The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 8, Issue 3, July - Sep, 2020
DIP: 18.01.072/20200803, DOI: 10.25215/0803.072
http://www.ijip.in

Case study

A case study of person with depression: a cognitive behavioural case work approach

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ABSTRACT

Individuals with depression often face problems in activities of daily living, work functioning and interpersonal relationships. ***Aim and Objectives****:* The present case study aimed to assess psychosocial problems and to provide psychiatric social work intervention based on cognitive behaviour therapy (CBT) to the client. ***Methods and materials:*** The single-subject case study design was used and the pre-post baseline assessment was done. Semi-structured clinical and socio-demographic data sheet, social history proforma, McMaster family assessment device, Rosenberg self-esteem scale, Beck depression inventory, Beck anxiety inventory, UCLA loneliness scale, the family questionnaire (expressed emotion) were administered before and after the intervention. Psychiatric social work intervention was provided by adopting a cognitive behavioural casework approach. ***Results:*** A cognitive behavioural case work intervention turned out to be effective in dealing with depression, anxiety and loneliness**.** ***Conclusion****:* Cognitive Behavioural Case Work can be effective in dealing with depression cases. Psychiatric social worker can practice CBT based case work under guidance and supervision.

Keywords: *Depression, cognitive behavioural casework approach, loneliness, psychiatric social work intervention*

There is sound evidence supporting Cognitive-Behaviour Therapy (CBT) in the treatment of depression, but little is known about the adaptation of CBT in social work practice in mental health settings especially in India. The delivery of CBT solely by social workers has been evaluated by a relatively small number of studies, and very few efficacies or effectiveness studies have been conducted. The person-in-environment approach is experiential that social work professionals provide psychological and social interventions (Hare, 2004). This viewpoint in the general consensus for clinical social workers use of CBT intervention and improves outcomes (Sheafor et al., 2000). González-Prendes and Brisebois (2012) stated that there are increasing numbers of clinical social workers to use CBT in their practice and CBT fits with social work values and in

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Received: July 18, 2020; Revision Received: August 26, 2020; Accepted: September 08, 2020

particular with social justice. Driessen and Hollon (2010) reported that CBT is efficacious in the acute treatment of depression and may provide a viable alternative to antidepressant medications (ADM) for even more severely depressed unipolar clients. CBT can play a role as an adjunct to medication in treatment of depression and prevent relapses. The cases of depression can be effectively handled using cognitive behavioural therapy (National Institute for Clinical Excellence (NICE), 2009; American Psychiatric Association, 2010; Cuijpers et al., 2013; Thase et al., 2007). Clinical social workers using CBT can possibly tackle interpersonal and social problems while treating individuals with mood disorders. The empirical evidence identifies the implication of CBT for clinical social workers, provided have proper training and appropriate clinical supervision Gregory (2010). The psychiatric social worker can help a person with depression using the CBT approach along with other social work treatment modalities.

METHODOLOGY

Case study research can be effective in many forms of social work practice. Although disparaged as uncontrolled and uninterruptable, the case study has great potential for building social work knowledge for assessment, intervention, and outcome (Gilgun, 1994). The single-subject case study design was used in which pre and post-assessment was carried out. Cognitive behaviour casework intervention was used in dealing with a client with depression. Through an in-depth case study using face to face interview with the client and family members the detailed clinical and social history of the clients was assessed. The psychosocial problems were explored from the clients and family members. After exploration of information psycho-social formulation was made and a psychiatric social work intervention was provided at individual and family level. Post assessment was done after one month of intervention.

Instruments

Semi-structured clinical and socio-demographic data sheet: A relevant socio-demographic and clinical details were collected using this proforma such as age, sex, residence, duration of illness, treatment mode, hospitalization, etc.

Family Assessment Device (FAD): The McMaster Family Assessment Device (FAD), originally developed by Epstein et al. (1983), measures different aspects of family functioning. It is composed of seven subscales; Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behaviour Control, General Functioning. The internal consistency, measured by Cronbach's alpha, for each subscale range from 0.72 to 0.92.

The Rosenberg Self-Esteem Scale: The Rosenberg Self-Esteem Scale by Rosenberg (1965), was used to measure self-esteem. The scale has high reliability: test-retest correlations are typically in the range of 82 to 88, and Cronbach's alpha for various sample in the range of 77 to 88.

Beck Depression Inventory (BDI, Beck et al., 1961): Rates 21 items, each with four or five response categories ordered by severity. Each item is scored on a scale of 0 (no problem) to 3. A total score is the simple sum of the 21 item scores. Generally, a score <9 indicates no or minimal depression, 10–18 indicates mild-to-moderate depression, 19–29 indicates moderate-to-severe depression, and >30 indicates severe depression. It had showed .84 of sensitivity and .81 of specificity.

Beck Anxiety Inventory: The Beck Anxiety Inventory (BAI) was developed and published by Aaron Beck in 1988. The test consists of 21 items which gauge both physiological and cognitive components of anxiety by measuring subjective, somatic, and panic-related symptoms. The inventory measures the severity of common symptoms of anxiety on a scale from 0 (none) to 3 (severe). A sum between 0-21 indicates very low anxiety; 22-35 indicates moderate anxiety; exceeds 36 is a potential cause for concern of persistent and high anxiety. It is based on test-retest reliability of .75 after 7 weeks in its original research inception. It was also tested using internal consistency with a reliability of .92.

UCLA Loneliness Scale: The UCLA Loneliness Scale was developed to assess subjective feelings of loneliness or social isolation (Russell et al., 1978). The scale is rated on a 4-point Likert scale ranging from 1 (never) to 4 (always). The scores range from 20 to 80 with higher scores indicates greater loneliness. It assesses the subjective feeling of loneliness at a particular time or situation. It is a 20 items scale designed to measure loneliness in a variety of populations. It had shown high internal consistency with Cronbach's alpha .92.

The Family Questionnaire (Expressed Emotion): Expressed emotion was measured via the Family Questionnaire (FQ) (Wiedemann et al., 2002). The FQ is a 20-item self-report questionnaire measuring the EE status (emotional over-involvement (EOI) and criticism critical comments (CC) of relatives of clients. The responses ranged from ‘‘never/very rarely,’’ with a score of 1, to ‘‘very often,’’ with a score of 4, and a higher total score indicates higher EE. The cut-off point of CC is 23, and for EOI is 27 the higher can cut-off indicates higher CC or EOI. It has shown good internal consistency ranging from 0.78 to 0.80 for EOI and from 0.91 to 0.92 for CC.

Case introduction

The client was a 38 years old unmarried male, studied up to 12th Std., hailing from a rural background of Sonitpur district of Assam. He was a Hindu, businessman and fall in to middle socio-economic status. The case study used patient (client), his family members and the case record file as sources to collect information which were reliable and adequate. The case was referred to the dept. of psychiatric social work for psychosocial management and intervention from the OPD of LGBRIMH, Tezpur.

Brief clinical history

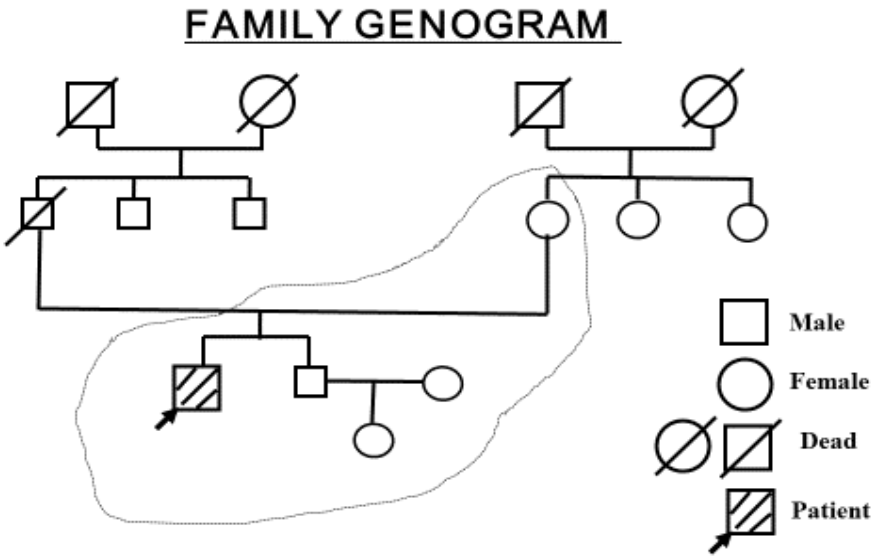
The index client was apparently well 5 years back. The family members stated seeing changes in client’s behavior as he started keeping himself quiet and interactions with other people decreased. He was not showing any interest in speaking to the people. Initially family members thought he had some issue with business which he couldn’t sort out. But then they found his mood was low which was observed by his mother at first and she asked his younger brother to look into it. But client did not reveal anything to him. Gradually he started having apprehensive ideas that something wrong will happen to him and he will die. He also started having a pessimistic view about the future which resulted in low interest in work. Later on, he stopped working and he would spend time at home thinking about his life. His biological functions such as sleep and appetite were decreased. Family members brought the client to LGBRIMH, Tezpur for further treatment. The clinical interview reveals insidious onset, continuous course and deteriorating progress of present illness with total 5 years of duration, with nil precipitating factors, nil significant past history, with treatment history from faith healers and private psychiatrist, no family history of mental illness, with nil contributory personal history, with well-adjusted pre-morbid personality. Mental State Examination revealed partial eye contact, cooperative, the speech was low with increased

reaction time, in thought content, hopelessness, worthlessness was present and affect was depressed with Grade one insight. The index client was diagnosed with F 32 according to ICD-10 classification.

Family composition

Index client belonged to a joint family of 5 members includes his mother, younger brother and younger sister in law and his niece. Client's younger brother, client and sister-in-law were the earning source of family income.

Family Genogram (figure-1)



PSYCHOSOCIAL FORMULATION AND ANALYSIS

Index client Mr A.K.N. 38 years old Hindu, unmarried male, studied up to HSLC, worked as a businessman hailing from middle socioeconomic status with the urban background of Tezpur, Sonitpur. Brought by brother to the OPD of LGBRIMH with complains of low mood, decreased social interaction, apprehension, pessimistic view about future, decreased interest in work, thinks that people are talking about him, decreased libido, decreased sleep and decreased appetite. The total duration of 5-year illness, insidious onset, deteriorating progress. MSE findings were partial eye contact, increased reaction time, hopelessness, and worthlessness. The index client diagnosed with Depression (F 32). Family members were having some misunderstandings and carry myths regarding mental illness. Client's illness causes a marked impact on a family's daily functions & task accomplishment. He had a well-adjusted pre-morbid personality. The family assessment revealed that problem-solving and general functioning was at dysfunctional level. Emotional over-involvement was present for the client. The client had a moderate level of depression, low level of anxiety, low self-esteem and high level of loneliness.

PSYCHIATRIC SOCIAL WORK INTERVENTION

Psychiatric social work intervention was provided using CBT approach. The total number sessions were 18 i.e.14 individual sessions and 4 with family.

Individual-level

Rapport and therapeutic alliance:

The close and harmonious relationship is essential to build rapport (Pearsall, 1999). This was to maintain a good relationship with the client and to assess the level of cooperation and participation of the client. The session was given to the client where the client was informed about the importance of therapy and benefit he would gain. The therapist gave opportunity to the client to ventilate his views, opinion regarding his problems. The therapeutic alliance was established after proper consent from the client and family. Client and family was explained about how therapy will go further, participation of client and family in the intervention process and professional contract was made.

Cognitive behavioural therapy

CBT was used as an intervention in this case. Individual therapy manual for CBT of Depression by Muñoz et al. (2000) was followed to plan the CBT based treatment to deal with depression. The session was planned keeping content of manual for treatment. The session initiated with a general talk about clients daily living to create a therapeutic environment. The client was asked to share about his thought, actions and feelings of day to day life. He was explained about how thought, activities and feelings affect on body and mood. The client was explained about therapy and how does it help in the treatment of depression.

Thought-affect-mood

The client was explained about thought, how thought affects mood. The physical and psychological changes associated with thoughts which person used to have in daily routine. He was explained by giving examples, like if you have a positive thought about how it affects physically and psychologically. *E.g., if a person came to know "he won a lottery" what will happen to him? What thought will come to his mind? Say he may think that "I am rich now; I can get what I want" how this will reflect? He will have a happy face; you might observe his enthusiasm.* So, having a happy thought influences the physical and psychological changes in the person. Likewise, if you have a positive thought it will affect you physically and mentally. He was explained how negative thought affects the individual with suitable examples.

Psychoeducation

Having understanding about own mental illness is important for the good treatment outcome. Psychoeducation can help to reduce symptoms of depression (Donker et al., 2009). Psychoeducation is indispensable adjunctive psychotherapy in the field of mental health (Bhattacharjee et al., 2011). Psychoeducation based interventions are effective in treating or preventing mental disorders (Cuijpers, 1997; Merry et al., 2004). The client was asked to share his understanding of depression. He came up with an inadequate understanding of his illness. Further psychoeducation was provided to the client he has explained the feeling of down, decreased interest or unable to enjoy things as used to enjoy before. Changes seen during phase of depression in appetite/weight, feeling of tired, and feeling of worthless was explained. Signs and symptoms of depression, causes, course, prognosis, importance and side effects of medication, early warning signs, and importance of follow up. During the session, the client was found to have active listening and was able to answer the questions asked by the therapist regarding his illness.

Mood chart

The mood chart is one of the activities which help to track the mood of the individual. The client was given a "mood chart sheet" where he was asked to rate his mood on a daily basis. Mood chart is divided in three domains 1. Very good/ best mood (7-10), 2. Average mood (4-6), and 3. Worst mood (0-3). Client needs to tick the right number which can explain his mood state. He was also asked to keep a record of the thoughts which make his mood happy or sad during his daily routine. The number of thoughts and occasion he will have to write along with the mood chart. The client was given homework to assess his mood using a mood chart. He was explained how to mark his mood, the rating of mood, thoughts which affect his mood.

Negative thoughts/ depressed thoughts

The session was intended to discuss the thought process in details. The client was asked to review the previous sessions and then the therapist started explaining the thought process. After that differences between not flexible thoughts, judgmental thoughts; constructive thinking and destructive thinking; necessary thinking, unnecessary thinking; positive thinking and negative thinking were discussed. It was advised to him to recognize mistakes in his thinking. The different thought which was shared by the client during the session was taken for knowing the thoughts. He was also asked to differentiate depressed thoughts and non-depressed thoughts. During the session he could identify the depressed thoughts he used to have. Further, he was discussed on the cognitive distortions he had in the thought process. Like mind reading, self-blame, labelling, overgeneralization was present in the client.

A-B-C-D Method

The session was aimed to make the client talk back to his thoughts. The session started with the feedback of the mood chart. The client was asked to relate thought, affect and mood with the A-B-C-D method. To improve his understanding of positive and negative thoughts, A-B-C-D method was elaborated to engage client in a structured and productive daily routine. A is Activating event, B is Belief, C is Consequence and D is Dispute was explained to the client. He was further asked to remember the thoughts (negative or positive) and further elaborated how he can see his thoughts with A-B-C-D method. He was explained how negative thought makes trouble in daily living. Clients were encouraged to alter these negative thoughts with positive ones. Thought stopping techniques and distraction technique was discussed. Homework was given to practice the A-B-C-D method at home to understand his thoughts.

Activity scheduling

Behaviour activation is one of the important tasks of CBT in dealing with depression (Iqbal and Bassett, 2008; Veale, 2008). Chowdhary et al. (2016) stated in his study the healthy activity schedule program is effective brief psychosocial intervention in the treatment of depression. To make client's daily routine structured and productive activity schedule was formulated based on client interest in pleasurable and mastery activities. Priority was given to enhance productivity, interpersonal interaction and health of the client. Schedule involved visiting his workplace, interacting with people taking part in small work at workplace; to enhance health condition he was recommended to join a gym or have morning walk, healthy breakfast and meal on time.

Problem-solving skills

Bell and D'Zurilla (2009) had given positive evidence that problem solving therapy equally effective as other psychosocial therapies in reducing depressive symptoms. Problem-solving

therapy and homework are helpful in reducing mental and physical health problems (Malouff et al., 2007), interpersonal relationship (Bell and D'Zurilla, 2009) and supports the improvement of mental health (Cuijpers et al., 2007; Malouff et al., 2007). The session was aimed to describe problem solving techniques to the client to improve his abilities to enhance problem-solving in day to day life. at first problem solving techniques was discussed with appropriate examples. the client was explained seven steps of problem solving techniques with appropriate examples. The 7 steps were explained by taking one of the problems of the client (Hegel et al., 2004).Identifying the Problem; Defining Goal; Brainstorming; Assessing Alternatives; Choosing the Solution; Active Execution of the Chosen Solution and Evaluation.

Family level

Family Psychoeducation

Family psychoeducation has significant relationships in preventing relapse and improvement in depressive symptoms (Shimazu et al., 2011; Miklowitz et al., 2000). Family members were explained about the illness, they were given information about the sign and symptoms and causative factors were discussed. Treatment and adherence issues were also discussed with the family members. Role of expressed emotion in the recovery process was also discussed. How mother and younger brother had emotionally over-involved in the client was discussed. Family members were guided how they can control their emotional over involvement. The therapist provided information regarding the role of the family and family support in dealing with depression.

RESULTS

Table 1 showed the family dynamics of the client's family. It reveals that problem-solving (3.0) and general functioning (3.16) of the family was at the dysfunctional level. Whereas other domains communication (2.7), roles (2.20), affective responsiveness (2.11), affective involvement (1.90), and behavioural control (1.50) was at a normal level. Table 2 showed the level of expressed emotions present in the family. It revealed that the family has high emotional over-involvement (28) and low criticism (21). Family members are emotionally over-involved with the client. Table 3 showed the pre-intervention and post-intervention assessment score of the client on self-esteem, depression, anxiety and loneliness. Pre-intervention assessment scores of the client 7 (low level) self-esteem, 27 (moderate level) depression, 20 (low level) anxiety and 62 (high level) loneliness whereas after intervention post-assessment scores 21 (normal) self-esteem, 8 (no or minimal) depression, 11 (low level) anxiety and 32 (rarely) loneliness. There was a change in pre and post a score after intervention in the areas of self-esteem, depression, anxiety and loneliness.

Table 1: Family dynamics of the client's family on the basis of Mc Master Family assessment device

Family Assessment Device (FAD)	Scores	Findings
Problem solving	3.0	Dysfunction
Communication	2.7	Normal
Roles	2.20	Normal
Affective responsiveness	2.11	Normal
Affective involvement	1.90	Normal
Behavioral control	1.50	Normal
General functioning	3.16	Dysfunction

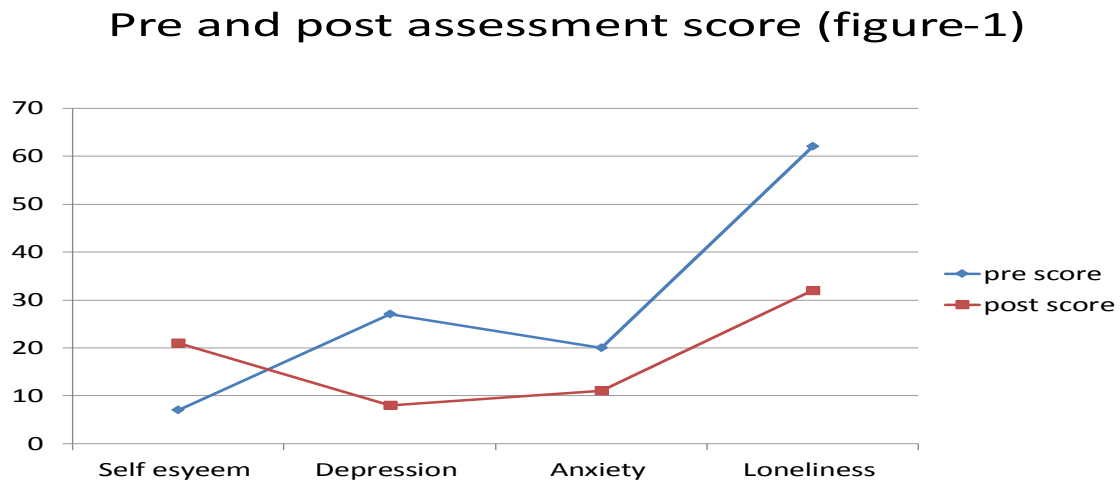
Table 2: The Family Questionnaire (Expressed Emotion)

Subscales of FQ-EE	Score	Findings
Emotional Over Involvement (EOI)	28	High Emotional over involvement
Critical Comments (CC)	21	Low Critical comments

Table 3: Self-Esteem, Depression, Anxiety and Loneliness of the client on the basis of pre and post intervention assessment

Variables	Pre-test scores	Findings	Post-test scores	Findings
Self-Esteem	7	Low level of Self Esteem	21	Normal
Depression	27	Moderate level of depression	8	No or minimal depression
Anxiety	20	Low level of anxiety	11	Low level of anxiety
Loneliness	62	High level of loneliness	32	Rarely lonely

Outcome



1. Client's knowledge about his mental illness improved
2. Decreased level of depression and anxiety
3. Increased in the level of self-esteem and decreased feeling of Loneliness
4. Positive thoughts and a stable mood along with increased engagement in productive work functioning

DISCUSSION

The psychiatric social work intervention using CBT approach observed difference on pre-post assessment scores. The improvement in symptoms of depression and anxiety was found along with elevation in self-esteem and decrease in loneliness after providing psychiatric social work intervention (based on CBT approach). Cognitive behavioural therapy states that thoughts, emotions and behaviour are intertwined and affect one another. Consistent maladaptive thoughts and/or behaviours can cause presenting problems for a client. Jasubhai and Mukundan (1998) reported vital role of CBT and emotional freedom techniques to treat depression and anxiety in Indian adults. Cognitive behavioural therapy in social work is a theoretical framework that understands the importance of both cognition and behaviour, with

the outcomes based on cognitive, behavioural and emotional changes (Beltman at al., 2010). Cognitive behavioural therapy emphasizes that it is neither a situation nor circumstance that causes client distress; rather, it is how the client interprets or views a particular event that will cause internal distress (Butler et al., 2006). Hofmann et al. (2012) suggest that CBT is as effective as other psychological treatments, such as psychodynamic psychotherapy, behaviour therapy, problem-solving therapy, and interpersonal psychotherapy. CBT treatments for depression have typically employed behavioural activation to increase natural reinforcers in the environment and cognitive restructuring to reduce negative automatic thoughts and increase positive ones, which in turn improve mood and behaviour (Keyho et al., 2020). The superiority in the effective outcome of the CBT methods has been depicted from meta-analysis studies over waitlist control and placebo treatment effects (Beltman et al., 2010; Butler et al., 2006).

Psychiatric social work intervention based on CBT can be practiced in clinical set up for the person with Depression. The casework approach can handle the psychosocial issues of the client using the social casework process. Other social work interventions like social group work, environmental manipulation, etc., can also help in the management of the case. The CBT can be put into practice in future with long term interventions, enhanced number of sessions and follow ups assessments.

CONCLUSION

The case study emphasized on psychiatric social work intervention based on cognitive behavioural therapy approach for reduction of depressive symptoms, improving insight about the illness, enhancement of positive thought, improvement in client's social functioning, problem-solving skill and enhancement of self-esteem is effective. After PSW intervention there was an improvement in client's mood state, thoughts, communication, i.e., reduction in depression and anxiety symptoms, improvement in an interpersonal relationship, decreased in the feeling of loneliness and better self-esteem.

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Acknowledgements

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author declared no conflict of interest.

How to cite this article: Saikia P, Gujar N M & Ali A (2020). A case study of person with depression: a cognitive behavioural case work approach. *International Journal of Indian Psychology*, *8*(3), 620-630. DIP:18.01.072/20200803, DOI:10.25215/0803.072