressed mood | 8 | 9 | 9 |
| Anhedonia | 8 | 8 | 9 |
| Negative Symptoms | | | |
| Social withdrawal | 7 | 9 | 9 |
| Sleep related problems | 9 | 8 | 9 |
| Decreased appetite | 6 | 9 | 8 |
| Weight loss | 7 | 8 | 8 |

**Table 2:** BDI-II score, and interpretation.

| BDI - II Score | Severity of Depression |
|---|---|
| 28 | Moderate |

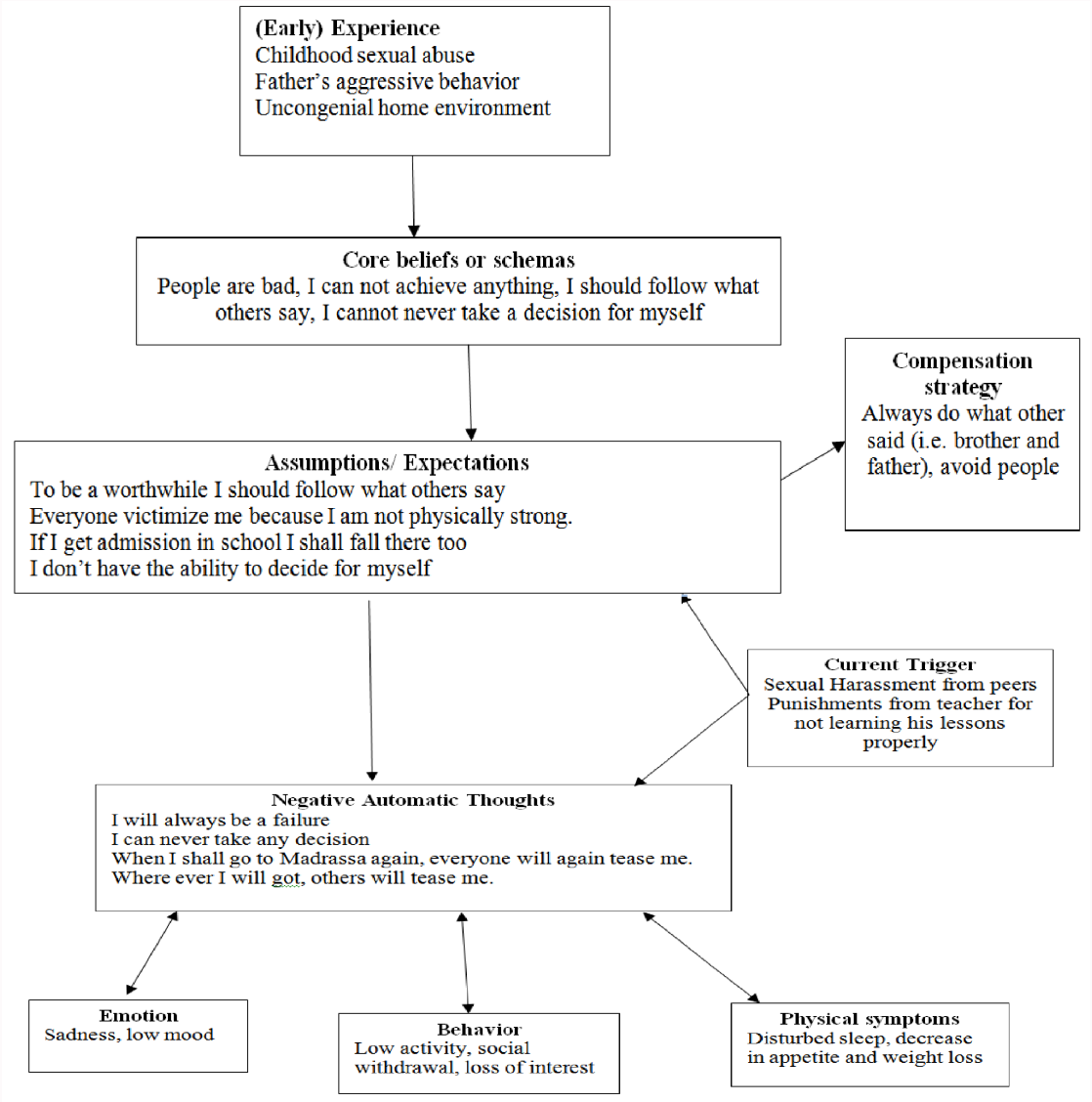



**Figure 1:** Case conceptualization.

evident during administration and history taking (Table 2).

## Diagnosis

300.4 (F34.1) Persistent Depressive Disorder, Moderate, Early onset (Figure 1).

## Model for depression

**Therapeutic process:** First session included initial history taking including history of present illness from the informants and reinforcers were identified. Deep breathing was also taught to the client and symptom diary was given [7].

Second session consisted of detailed History and assessment including HTP and BDI-II. Symptom diary was reviewed, and ratings of presenting complaints were also obtained.

In the third session case conceptualization was done and client and his informant were psycho-educated regarding the depression and CBT protocol. Activity schedule was made with the help of the client to increase his activity. As client was unable to identify any activity, he liked or pleasant for him, a list of fun activities catalogue was used and client was asked to identify activities he liked to do.

Initially, Television watching, playing games on phone, having favorite shake or drink and walking for at least half an hour were added in the schedule along with taking bath and dressed up regularly and offering Namaz. Later, activities like spending time with siblings, playing cricket, cycling and making drawings were added.

Sleep hygiene was also given to the client to improve his quality of sleep. Sleep time imagery was also introduced, practiced and taught to the client i.e. self-guided imagery to help the client fall asleep more easily.

Fourth and Fifth session consisted of rapport building with the client. As rapport building was a difficult task with the client, and it took many sessions to open up the client. Rapport was done with the client through coloring, asking about his likes and dislikes and about his routine. Different worksheets were also used for rapport building.

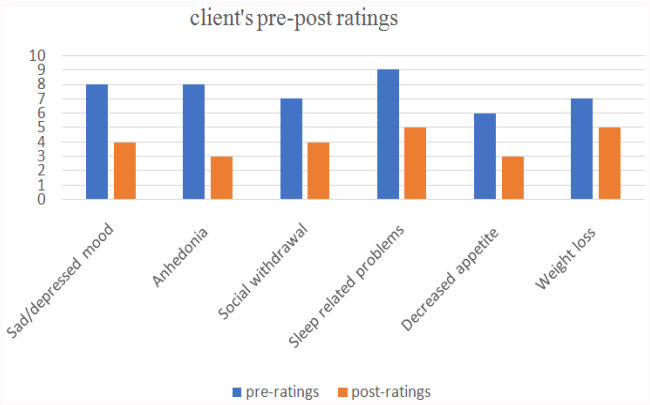
In the Sixth session insight was developed and thought feeling connection was explained to the client. DTR was reviewed and negative thoughts were enlisted. Mood thermometer was also given as homework assignment. Model was given to the client how to

**Table 3:** Problematic areas and post-treatment rating by the therapist and client on (0-10) scale.

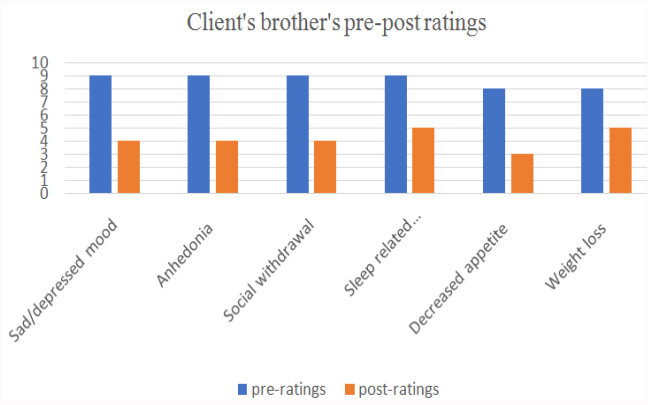
| Problematic Areas | Post-treatment Ratings Client | Post-treatment Ratings Client's brother |
|---|---|---|
| **Mood Related Symptoms** | | |
| Sad/depressed mood | 4 | 4 |
| Anhedonia | 3 | 4 |
| Negative Symptoms | | |
| Social withdrawal | 4 | 4 |
| Sleep related problems | 5 | 5 |
| Decreased appetite | 3 | 3 |
| Weight loss | 5 | 5 |

**Table 4:** BDI-II Score, post assessment.

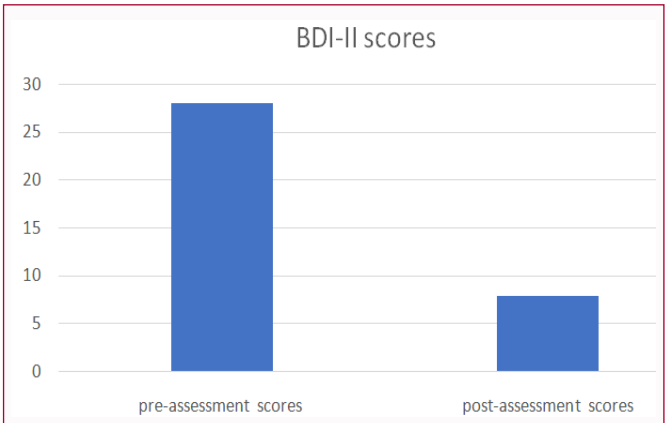
| BDI - II Score | Severity of Depression |
|---|---|
| 8 | Minimal Range |




**Graph 1:** Pre and post-rating by client on 0-10 point scale.




**Graph 2:** Pre and post-rating by therapist on 0-10 point scale.




**Graph 3:** Pre and post-assessment scores on **BDI-II.**

complete mood thermometer and it was practiced with the client by the therapist based on his mood yesterday.

In the seventh session homework was reviewed client was reinforced for doing homework. A-B-C model was explained. Progressive Muscle relaxation exercise was taught to the client to help him relax his muscles. And behavioral activation chart was given. Personal contract was also made with the client. He was asked to pick pleasant activities that he could do in the next week and establish a reward for himself if he did it. It was done to make him realize that he can plan and program activities for himself and it was a way to make him able to gain control of his life.

In the eighth session homework was reviewed and client was reinforced. Discussion about thoughts was made during two sessions to help the client in identifying negative as well as positive thoughts. Client was told that thoughts are what we actually telling ourselves. We are constantly telling ourselves internally, but we are not always aware of it. These internal talks have real effect on our body (explained by client's own example).

In the ninth and tenth session negative thoughts were elicited, and different techniques of verbal challenging were used to change the cognitive errors. Techniques were practiced during the session and client was asked to practice it with other cognitive errors as homework assignment.

In the eleventh session as client was feeling better than before and was made able to identify negative thoughts and challenge them, problem solving skills were taught to the client to make him able to effectively solve problem in life. Problem solving was taught to the client with different real life examples from his life and client was asked to make a list of all possible solutions for the problem. Then client was asked to evaluate potential consequences of each the solution and decide most appropriate solution.

In the twelfth session, previous sessions were reviewed, and assertiveness training was given. Client was told about the difference among being passive, aggressive and assertive. Client was told to use 'I' statements, broken Record technique, express feelings and say 'no' up front, firmly, without fear to be assertive. These techniques were practiced at imaginal level during the session in different situations.

Thirteenth and the last session included feedback of the therapy and post-assessment. Post-assessment and client's feedback showed decreased in the client's depressive symptoms. To avoid relapse client was asked to rehearse the techniques taught during the sessions, whenever he needs. Client was also encouraged to use techniques taught during the sessions in daily life.

## Outcome

Cognitive behavior therapy helped the client in reducing his depressive symptoms to great extent (Table 3 and Graph 1, 2). Improvement in his feelings, mood and behavior was also reported by the client and his brother who accompanied him (Table 4 and Graph 3).

## Conclusion

Present case study illustrates the case of 15 years old boy that was presented with depressive symptoms. Cognitive behavior therapy was used to help him reduce his symptoms of low mood and loss of interest by changing his thoughts. His sleep and appetite was also improved. Hence, it can be said that cognitive behavior therapy is effective in dealing with depression in adolescents also.

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