The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 12, Issue 3, July- September, 2024
DIP: 18.01.240.20241203, DOI: 10.25215/1203.240
https://www.ijip.in

Case Report

Step-by-Step CBT Management of Depressive Disorder: A Case Report

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ABSTRACT

Cognitive behavioural therapy (CBT) for depression has been empirically proven as one of the most effective modes of treatment for depression. In this article, the author describes a step-by-step case management plan for depression from a cognitive behavioural perspective.

Keywords: *Depression, Recurrent Depressive Disorder, Cognitive Behaviour Therapy*

CBT for depression was first developed by Aaron. T. Beck in the 1960s, and it has since been expanded and studied extensively ever since. (1) The typical course of CBT for depression consists of three phases. The first phase of treatment focuses on symptom relief. The aim of this phase is to re-engage clients in their daily activity and to promote resumed functioning. The middle phase of treatment addresses cognitive change. In this phase clients learn to identify automatic thoughts, critically evaluate these thoughts and examine alternative modes of thinking. The final phase focuses on maintenance of treatment effects and on relapse prevention. In this phase, clients are encouraged to challenge their underlying negative schemas by engaging in behavioural experiments that test the veracity of the schemas as well as their adaptiveness. (3,4,5)

CLINICAL CASE

Mrs. N is a 36-year-old graduate, married female. She lives in a joint family set up with her two children (9-year-old daughter and 6-year-old son) at her in-law's place. Her husband lives and works in a neighbouring city and comes home on weekends. She shared that she quit her job as a teacher around 5-6 months back to take care of her children. Since then, she has been experiencing low mood and irritability. She expressed that her sleep pattern is erratic and her sleep is often disturbed.

She shared that she keeps thinking about her past and all the negative events that have happened in the past. Her mother is suffering from Parkinson's disease and she feels that even her future is going to be dark. She feels that it is meaningless to engage in any activity as there is no ultimate purpose of life and things go wrong eventually. She shared that she can't stop crying during the day, feels lethargic and so is unable to take care of her children as well as she wants to.

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Received: April 10, 2024; Revision Received: September 18, 2024; Accepted: September 21, 2024

She shared that she avoids socializing because either people tell her that she looks dull and lifeless or they talk about negative events that continue to haunt her for days. She has stopped dressing up and stays inside her room most of the time except for cooking which she does half-heartedly because she shares that household responsibility with her sister-in-law. She feels like she is "good for nothing".

She revealed that she has had such episodes in the past. She couldn't remember one very clearly but shared that as a child, there was "a dark phase" when she felt like everything would go wrong. Another episode was triggered when she had a still birth around a decade back. Yet another episode happened post-partum when her daughter was born. And the recent one was last year after her father-in-law passed away. She has been diagnosed with Recurrent Depressive Disorder, currently moderate depressive episode with somatic symptoms.

PSYCHOTHERAPEUTIC MANAGEMENT

Session 1: After the initial assessment session, the first treatment interview was spent in establishing a co-operative and collaborative therapeutic relationship. Broad goals that the patient listed in the first session were specified. Psycho-education regarding the cognitive model of depression and CBT as a treatment method was provided. At the end of the session, patient was asked to start making a list of "pleasure" and "mastery" activities she does during the day at the end of each day. She was referred for psychiatric consultation as well owing to the intensity of her symptoms and considering the efficacy of combined treatment in the management of depression.

Sessions 2-4: The pleasure and mastery list revealed that the patient was not doing enough pleasure and mastery activities. Behavioural activation was introduced after psycho-education and pleasure and mastery activities scheduled. Along with it, the technique of successive approximations was discussed (breaking larger tasks into smaller tasks which are easy to accomplish). Weekly schedules of behavioural activation were made every week, which took care of the patient's inertia and isolation and gradually elevated her mood. The technique of cognitive defusion (from Acceptance and Commitment Therapy) was taught to deal with intrusive thoughts about the past.

Session 5-8: Journaling and grief worksheets were introduced to process her unresolved grief from the still birth and her father-in-law's death. She was advised to share her feelings with her sister and husband to further process the loss. Some rituals to commemorate both losses were discussed. Working from the restoration orientation of the dual process model of grief, some personal goals were listed and patient was encouraged to start working on them from the easiest to the hardest.

The core beliefs of hopelessness and worthlessness were identified and cognitive restructuring was done through guided discovery (socratic questioning) and behavioural experiments. She was encouraged to keep a credit list and start gratitude journaling.

Patient was psycho-educated on cognitive distortions and taught ways of challenging them. Guided imagery was introduced and she was told to practice it at a specific time each day. The above tasks were explained thoroughly, demonstrated where required and then homework assignments for the same were given.

Sessions 9-12: Assertiveness skills were taught to handle negative comments from people in an adaptive manner. As a behavioural experiment, she was advised to go for two upcoming gatherings, rehearsing in advance, her assertive response, for unwanted comments and unsolicited advice.

She was asked what she would do if she didn't feel the future was so hopeless (committed action). She made a list of few things out of which, 1-2 activities were scheduled for each week. Doubts and distortions related to each task were addressed. Sleep and irritability improved on its own, without working on it directly.

Sessions 13-16: The learnings in therapy were consolidated through these questions:

- How did your problems develop? (unhelpful beliefs and assumptions, the experiences that led to their formation, events precipitating onset)
- What kept them going? (maintenance factors)
- What did you learn from therapy that helped?
- What were your most unhelpful negative thoughts and assumptions? What alternatives did you find to them?
- How can you build on what you have learned? (a solid, practical, clearly specified action plan).
- Preparation for any potential setbacks was done by addressing these questions:
- What might lead to a setback for you? (Losses and stresses in the future)
- What early warning signs do you need to be alert for? (Feelings, behaviours, and symptoms that might indicate the beginning of another depressive episode were identified and listed)
- If you notice that you are becoming depressed again, what should you do? Clear simple instructions, which will make sense despite low mood were discussed. (6)

DISCUSSION

Cognitive behavioural therapy (CBT) along with pharmacology is the gold standard treatment intervention for depression. A meta-analysis of 115 studies has shown that CBT is an effective treatment strategy for depression and combined treatment with pharmacotherapy is significantly more effective than pharmacotherapy alone. (7) Evidence also suggests that relapse rate of patient treated with CBT is lower in comparison to the patients treated with pharmacotherapy alone. (8)

REFERENCES

1. Beck AT. Cognitive therapy: A 30-year retrospective. Am Psychol 1991; 46: 368–375.
2. Mor, Nilly & Haran, Dafna. (2009). Cognitive-Behavioral Therapy for Depression. The Israel journal of psychiatry and related sciences. 46. 269-73.
3. Young JE, Weinberger AD, Beck AT. Cognitive therapy for depression. In: Barlow DD, editor. Clinical handbook of psychological disorders: A step-by-step treatment manual. New York: Guilford, 2001: pp. 264–308.
4. Beck AT, Rush AJ, Shaw BF, Emery G. Cognitive therapy of depression. New York: Guilford, 1979.
5. Persons JB, Davidson J, Tompkins MA. Essential components of cognitive-behavior therapy for depression. American Psychological Association; 2001.
6. Gautam M, Tripathi A, Deshmukh D, Gaur M. Cognitive Behavioral Therapy for Depression. Indian J Psychiatry. 2020 Jan;62(Suppl 2): S223-S229. doi: 10.4103/ps

ychiatry. IndianJPsychiatry_772_19. Epub 2020 Jan 17. PMID: 32055065; PMCID: PMC7001356.
7. Fennell M. Cognitive behaviour therapy for depressive disorders. In: Gelder M, Andreasen N, Lopez-Ibor J, Geddes J, editors. New Oxford Textbook of Psychiatry. New York: Oxford University Press; 2012. pp. 1304–12.
8. American Psychiatric Association. Practice Guideline for the Treatment of Patients with Major Depressive Disorder. American Psychiatric Association. 2010.

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

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Singh, S. (2024). Step-by-Step CBT Management of Depressive Disorder: A Case Report. *International Journal of Indian Psychology*, *12*(3), 2461-2464. DIP:18.01.240.20241203, DOI:10.25215/1203.240