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Case Study

Effect of Positive Cognitive Behavioural Therapy Intervention on Psychological Well-Being: Case Study of a Mother of Two Intellectually Disabled Children

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ABSTRACT

The present study was carried out to examine the effect of a Positive Cognitive Behavioral Therapy (Positive CBT) intervention on the psychological well-being, irritability, depression, and anxiety of a mother caring for two children with mild intellectual disabilities. A single-subject case study design was utilized, wherein pre- and post-intervention assessments were conducted over a two-month period. The Irritability, Depression, and Anxiety (IDA) Scale by Snaith et al. was administered to measure levels of negative affect, while Ryff's Psychological Well-Being Scale was used to assess overall well-being. Qualitative data were gathered using a semi-structured interview guide adapted from the Kansas Inventory of Parental Perceptions (KIPP) to understand the mother's caregiving challenges and positive experiences. Results revealed that, prior to the intervention, the mother reported moderate irritability and high levels of depression and anxiety, along with low psychological well-being. Following the eight-session Positive CBT program, her scores showed a marked decrease in irritability, depression, and anxiety, and a notable increase in psychological well-being. These findings underscore the potential of Positive CBT in enhancing the mental health of caregivers of children with intellectual disabilities. The study highlights the importance of using strength-based therapeutic approaches and offers practical implications for mental health professionals and policy makers to support and empower caregivers in similar contexts.

Keywords: *Positive Cognitive Behavioural Therapy, Intellectual Disability, Psychological Well-Being, Irritation, Depression, Anxiety*

With the emergence of the field of Positive Psychology and its promising nature, studies have shown the effectiveness of Positive Psychology Interventions (PPI) in increasing the psychological well-being of an individual through scheduled exercises and practices. Positive psychology interventions, or PPIs, are a set of scientific tools and strategies that focus on increasing happiness, wellbeing, and positive cognitions and emotions (Keyes, Fredrickson, & Park, 2012). Carr et al (2020) have conducted meta-analysis on PPI and have concluded that there is extensive evidence supporting the effectiveness of these forms of interventions. Different exercises regarding areas such as

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empathy, optimism, and kindness have shown drastic changes in the thinking, behaviour, and emotional reaction of individuals.

Sin and Lyubomirsky (2009) defined PPI as a psychological intervention that primarily focuses on raising positive feelings, positive thoughts, and positive behavior. According to Sin and Lyubomirsky, all positive psychology interventions have two essential components: Focusing on enhancing happiness through positive thoughts and emotions.

Sustaining the effects for long-term

Bolier et al (2013) have emphasised that the use of positive psychology interventions can be effective in the enhancement of subjective well-being and psychological well-being, as well as in helping to reduce depressive symptoms. Positive psychology interventions were also seen to increase the levels of life satisfaction, gratitude and happiness (Yeung & Kwok, 2013). Further studies conducted have not only shown the immediate effect of positive psychology interventions on mental health, but also long-lasting ones, up to 3.5 years (Proyer et al, 2014). PPIs have been found to be responsible for not only improvement of the self, but also extended to an increase in the quality of social relationships in their life as well (Connell et al, 2015).

There are many types of PPI available, out of which Positive Cognitive Behavioural Therapy (Positve CBT) has come out as one of the most effective ones. While traditional Cognitive Behavioural Therapy models focus on specific problems with the individuals like depression and anxiety, and the causes of these problems (Rush & Beck, 1978); Positive Cognitive Behavioural therapy focuses more on what are the strengths of the person and what is working right for them (Bannink,2017).

Positive CBT is based on several different theories and therapies. It draws on concepts from CBT, using both Cognitive Therapy and Rational Emotive Behavior Therapy. It also uses concepts from positive psychology, Solution-Focused Brief Therapy, and of Functional Behavior Analysis (Bannink, 2017). Positive CBT, as explained by Bannick (2017), is also grounded in a strengths-based approach to helping people. This perspective emphasizes that the individual is capable and has the resources within him to deal with conflicts, effectively cope with stressful situations, and find solutions to his problems.

Additionally, Bannock (2017) shares 6 essential elements of Positive CBT that must be kept in mind while conducting the interventions. These 6 elements are:

1. **Therapeutic Alliance:** It refers to the agreement between the therapist and the client to have a positive relationship between each other and that both would rightly play the role that is expected of them.
2. **Build Rapport:** The positive relationship starts with the therapist's questions which will further act as an icebreaker into making the client comfortable to start getting to know more information about the client.
3. **Acknowledge Problems:** It emphasises that Positive CBT does not ignore problems. But rather helps the client to view the problem differently and discover strengths and possibilities instead.
4. **Shift to Strengths and Solutions:** The therapist guides and helps the client focus on solutions, strengths and available resources by using different tools and techniques.
5. **Set Goals:** The therapist can set goals as a way to shift the client's intention from problems to possibilities. It shows the client where he could change.

6. **Positive Self-Monitoring:** The client is given the power and encouraged to review his progress, strengths and exceptions to the problem.

A majority of literature related to Intellectual Disabilities (ID) have been negative. Intellectual Disability is a developmental disability characterized by mild to profound limitations in cognitive function (e.g., learning, problem solving, reasoning, planning) and in adaptive behavior, impairing one's ability to acquire skills typical for one's age group as a child or necessary for one's later independent functioning as an adult (*APA Dictionary of Psychology*, n.d.) This negativity pertains not only to the person who has ID, but also to the ones who are taking care of them. The primary caregiver of an intellectually disabled child is often the mother. Studies have been conducted which have shown that the mother faces caregiver burden, burnout, stress, financial constraints and marital conflicts (Graham et al., 2010). This leads to a steep increase in the mother's level of depression and anxiety which in turn reduces their quality of life (Raj & Ranjan, 2017). Similarly, compared to other caregivers and adults in the child's life, it is the mother who faces the brunt of caregiving stress which leads to unchanneled anger and irritability (Sharma et al, 2021).

However, there are positive aspects as well such as building of resilience, source of fulfillment, personal growth and maturity, and expanded social network (Hastings et al., 2005). Both these positive and negative aspects can coexist in a caregiver at the same time as proposed by Lawton in 1991. Several studies have documented these positive outcomes in the context of caregiving for children with ID. For example, Hastings et al. (2005) found that parents of children with intellectual disabilities often report experiencing increased resilience, a deeper sense of purpose in life, and greater family cohesion. Similarly, Behr et al. (1992) developed the Kansas Inventory of Parental Perception (KIPP), which identified several areas where parents of children with disabilities perceived positive contributions, such as learning through experience, happiness and fulfillment, and personal growth. King et al. (2006) found that parents of children with developmental disabilities often report that their caregiving role has led to a greater sense of life purpose and an enhanced appreciation for life's small joys.

Thus, in order to focus on this level of positivity, and to increase a mother's level of psychological well-being and reducing levels of anxiety, depression, and irritability through Positive CBT Interventions has become essential.

METHODOLOGY

The present study utilises the single subject case study design with pre-and-post Positive CBT intervention assessment. Case study research is an in-depth study of an individual who is in unique situations. Although disparaged as uncontrolled and uninterruptible, the case study has great potential for building social work knowledge for assessment, intervention, and outcome (Gilgun, 1994). Positive Cognitive Behavioural Therapy is the form of intervention chosen to study its effect on psychological well-being of the client as a result of their levels of Irritation, Depression, and Anxiety. The case study utilised both in-person interviews and psychometrics to gather a detailed history of the client, assess the level of psychological well-being, anxiety, depression, and irritability and understand the effect of the intervention on the client. The intervention lasted for a period of 2 months.

Problem:

The present research aims to explore the effect of positive psychology intervention on the overall well-being i.e. psychological well-being, irritability, anxiety and depression, in a mother of two intellectually disabled children.

Objectives:

1. To evaluate the level of irritability, depression, and anxiety in the mother of two children with intellectual disabilities prior to the conduction of Positive CBT intervention.
2. To assess the level of psychological well-being in the mother of two children with intellectual disabilities prior to the conduction of Positive CBT intervention.
3. To gauge the level of irritability, depression, and anxiety in the mother of two children with intellectual disabilities post the conduction of Positive CBT intervention.
4. To examine the level of psychological well-being in the mother of two children with intellectual disabilities post the Positive CBT intervention.

Hypotheses:

1. The mother would report higher levels of irritability, depression, and anxiety prior to the conduction of the Positive CBT intervention.
2. The mother would report lower levels of psychological well-being prior to the conduction of the Positive CBT intervention.
3. A lower level of irritability, depression, and anxiety would be found post the Positive CBT intervention in the mother.
4. A higher level of psychological well-being would be found post the Positive CBT intervention in the mother.

Operational Definitions:

1. **Depression**: In this study, depression refers to a psychological state of sadness and hopelessness associated directly as a result of the children with intellectual disabilities in the mother's life.
2. **Anxiety**: In this study, anxiety refers to a psychological state of uncertainty, fear, and tension usually related to matters concerned with the children with ID.
3. **Irritability**: In this study, irritability refers to both inward and outward irritability which is characterised by feelings of frustration, anger, and annoyance that is directed either inwards (towards the mother) or outwards (towards the children or others).
4. **Psychological Well-Being**: In this study, psychological well-being refers to the mother's perception of her autonomy, environmental mastery, personal growth, and positive relationships with others which is the result of having children with ID in her life.

Description of Tools:

Semi-Structured Interview through Kansas Inventory of Parental Perception by Behr, Murphy and Summers (1992)

The Kansas Inventory of Parental Perception (KIPP) is a psychological assessment tool designed to measure how parents perceive their children with disabilities, specifically focusing on four key domains: positive contributions, social competence, family stress, and personal adjustment. The interview guide was developed based on (KIPP), focusing on sub

themes from the Positive Contributions Domain such as Learning Through Experience with Special Problems, Happiness and Fulfillment, Personal Growth and Maturity, and Expanded Social Network.

IDA Scale by Snaith et al

The IDA Scale is the Irritability, Depression, and Anxiety Scale developed by Snaith et al in 1978. This scale allows respondents 4 possible answers for each item. Four aspects of well-being are covered: Depression, Anxiety, Inward Directed Irritability and Outward Directed Irritability. It is an 18 item scale.

Psychological Well-Being Scale by C.D. Ryff

The Psychological Well-Being Scale is a self-report questionnaire that measures six key dimensions of psychological well-being: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth by assessing how individuals perceive their overall quality of life based on these aspects, with higher scores indicating greater psychological well-being.

Positive Cognitive Behavioural Therapy Intervention:

The form of intervention used in this case study is Positive Cognitive Behavioural Therapy (Positive CBT) Intervention. The Positive CBT in Practice Manual by Fredrike Bannink was followed to plan the Positive CBT based treatment. It consists of 8 sessions that were planned over a period of 2 months i.e. 8 weeks. It comprises therapy questions, guidance, activity, and homework exercises. The client was provided with a workbook called, "Positive CBT: Client's Workbook Individual Positive Cognitive Behavioural Therapy" where they were able to do the exercises. Some of these exercises were to be done only once, some over the period of the whole period of 8 weeks. The following table is a brief overview of how the intervention was planned:

Session	Activities	Homework suggestions
Session 1	1 Welcome and building rapport, with a focus on client's strengths, values, and preferences 2 Explain the rationale of positive CBT 3 Ask about *pretreatment change* (what is better or different since client made the appointment?) 4 Ask the *miracle question* or other questions about the client's goal 5 Evaluate the collaborative relationship 6 Explain exercise "Your Best Possible Self" (King, 2001) 7 Explain exercise "Three Blessings" (Seligman et al., 2005) 8 Request client's feedback	1 Observe daily what goes well (enough) in your life. What does not need to change, or should not even change? 2 Exercise: "Your Best Possible Self" 3 Daily exercise: "Three Blessings"
Sessions 2–8	1 Start all sessions with opening question about progress, "What is better?" 2 Focus on exceptions, (small) successes and the client's contribution to make those exceptions happen, using EARS (De Jong & Berg, 2002) 3 Ask *scaling questions* to assess progress 4 Ask *competency questions*, "How did you do that?" and 'How do you cope?' 5 Discuss the homework suggestions, unless the client has not done any of them 6 Do the in-session exercises (see specific suggestions for each session). Do not do the proposed exercise when the client does not want to do it, or when you need more time to use EARS properly [28] 7 Invite the client to start keeping the Diary of Better Moments (exceptions to the problem and/or the moments where there is already a glimpse of the preferred future) 8 Ask the client if they might find it useful to do a specific homework suggestion. If so, explain the suggestion and check if they have any questions 9 At the end of every session: request the client's feedback using the SRS (Duncan, 2010), including the question, "What can I (as your therapist) do better or different in the next session?" All exercises and homework suggestions will now be discussed per session	

	Suggestions for themes and exercises per session	Homework suggestions
Session 2	1 See to it that the goal formulation from Session 1 is stated in positive, concrete, and realistic terms (also use the results from exercise "Your Best Possible Self") 2 Ask scaling questions to find out where on a scale from 10 to 0 (10 being the ideal situation and 0 being the opposite) the client wants their situation to be in the preferred future, and then where on the scale the client would rate their current situation 3 Use further scaling questions to identify what progress the client has made and what next steps will look like 4 Consider asking scaling questions regarding the client's motivation, hope, and/or confidence that they will reach their goal 5 Explain exercise "Positive Self-Portrait"	1 Diary of Better Moments 2 Start making a Positive Self-Portrait
Session 3	1 Make topographic analyses of Better Moments, together with the client 2 Make positive FBAs of Better Moments, together with the client 3 Explain the VIA Character Strengths Survey	1 Diary of Better Moments 2 Fill in the VIA Character Strengths Survey online 3 Finish your Positive Self-Portrait
[29] Session 4	1 Discuss the Positive Self-Portrait (homework started in Session 2) 2 Discuss the VIA Character Strengths Survey and how the client may use their top five to experience more well-being 3 Explain exercise "Create Powerful Beliefs"	1 Diary of Better Moments 2 Visualize daily your Powerful Beliefs
Session 5	1 Introduce "self-compassion" (Gilbert, 2010) 2 Do "Self-Compassion" exercise together 3 Explain exercise "Acts of Kindness" (Lyubomirsky, 2008)	1 Diary of Better Moments 2 Daily "Self-Compassion" exercise 3 Do 1 day each week: five acts of kindness
Session 6	1 Introduce "optimism" 2 Do exercise "Optimistic Thinking Style," together with the client (Seligman, 2002) 3 Do exercise "Upward Arrow Technique," together with the client	1 Diary of Better Moments 2 Daily exercise "Optimistic Thinking Style"
Session 7	1 Introduce "gratitude" 2 Discuss which three people the client is grateful for 3 Do exercise "Gratitude in Four Steps" 4 Explain Gratitude Letter	1 Diary of Better Moments 2 Do exercise "Gratitude in Four Steps" 3 Write Gratitude Letter and read the letter to that person
Session 8	1 Make plan for behavior maintenance 2 Request client's feedback for all eight sessions	1 Finish list of three times 50 things for behavior maintenance at home

Bannink, F. (2014). *Brief Overview of the Treatment Protocol for Individual Positive CBT* [Table].PPIP_Positive-CBT-inhttps://www.fredrikebannink.com/bannink/wp-content/uploads/2017/04/PPIP_Positive-CBT-in-Practice.pdf-Practice.pdf.

Procedure:

Baseline Assessment (Pre-Intervention):

In order to conduct this study, the client's informed consent was taken where the client was explained about the study, potential risks and benefits, and their right to withdraw at any time. Clinical history about the client was conducted through a semi-structured interview using the constructs of KIPP as a guideline. Prior to the conduction of the intervention, the baseline assessment was administered by asking the client to answer truthfully for the two questionnaires given i.e. IDA Scale & Ryff's Psychological Well-Being Scale.

Intervention Phase

Once the pre-assessment has been completed, the positive psychology intervention is implemented. The client was given the Positive CBT: Client's Workbook Individual Positive Cognitive Behavioural Therapy which they had to complete over a scheduled pace of 8 weeks. The client was called for a counselling session once or twice per week depending on the demand of that week's schedule. The intervention was consistently monitored to ensure consistency and adherence to the schedule.

Post-Intervention Assessment:

Once the intervention has been successfully implemented, the same assessments used in the pre-intervention phase are administered to measure any significant changes. The pre-

intervention and post-intervention scores are compared using statistical tests to see if the intervention had an impactful change in the individual.

RESULTS & DISCUSSION

Demographic Details:

- **Name:** Mrs. K
- **Gender:** Female
- **Age:** 52
- **Education Level:** B.Comm
- **Marital Status:** Married
- **Number of Children:** 2
- **Gender of Child 1:** Male
- **Gender of Child 2:** Female
- **Level of Intellectual Disability of Child 1:** Mild
- **Level of Intellectual Disability of Child 2:** Mild
- **Employment Status:** Unemployed
- **Socioeconomic Status:** Medium

Brief Clinical History:

Mrs. K is a 52 year old married woman who resides in Hyderabad, Telangana. She was born in November, 1970 and got married in August, 94 at the age of 24. The marriage was not a consanguineous one, and there were no known previous relations between the two families. Her first child, a son, was born in September 1996, when the mother was 26 years old. The notable incident during an otherwise normal delivery was the mother's umbilical cord had coiled around the baby's neck during labour. She had noticed delays in the physical development and reaching milestones of the child around the age of 10 months. The child would later be diagnosed with Mild Intellectual Disabilities at the age of 6 years. As the doctors had ruled out any genetic cause or reason for the child's disability, Mrs. K and her husband had decided to try for the second child. The second child, a daughter, was born in June 2000 when the mother was 30 years old. The second child also however, would be later diagnosed with Mild Intellectual Disabilities like her brother. Mrs. K had recalled many difficulties she had grown through during the upbringing of her children and how it had affected various aspects of her life.

The use of Kansas Inventory of Parental Perception as a guidelife in various domains of her life have been shown below:

Table 1: Summary of Caregiving Challenges and Positive Impacts (Qualitative Analysis) based on Kansas Inventory of Parental Perceptions (KIPP):

Theme	Subtheme
Personal Growth and Maturity	Increased resilience, problem solving skills
Strength and Family Closeness	Strengthened family bonds, cooperation among family members
Expanded Social Network	Increased interaction with support group, new friendships
Awareness of Future Issues	Better planning for future, managing future needs
Career/Job Growth	Adjustments in career plans, job growth
Pride and Cooperation	Sense of accomplishment, cooperation with family

Personal Growth and Maturity:
"When my 2nd child was born and diagnosed again with ID, I went into depression. With my first born, I took it as a challenge. But when my 2nd child was also diagnosed with the same thing, I became depressed. I looked at every day as being the same day repeating again and again. I have to brush their teeth, give them a bath and put them to sleep. During the night, I would feel relieved that one day was over. I would constantly cry with my parents and my siblings. People who would come over, they would say something and go, and it would make me more sad. One day, I asked my husband lets commit suicide all 4 of us. To that, my husband only asked me 1 thing: you answer these 2 questions, and I am ready to do it. "If both of us die, and the kids live or if the kids die, and we both live, will you be ok with it?." These questions changed the way I was thinking.

Strength and Family Closeness:
"When my son was around 9 years old, my husband started a new business with the thought that we have to do something to financially secure them and also, we realized that taking classes for them was becoming expensive. But that business faced a loss and we had cut off classes that my son would enjoy - like basketball and drum beating. It really tested our relationship as a family.

During this time, I have faced a lot with society as well. They would use hurtful words and some relatives stopped calling us to get togethers. It was a tough time to face. Once our income began to get set again, we have seen that people have started treating us "well" again. My husband has always been supportive. I have never had any problems from him. He would always put me and the children first. I can say with confidence that through our collective efforts for our children's betterment, they have become the reason for our family's closeness and strength."

Expanded Social Network:
"I can't go to all the get-togethers because I need to give my time to my child's needs. I want my husband to grow in his circle, so I put limitations on myself so that at least one of us can go outside. In the beginning I would not go because of the way people would look and judge my children. It made me feel very bad. But as my children got older, and I have gotten more mature I have realised I have not done anything wrong and I take my children out proudly. The only reason now that I might not go out is because sometimes, I do not have the physical energy to take care of both my children. Society has also become more aware and understanding about these problems. Before nobody knew. I didn't even know about this problem until my children got diagnosed with it. Now people are more kind. Through my children's schools and classmates, I have met a lot of other mothers who have children with ID. The more time I spend with them, I realize I am one of the luckier ones and my children are far better. My extended family of my siblings and parents also support me a lot. All of them together have helped me in taking care of my children."

Awareness of Future Issues:
"I have gotten BP because of the stress and tension that the children give. I also get headaches. As I am taking ayurveda and doing yoga, I feel better. But as age is growing, I can tell that I am becoming weaker and my children are becoming stronger. When my children were younger, I lived in a smaller house which was easier to manage. Now that I moved to a bigger house, it's becoming tiring. I have also gotten Covid 2 times which has weakened me much more. Though I am used to the routine with my children, there is a far

bigger worry. I do not know who will take care of my children when me and my husband don't have the energy anymore or when we are not around to take care of them. It keeps me awake at night not knowing about the future and the future of my children. They have to be safe and happy even when I am not around to take care of them."

Career/Job Growth:
"When my son was going to Future Kids, I wanted to join a Gemology course. Then I got pregnant with my second child. I thought I could work for a year. But when my 2nd child was also diagnosed, I dropped everything. But even now, I want to do something. I want to run my own business successfully. There is still a motivation inside me. I want to do something for myself. I want to create a name for myself. I don't know how but I will make sure it happens. I am starting a saree business as well. I should be an inspiration for others and I should have something for myself."

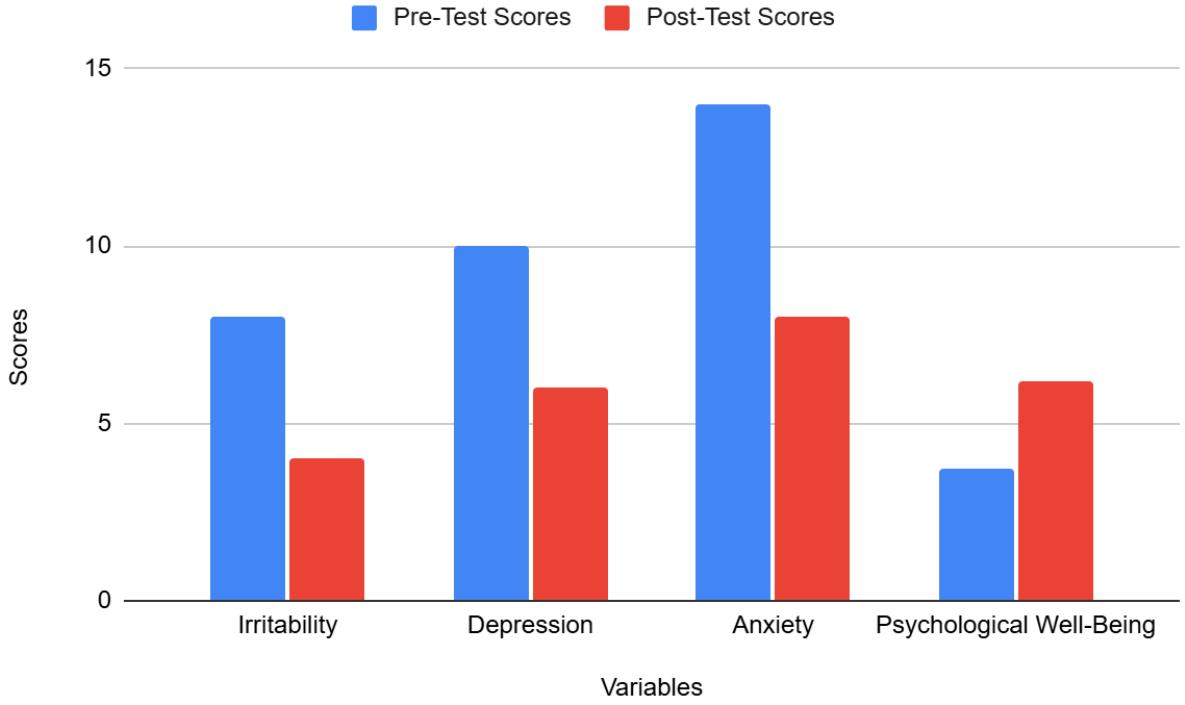
Pride and Cooperation:
"At one stage, I took care of my children because I had to do it. It was like working like a machine. It wasn't because I was happy or sad. It was a routine. Then I realized, I shouldn't be sad or depressed so I started telling myself that I should be happy. But even during that time, when my children irritate me it becomes hard for me to think like that. As parents, if we do work for them in a dedicated and positive manner, we will be closer to our child's goal. The area where I felt was really difficult was when my children couldn't express themselves to me, but I couldn't understand. It is important for me to be physically close to my child, because it is only when I am with them continuously that I can understand their needs. Now at this stage, if I see any difference even in the blinking of my child I can understand that something is wrong.

My goal is for them to do their own work and to be able to communicate their needs with me. I don't want or expect anything more from them. Now, I aim to make my children self-sufficient. It is through them that I will feel that I have achieved something. By making them become valuable, I will be valuable."

Table 2: Irritability, Anxiety, and Depression, of the client on the basis of Pre-and-Post Intervention Assessment:

Variables	Pre-Test Scores	Findings	Post-Test Scores	Findings
Irritability	8	Moderate level of Irritability	4	Low level of Irritability
Depression	10	High level of Depression	6	Moderate level of Depression
Anxiety	14	High level of Anxiety	8	Moderate level of Anxiety
Psychological Well-Being	3.7	Low Level of Well-Being	6.2	Moderate Level of Well-Being

Graph 1: Pre & Post Intervention Scores of Irritability, Depression, Anxiety and Psychological Well-Being in Client



The client's scores pre and post intervention have been compared. The following scores have been computed from the client's answers to the IDA Scale by Snaith et al. Initially before the Positive CBT intervention, the client has scored 8 in the construct of Irritability which has been interpreted to a Moderate Level of Irritability. Similarly, the client has scored 10 in the construct of Depression which is classified as a High Level of Depression. A score of 14 had been obtained by the client for the construct of Anxiety which is represented as a High Level of Anxiety. On the other hand, the client's level of psychological well-being before the intervention was seen to be a low level of well-being with a score of 3.7.

Post the Positive CBT Intervention, there have been changes in all the dimensions of the scores. The client has shown a decrease in the level of irritability from 8 (moderate level) to 4 (low level). Similar results were observed in depression and anxiety. The client had a reduced level of depression from 10 (high level) to 6 (moderate level). The client's anxiety level also went down from 14 (high level) to 8 (moderate level). The level of psychological well-being has increased from 3.7 (low level) to 6.2 (moderate level).

Thus, it can be seen that the effects of the intervention has caused the levels of irritability, depression, and anxiety to decrease and the levels of psychological well-being to increase.

CONCLUSION

The study aimed to explore the effect of a positive psychology intervention on the overall well-being i.e. psychological well-being, irritability, anxiety and depression, on a mother of two intellectually disabled children.

Hypothesis 1 proposed that the mother would report higher levels of irritability, depression, and anxiety prior to the conduction of the Positive CBT intervention. This hypothesis is **accepted.** These high levels of anxiety and depression could be a result of their reduced quality of life due to having intellectually disabled children (Ranjan et al, 2017).

Hypothesis 2 suggested that the mother would report lower levels of psychological well-being prior to the conduction of the Positive CBT intervention. This hypothesis is **accepted.** According to Norlin (2012), a mother of intellectually disabled children could have lower levels of well-being due to marital and coparenting quality.

Hypothesis 3 proposed that post the Positive CBT intervention, there would be a lower level of irritability, depression, and anxiety post the conduction of the Positive CBT intervention. This hypothesis is **accepted**. Studies have shown that positive CBT interventions have lasting results in reducing depression and anxiety as it focuses more on the individual's strengths than reminding the client of the problem (Hanson, 2018).

Hypothesis 4 suggested that a higher level of psychological well-being would be found post the Positive CBT intervention. This hypothesis is **accepted**. According to Tayyab Rashid (2009), Positive CBT intervention can act as a catalyst in improving an individual's well-being as it helps people get accustomed to a new life, where there is growth, insight, love and play.

Implications

1. The study highlights the potential of Positive Cognitive Behavioral Therapy (Positive CBT) in addressing the mental health challenges faced by mothers of children with intellectual disabilities (ID). The results can promote Positive CBT as a strong channel for enhancing psychological well-being and reducing irritability, depression, and anxiety.
2. The study highlights the necessity for policies that prioritize mental health resources for caregivers of children with ID. Governments and organizations can use this evidence to fund support programs and integrate caregiver well-being into health and education policies.
3. The study provides evidence that therapists and psychologists should be trained in Positive CBT to work effectively with caregivers, emphasizing strengths-based approaches rather than problem-oriented approaches. Also, the study creates opportunities for further research to replicate findings in diverse populations, including fathers, single caregivers, or caregivers of children with other disabilities.

REFERENCES

Bannink, F.P. (2012). Practicing positive CBT: From reducing distress to building success. Chichester, West Sussex: Wiley - Blackwell

Bolier, L., Haverman, M., Westerhof, G.J. *et al.* Positive psychology interventions: a meta-analysis of randomized controlled studies. *BMC Public Health* 13, 119 (2013). https://doi.org/10.1186/1471-2458-13-119

Carr, A., Cullen, K., Keeney, C., Canning, C., Mooney, O., Chinseallaigh, E., & O'Dowd, A. (2020). Effectiveness of positive psychology interventions: a systematic review and meta-analysis. *The Journal of Positive Psychology*, *16*(6), 749–769. https://doi.org/10.1080/17439760.2020.1818807

Gilgun, J. F. (1994). A case for case studies in social work research. Social Work, 39(4), 371- 380.

Keyes, C.L., Fredrickson, B.L., & Park, N. (2012). Positive psychology and the quality of life. In K.C., Land, A.C., Michalos & M.J Sirgy (Eds.). *Handbook of social indicators and quality of life research* (pp 99 - 112). Dordrecht: Springer.

Lyubomirsky, S., & Lepper, H.S. (1999). A measure of subjective happiness: Preliminary reliability and construct validation. *Social Indicators Research,* 46(2), 137-155. https://doi.org/10.1023/A:1006824100041

Proyer, R.T., Wellenzohn, S., Gander, F. and Ruch, W. (2015), What Makes Positive Interventions Work. Applied Psychology: Health and Well-Being, 7: 108-128. https://doi.org/10.1111/aphw.12039

Rush, A. J., & Beck, A.T. (1978). Cognitive therapy of depression and suicide. American Journal of Psychotherapy, 32(2), 201-219.

Sharma, Rachit; Singh, Harpreet1; Murti, Mangal1; Chatterjee, Kaushik; Rakkar, Jaspreet Singh. Depression and anxiety in parents of children and adolescents with intellectual disability. Industrial Psychiatry Journal 30(2):p 291-298, Jul–Dec 2021. | DOI: 10.4103/ipj.ipj_216_20

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Conflict of Interest

The author(s) declared no conflict of interest.

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