The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 13, Issue 3, July- September, 2025
DIP: 18.01.003.20251303, DOI: 10.25215/1303.003
https://www.ijip.in

The International Journal of INDIAN PSYCHOLOGY

Case Study

# Effectiveness of Dialectical Behavior Therapy in a Case of Mixed Anxiety and Depressive Disorder: A Case Study

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## ABSTRACT

**Background:** Dialectical Behavior Therapy is a structured therapy that combines CBT and mindfulness to help manage intense emotions and improve coping skills, that was originally designed for adult women diagnosed with borderline personality disorder and a background of persistent suicidal behavior. To understand and evaluate the effectiveness of Dialectical Behavior Therapy on mixed anxiety and depressive disorder using a single-subject design by comparing the pre- and post- intervention data. A single case study report design was used for a clinical intervention based pre and post assessment for evaluating the effectiveness of DBT in a case of the diagnosis F41.2 Mixed Anxiety and Depressive Disorder. Assessments such as, Beck anxiety inventory, Beck depression inventory, Sacks sentence completion test and Rorschach psychodiagnostic test were used for the comparison of pre and post intervention symptoms severity in the patient. DBT techniques like, mindfulness skills, emotion regulation, distress tolerance and interpersonal effectiveness were used during the intervention at CIIMHANS, Dewada, Chhattisgarh. **Result & Conclusion:** Clinical psychology treatments for mixed anxiety and depressive disorder focus on thoughts, emotions, behaviors, and social context. An integrated approach is key to lasting recovery and improved quality of life.

***Keywords:*** *Dialectical Behavior Therapy, Mixed Anxiety and Depressive Disorder, Case Study, Sack's Sentence Completion Test, Rorschach Psychodiagnostic Test*

Mixed anxiety and depressive disorder (MADD) is identified by a clinical presentation that includes a blend of anxiety and depression symptoms, both severe enough to warrant a psychiatric diagnosis, while neither symptom dominates. Additionally, when evaluated separately, the symptoms do not fully meet the criteria for either anxiety or depressive disorders. MADD is quite common, especially in primary care settings, although estimates of its prevalence can vary based on the diagnostic criteria employed. This disorder is linked to levels of distress, challenges in daily functioning, and diminished health-related quality of life that are comparable to those experienced in fully diagnosed anxiety and depression. About half of the individuals affected may see a remission within a year; however, those who do not recover are at an

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**Received: June 23, 2025; Revision Received: July 04, 2025; Accepted: July 07, 2025**

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increased risk of developing a complete psychiatric disorder. Furthermore, individuals with concurrent anxiety and depression tend to have higher disability scores and are more likely to suffer from co-existing physical health issues than those with just one of these conditions. Nevertheless, some reviewers question the validity of MADD due to inconsistent findings regarding its prevalence, progression, diagnostic reliability over time, and classification discrepancies between subthreshold and threshold presentations of anxiety and depression disorders (Möller et al., 2016).

Dialectical behavior therapy (DBT) is part of the 'third wave' of cognitive therapies, characterized by a modular and hierarchical approach. Although it was initially designed to address the challenges of borderline personality disorder, its applications have expanded to various psychiatric conditions. DBT includes individual therapy, group skills training, telephone coaching, and team meetings. By integrating cognitive and behavioral techniques, the primary aim of DBT is to cultivate skills that foster mindfulness, improve interpersonal effectiveness, regulate emotions, and enhance distress tolerance.

Originally created for borderline personality disorder (BPD), DBT may also be relevant for mood and anxiety disorders since there are overlapping symptoms such as mood instability, impulsivity, and suicidality that can fluctuate with mood states. Given this similarity in key symptoms and the diversity of presentations, it suggests that DBT could be useful in addressing certain MADD symptoms. It is proposed that DBT might help individuals with MADD become more aware of their mood changes, improving symptom recognition and potentially promoting earlier help-seeking before a mood episode worsens (Jones et al., 2023).

Dialectical Behavior Therapy is well-suited for the index child given her history of emotional dysregulation, self-harming behaviors, interpersonal difficulties, and chronic feelings of emptiness and worthlessness. The therapy's structured approach targets core issues such as distress tolerance, emotion regulation, and interpersonal effectiveness, which are significantly impaired in her case. DBT also helps in reducing impulsive behaviors and suicidal ideation by promoting mindfulness and acceptance-based strategies. Given her persistent overthinking, low self-esteem, and inability to manage overwhelming emotions, DBT provides a comprehensive framework to build coping skills, improve emotional stability, and enhance overall psychological functioning in a safe, validating environment.

***Aim***

To understand and evaluate the effectiveness of Dialectical Behavior Therapy on mixed anxiety and depressive disorder using a single-subject design by comparing the pre- and post- intervention data.

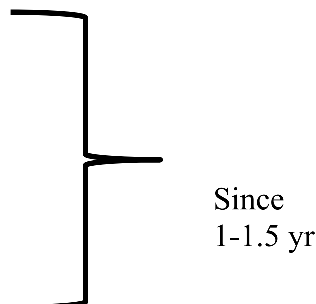
***Assessment***

1. Semi-structured clinical and socio-demographic data sheet: A relevant socio demographic and clinical detail was collected using this proforma.
2. Beck Anxiety Inventory
3. Beck Depression Inventory
4. Sacks Sentence Completion Test
5. Rorschach Psychodiagnostic Test

## CASE INTRODUCTION

The index child, Ms. A. M, 17 years Old, Female, Hindu, Hindi & English speaking, Single, Educated up to 11th Std, belongs to middle socio-economic stratum of the society, hails from urban area of Bhilai, Chhattisgarh was brought to CIIMHANS OPD on June 26, 2024 by her school authorities with following chief complaints:

**Chief Complaints**
Headache
Breathlessness
Restlessness
Foot tremors
Loss of interest
Preoccupation with random negative thoughts
Feeling of guilt
Reduced social interaction
Self-harming acts



Since
1-1.5 yr

- **PRECIPITATING FACTORS -** Separation from friends and family
- **PERPETUATING/ MAINTAINING FACTORS -** Poor coping skills, Excessive worry, Less social interaction
- **NATURE OF ILLNESS**
- **Mode of Onset:** insidious
- **Course of Illness:** Continues
- **Progress of Illness:** Deteriorating

***Brief Clinical Background***

The Index child has had an uncongenial environment in her family since childhood as there have been multiple fights between the parents and also between other family members. She also hasn't experienced the necessary parental care needed by a child as her mother has always been careless towards her and other family members. Her mother has been neglectful of her needs and did not provide the emotional comfort of a mother that is needed by the child. Although, her father was considerate of her needs and wishes and did provide adequate emotional care to the index child, but failed to develop an emotionally strong bond with her. The index child has also been an overthinker since childhood as she has a tendency to keep her mind occupied with random negative thoughts or random instances happening in her life for months. In 2018–19, due to uncontrollable fights in the family and her father's extra-marital affair, she was sent to live in a hostel away from her family to not let all this affect her studies. As her mother got to know about the husband's extra-marital affair, she met the other lady's family members and got her married somewhere else. This separation of the index child's father from her romantic partner made him a child of depression and a regular alcohol drinker. He also became excessively abusive and aggressive with all the family members as he would scream on everybody unnecessarily and beat his wife for no major reason. All these incidents in the child's life and her being separated from her family disturbed her emotionally to an extent that she tried to harm herself by slitting her wrist. This behaviour was under control since then and the child was also being focused in her studies and other school activities and was performing quite well academically. In 2023, when she came to 11th standard, her friends changed school which led to another major separation in the child's life from whom she was emotionally attached. Also, unmanageable

financial problems in the family after her father stopped managing the family business made her tensed and worried as she was concerned about her school fees and other related expenses. Along with this, academic pressure and stress made her overthinking grew to an extent that she started staying aloof in the hostel and reduced her social interactions with everybody in her friends and family, as she was preoccupied with thoughts related to her family and her father all the time. At times, she would feel goosebumps all over her body and feel her feet uncontrollably shaking. During this time period, she tried to harm herself quite a few times either by cutting herself on the wrist or on the thighs, or biting herself. The child also reported of having continuous back pain and headache which hampered with her ability to perform daily activities. In February 2024, her father suddenly started vomiting blood due to which he was rushed to hospital immediately. It came out to be a severe liver infection due to which he had to cut-off on alcohol completely. He was then sent to a rehabilitation centre for treatment, after which sudden changes in the child's behaviour were observed by the teachers and other school students. She was seen sitting alone and quite most of the time and also loosing interest in any of the activities she enjoyed before. It was also reported by the child that she would experience breathlessness and became restless if any thoughts related to her family or father struck her mind. Her body pains and headache became intense and her self-harming tendencies also increased. Her appetite and sleeping patterns were also hampered severely. As the symptoms became worst and the child's health deteriorated, she was brought to CIMHANS OPD for check-up and was advised a course of medications for her symptoms. Within a few months, although her sleeping and food habits and her back pain were reduced, other symptoms showed no positive change. It was also reported by the child that she felt ugly and did not like her body and was loosing interest in getting dressed and taking care of herself. She felt that her hostel mates judge her and make faces when she passes by due to her looks, although no direct verbal comments were passed by any of them. The index child also expressed that she feels stuck in her thoughts and feels that if her situation doesn't get better, then there's no point in living. As her symptoms did not show any reduction in the intensity, she was brought to CIIMHANS again for the treatment.

***No history suggestive of*** early infantile autism, child with hearing impairment, persistent fever, substance abuse, intellectual disability, learning disabilities, childhood psychosis, childhood onset schizophrenia, visual handicap, hallucination, head injury, epileptic seizures or endocrinal imbalances elated mood, inflated self-esteem and any chronic medical illness.

**FAMILY HISTORY -** Father has a positive history of substance abuse and was admitted in a rehabilitation centre. No other significant physical and psychiatric illness was found in any other family members.

## MENTAL STATUS EXAMINATION

The Index child was called for interview. The child came for interview by herself and sat on the chair. The child had an average body built. Hair were well groomed. Overall appearance was well-kempt and tidy. Touch with the surroundings was present. Eye to eye contact was established and maintained for appropriate period of time with the examiner. Rapport was easily established. Attitude towards examiner was cooperative. Reduced psychomotor activity. Speech of the index child was coherent, relevant and goal directed. Intensity of the speech was within normal range with audible tone and normal reaction time. Speed of the speech was within normal range. Prosody was present and spontaneous ease of speech. Productivity was within normal range. The attention was easily aroused and sustained for

considerable period of time. The child was oriented to time, place and person. Remote memory, recent memory and immediate memory were intact. Abstract ability was at functional level. Mood, as reported by the child was irritable and the verbatim was *"Thik nahin lag raha hai"*. Affect was anxious. Affect was full ranged, reactive, adequate mobility and communicable. No disturbances could be detected in thought stream, thought form and thought possession at present. Thought content- 'Negative attitute towards the future- *Mujhe lagta hai agar solution nhi mila ya main thik nhi hui toh main aage nhi jee paungi*', 'ideas of guilt- *Main apni family k liye khuch krr nhi paa rhi hun aur boht preshan hai vo meri wajahse*' and 'suicidal ideas- *Jab boht zada soch leti hun family k bare me toh ajeeb lgta hai aur aesa krne ka mnn krta hai*'. No perceptual disturbances detected at present. The index child's personal judgement was unsatisfactory and social and test judgement were satisfactory. Insight was at Grade-IV level (Awareness of being sick due to something unknown in herself).

**PROVISIONAL DIAGNOSIS: F41.2 Mixed Anxiety and Depressive Disorder**

## TEST ADMINISTERED

1. Semi-structured clinical and socio-demographic data sheet: A relevant socio demographic and clinical detail was collected using this proforma.
2. Beck Anxiety Inventory
3. Beck Depression Inventory
4. Sacks Sentence Completion Test
5. Rorschach Psychodiagnostic Test

## BEHAVIORAL ANALYSIS

### Clinical Interview

Detailed clinical interview was taken from the child, her uncle and school authorities about the mode of onset of illness, its nature of development across the course of time, progress of deterioration, precipitating factors and predisposing factors which might have contributed towards the development of illness. Information about the premorbid impression was also elicited.

### Test Behavior

The index child was called for interview and the above mentioned tests were administered on the child. The index child came by herself and sat down for further test administration. She was interested in the tests and answered all the questions and was able to easily comprehend the test instructions.

### Test Finding

#### *Beck Anxiety Inventory*

The Beck anxiety inventory is a self-report inventory which was administered on the index child to assess the severity of the anxiety symptoms, such as nervousness, fear, and physical sensations, in the child. The BAI demonstrates strong internal consistency (Cronbach's alpha = .94) and shows acceptable reliability over an average period of 11 days (r = .67) (Fydrich et al., 1992).

#### *Beck Depression Inventory*

The Beck's depression inventory is a self-report questionnaire which was administered on the index child to assess the severity of depressive symptoms in the child. The internal

consistency is reported to be approximately 0.9, while the retest reliability varied between 0.73 and 0.96. There was a strong correlation between the BDI-II and the Beck Depression Inventory (BDI-I), and significant overlap with assessments of depression and anxiety was noted. The criterion-based validity indicated strong sensitivity and specificity for identifying depression in relation to the established gold standard (Wang & Gorenstein, 2013).

***Sacks Sentence Completion Test***

The Sentence Completion Test, created by Sacks and Levy in 1950, aims to investigate particular clusters of attitudes or important aspects of an individual's life. This assessment consists of 60 items organized into four subscales: Family, Sex, Interpersonal Relationships, and Self-Concepts, with each subscale addressing 15 distinct attitudes like fears, guilt, and goals. A rating sheet rearranged according to the 15 attitude categories enables clinicians to evaluate the examinee's responses along a spectrum from no significant disturbance to severe disturbance. The interrater agreement coefficients reported range from .48 to .57, and "77% of the statements were rated in close agreement with clinical findings" (Sacks & Levy, 1950).

***Rorschach Psychodiagnostic Test***

Rorschach Psychodiagnostic Test, developed by Hermann Rorschach in1921, is a projective test used to assess the structures of the personality. The findings from a meta-analysis of Rorschach studies suggest that when hypotheses backed by empirical or theoretical justifications are assessed using sufficiently robust statistics, one can anticipate reliability scores of .83 or above and validity coefficients of .45 or .50 or higher for the Rorschach test (Parker, 1983).

***Table 1 presents the child's pre-intervention (baseline) assessment scores prior to the Dialectical Behavior Therapy (DBT) intervention.***

| **BASELINE ASSESSMENT SCORES** | | | | |
|---|---|---|---|---|
| **S.No.** | **Assessments** | **Scores** | | **Interpretation** |
| 1. | Beck Anxiety Inventory | 32 | | Moderate Anxiety |
| 2. | Beck Depression Inventory | 27 | | Moderate Depression |
| 3. | Sacks Sentence Completion Test | Family | 13 | moderate discomfort and disturbance |
| | | Sex | 5 | no discomfort or disturbance * |
| | | Interpersonal Relations | 7 | no discomfort or disturbance * |
| | | Self-Concept | 18 | mild discomfort and disturbance |
| 4. | Rorschach Psychodiagnostic Test | 31 responses | | valid response set |
| | | average initial reaction time | 21.4 seconds | adequate mental processing |
| | | 'Dd' dominant approach | | percieve specific irrelevant content in the inkblots consistently and has a personality trait of focusing on minute details and getting |

| BASELINE ASSESSMENT SCORES | | | | |
|---|---|---|---|---|
| **S.No.** | **Assessments** | **Scores** | | **Interpretation** |
| | | | | stuck on those details |
| | | approach sequence | Dd! - W - D | first focus on the irrelevant details of the situation, then merge these parts to see the whole situation as one and then again break the problem situation in different parts to solve it segment-by-segment |
| | | confused sequence of responding | | difficulties with cognitive processing, emotional regulation, interpersonal communications and emotional distress. |
| | | F+% | 53.33% | poor reality contact, poor ego strength and poor abstract ability |
| | | Zsum | 18.32 | psychological distress or impairment in the child and lower levels of flexibility in thinking |
| | | above average 'C' (colour) responses | | impulsivity, aggression and immature thinking |
| | | below average 'FC'(form-colour) | | emotionally cold tendency towards others |
| | | High 'M' (movement) responses | | good prognosis and being able to use internal resources to cope with difficult situations with proper intervention and help provided. |
| | | High 'H'(human) responses | | good interpersonal relationships |
| | | A% | 38.70 | immature and stereotypical level of thinking |
| | | 'Hd' (human detail) and 'An' (animal) responses | | body image issues and somatic preoccupations |
| | | 'Blood' responses | | aggression |
| | | 'Mythological' responses | | hidden fear and worry thinking style |

| BASELINE ASSESSMENT SCORES | | | | |
|---|---|---|---|---|
| **S.No.** | **Assessments** | **Scores** | | **Interpretation** |
| | | EB: M=Csum | | ambivalent tendency, the child tends to be very flexible during interpersonal relationships making them vulnerable to interpersonal relationships. |
| | | High 'EA' | | obsessive thoughts |
| | | popular responses | 3 | poor touch with reality |
| | | lambda | 2.875 | tensed and constricted inner state of mind representing depressive reaction condition |

* There must have been an attempt by the child to hide her preoccupation and discomfort related to her sex-life and interpersonal relations.

Table 1 presents the child's pre-intervention (baseline) assessment scores. Prior to the Dialectical Behavior Therapy (DBT) intervention, the Child exhibited moderate levels of depressive symptoms and high levels of anxiety, as reflected in the Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI) scores, respectively. The Sacks Sentence Completion Test (SSCT) responses indicated themes of self-doubt, emotional distress, and interpersonal insecurity, while the Rorschach test revealed features suggestive of internal conflict and impaired emotional regulation.

***Table 2 presents the child's post-intervention assessment scores following one month of DBT-based intervention***

| POST-INTERVENTION ASSESSMENT SCORES | | | | |
|---|---|---|---|---|
| **S.No.** | **Assessments** | **Scores** | | **Interpretation** |
| 1. | Beck Anxiety Inventory | 14 | | No or Mild Anxiety |
| 2. | Beck Depression Inventory | 12 | | No or Minimal Depression |
| 3. | Sacks Sentence Completion Test | Family | 6 | mild discomfort and disturbance |
| | | Sex | 4 | no discomfort or disturbance |
| | | Interpersonal Relations | 7 | no discomfort or disturbance |
| | | Self-Concept | 11 | no discomfort or disturbance |
| 4. | Rorschach Psychodiagnostic Test | 27 responses | | valid response set |
| | | average initial reaction time | 19.6 seconds | adequate mental processing |
| | | 'W' dominant approach | | primarily percieves the entire inkblot and gives responses based on the whole |

| POST-INTERVENTION ASSESSMENT SCORES | | | | |
|---|---|---|---|---|
| S.No. | Assessments | Scores | | Interpretation |
| | | | | inkblot,and thus, has a holistic cognitive style, preferring to see the big picture rather than fixating on isolated elements. |
| | | approach sequence | D- Dd | focusing on the inkblot stimuli from a general to a specific level, thus, a well-organised individual who can first percieve the broader picture, then systematically focus down to finer details. |
| | | Methodical sequence of responding | | well-organised mind with sustained attention and deliberate problem solving, realistic perception and adaptive functioning. |
| | | F+% | 61.18% | adequate reality contact, adequate ego strength and adequate abstract ability |
| | | Zsum | 18.32 | psychological distress or impairment in the child and lower levels of flexibility in thinking |
| | | average ‘C’ (colour) responses | | adequate ability to experience the pleasurable aspects of life. |
| | | High ‘M’ (movement) responses | | good prognosis and being able to use internal resources to cope with difficult situations with proper intervention and help provided. |
| | | Afr | 0.42 | adequate expression of emotion |
| | | High ‘H’(human) responses | | good interpersonal relationship and empathetic |
| | | A% | 43.25 | adequate emotional regulation and intellectual |

| POST-INTERVENTION ASSESSMENT SCORES | | | | |
|---|---|---|---|---|
| **S.No.** | **Assessments** | **Scores** | | **Interpretation** |
| | | | | functioning |
| | | No ‘Hd’ (human detail) and less ‘An’ (animal) responses | | reduced somatic preoccupations |
| | | less ‘Mythological’ responses | | reduced hidden fear and worry thinking style |
| | | EB: M > Csum | | intratensive trend of personality, i.e. more introspective, controlled and emotionally stable. |
| | | Average ‘EA’ | | adequate coping ability |
| | | popular responses | 6 | adequate ability to conform to the social norms |
| | | lambda | 2.12 | adequate coping and adaptive ability leading to self perception, self esteem and self concept. |

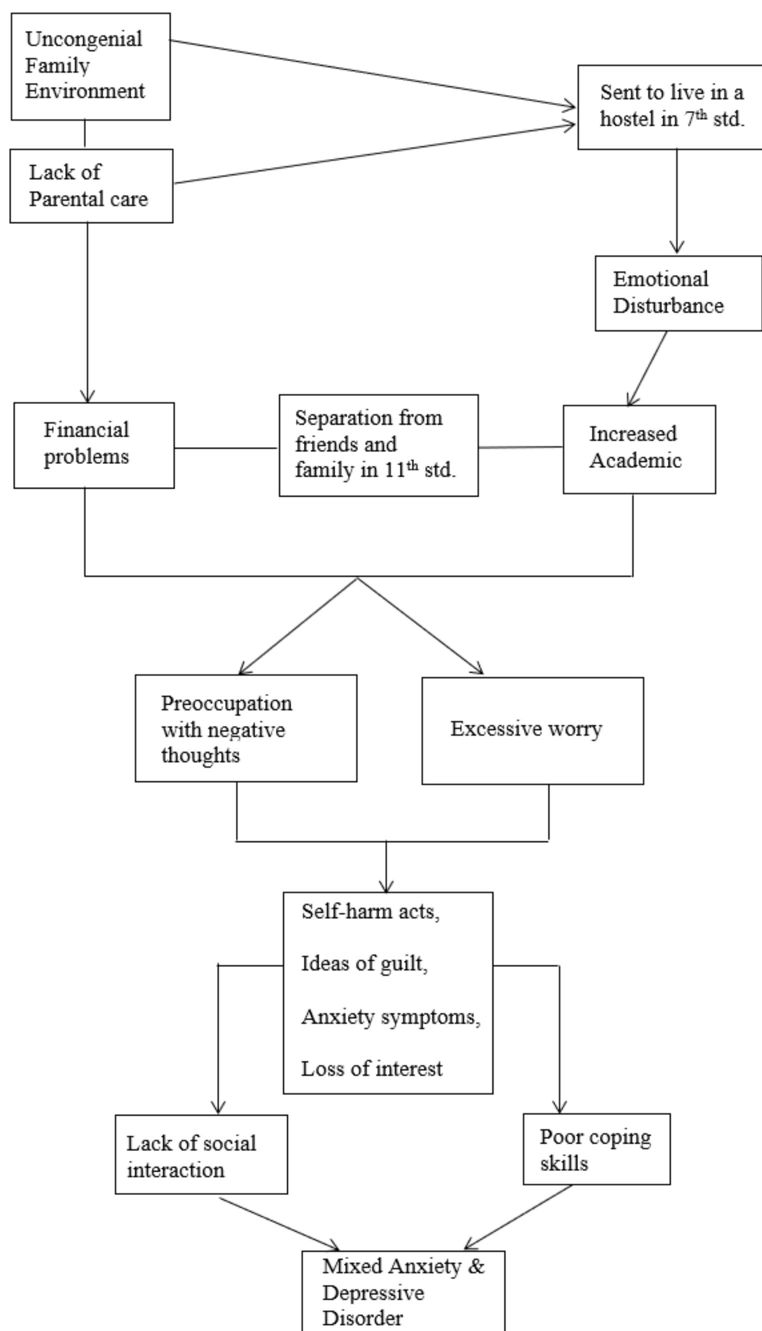
Table 2 presents the child’s post-intervention assessment scores. Following one month of DBT-based intervention targeting emotion regulation, distress tolerance, and interpersonal effectiveness, post-test assessments demonstrated a marked reduction in both anxiety and depressive symptoms. SSCT responses reflected increased clarity, goal-directed thinking, and improved interpersonal perspective. Rorschach findings also suggested greater affect modulation and decreased indicators of psychological distress.

## CLINICAL PSYCHOLOGY INTERVENTION

### DIALECTICAL BEHAVIOR THERAPY (DBT)

The primary aim of Dialectical Behavior Therapy (DBT) is to assist Childs in creating a fulfilling life. Originally, DBT is an extensive outpatient therapy composed of five key functions that facilitate this goal: (a) boosting the Child's motivation to alter problematic behaviors, (b) enhancing their skills, (c) applying new adaptive behaviors to relevant situations, (d) organizing the Child's surroundings to encourage these behaviors, and (e) increasing the motivation and skills of therapists. Fundamentally, DBT is a variant of cognitive-behavioral therapy (CBT). However, it was created to address the shortcomings of traditional CBT in treating patients with chronic suicidal tendencies and borderline personality disorder. This development gave rise to three key theoretical foundations that shape DBT: behavioral science, acceptance, and dialectical philosophy (Rizvi et al., 2024).
The index child was exposed to Dialectical Behavior Therapy. A baseline assessment on understanding the mood disturbances, suicidal patterns, locus of control, coping pattern, internal relationship problems, and child’s attitude toward oneself was done. Through- out the DBT sessions, the therapist recognized the child’s individual efforts, appreciated her strengths, and feedbacks were provided. Further, in DBT the child was provided warmth, advice, empowerment, and support.

## PSYCHOTHERAPEUTIC FORMULATION




## GOALS OF DIALECTICAL BEHAVIOR THERAPY

The primary goals of using Dialectical Behavior Therapy (DBT) for this patient are to reduce self-harming behaviors, manage overwhelming emotions, and enhance her ability to cope with distress without resorting to maladaptive strategies. DBT aims to improve her emotional regulation by helping her identify, understand, and manage negative thoughts and feelings, particularly those related to family trauma, low self-worth, and academic stress. The therapy also focuses on building healthier interpersonal skills to reduce isolation and improve her relationships. Additionally, DBT targets her distorted self-image and feelings of hopelessness, working toward creating a more stable, mindful, and balanced emotional state.

**DIALECTICAL BEHAVIOR THERAPY: Session by Session** *(Process of intervention)*

**Session I: Orientation, Psychoeducation and Commitment**

**Target:** *Establish therapeutic alliance and introduce DBT framework.*

The session began with building rapport using validation techniques to acknowledge the child's past emotional struggles and distress. The Dialectical Behavior Therapy model was introduced, explaining the biosocial theory - how emotional vulnerability and an invalidating environment have contributed to her condition. Therapy structure, duration, rules, and expectations were clearly outlined. Emphasis was placed on the hierarchy of treatment targets: life-threatening behaviors (e.g., self-harm), therapy-interfering behaviors, and quality-of-life issues. A therapy agreement was discussed and signed, involving both therapist and child commitment to the process. Therapy hesitancy was normalized and the importance of skill acquisition and emotional resilience were discussed. This foundation helped to prepare the child for the upcoming structured work while establishing a collaborative, safe space.

**Outcome:** Child becomes oriented to DBT and agrees to participate in the full course of therapy. Initial trust is built, and expectations are clarified.

**Session II: Chain Analysis and Diary Card Introduction**

**Target:** *Identify patterns in self-harming behavior and introduce self-monitoring.*

This session introduced the chain analysis technique to help the Child understand the sequence of events, thoughts, and emotions that led to self-harm. Using a past incident of wrist-cutting, the Child was guided to reconstruct the event: prompting questions such as "What happened before you felt the urge?" or "What thoughts came right before the act?" the links between vulnerabilities were highlighted (like poor sleep or academic stress), prompting events, interpretations, emotional responses, action urges, and consequences. Through this, the child was able to see self-harm as part of a predictable and modifiable chain. The Diary Card, a daily self-monitoring tool, was introduced to track urges, emotions, behaviors, and skills used. The therapist modeled how to fill it out, emphasizing consistency and honesty. A copy of the same and instructions for daily completion were given at the end of the session.

**Outcome:** Child begins recognizing behavior patterns and starts using the diary card daily. Awareness of emotional and behavioral links increases.

**Session III: Mindfulness Skills – "What" and "How" Skills**

**Target:** *Increase present-moment awareness and reduce overthinking.*

Mindfulness, a core DBT skill, was introduced emphasizing its importance in managing emotional instability and impulsivity. The Child learns the "What" skills: Observe (noticing experiences), Describe (labeling experiences with words), and Participate (fully engaging in the moment). The "How" skills include Nonjudgmentally (acknowledging without evaluation), One-Mindfully (focusing on one thing at a time), and Effectively (doing what works). Activities such as mindful breathing, body scans, and mindful observation exercises (e.g., observing a raisin or a leaf) were practiced in the session. The Child was encouraged to journal daily observations of her thoughts without judgment and was helped to relate these skills to real-life examples like overthinking after peer judgment or ruminating on family issues. Homework including mindfulness practice for 5 minutes daily and recording observations in a journal was given. These exercises were aimed to anchor the Child to the present and reduce mental spirals.

**Outcome:** Reduction in cognitive rumination and increased ability to stay grounded in the present moment.

**Session IV: Emotion Regulation – Understanding Emotions**
**Target:** *Develop insight into emotional patterns and functions.*
This session explored the role of emotions in daily functioning, especially in shaping behavior and influencing self-harming urges. The "Model for Describing Emotions" was introduced- prompting event, interpretation, physiological changes, action urges, and aftereffects. The Child was guided to identify recent strong emotional episodes and map them using this model. A distinction was made between primary emotions (immediate response) and secondary emotions (response to the initial emotion or its judgment). Psychoeducation was provided on how emotional avoidance and suppression can intensify distress. Emotional vulnerability factors such as sleep deprivation, chronic stress, and invalidation were discussed. The Child was asked to start keeping an emotion log, tracking intensity and triggers. Role-play helped the Child describe feelings using accurate language rather than vague terms like "bad" or "fine." The Child gained insight into how emotional buildup leads to impulsive behaviors, paving the way for more effective regulation strategies in future sessions.

**Outcome:** Child begins identifying triggers and starts developing language to describe emotional experiences.

**Session V: Distress Tolerance – Crisis Survival Skills (TIPP)**
**Target:** *Equip the Child with immediate coping skills during emotional crises.*
The session focused on teaching the TIPP skills- Temperature, Intense exercise, Paced breathing, and Paired muscle relaxation- as part of DBT's distress tolerance module. The therapist explained how these physiological interventions can rapidly change the body's arousal state during high distress. Each skill was practiced in session: cold-water splash or holding an ice cube to stimulate the dive reflex (Temperature), jumping jacks for 2 minutes (Intense Exercise), slow diaphragmatic breathing (Paced Breathing), and systematic muscle tightening and release (Paired Relaxation). The Child was encouraged to apply these skills at times of overwhelming emotions, such as after an argument or when experiencing intrusive thoughts. Practical examples were given for use in hostel or academic settings. Homework including identifying and recording distress episodes and applying one TIPP skill in each was given. The emphasis was made on how using these tools regularly can reduce the need for harmful coping strategies like self-injury.

**Outcome:** Child reports reduced intensity of distress during crisis moments and fewer urges to self-harm.

**Session VI: Emotion Regulation – Opposite Action**
**Target:** Modify maladaptive emotional responses by engaging in opposite behaviors.
The session began by reviewing the emotion log and identifying a specific emotion such as sadness or fear that frequently leads to social withdrawal or self-isolation. The Opposite Action skill was then introduced, which involves acting opposite to the action urge of an emotion when the emotion is unjustified or overly intense. An example was given of sadness that if it leads to isolating, the opposite action might be initiating a short conversation or participating in a group activity. Through role-play and guided visualization, the Child was helped to identify realistic scenarios where she can apply this skill. The Child was

encouraged to rate emotional intensity before and after the opposite action. Homework involving choosing one emotion each day and applying opposite action to reduce its hold was given. This session helped break the cycle of emotion-driven avoidance and introduced behavioral activation.

**Outcome:** Child begins resisting avoidance and starts engaging in minor positive behaviors even when feeling low.

**Session VII: Interpersonal Effectiveness – DEAR MAN**
**Target:** *Improve assertiveness and boundary-setting in relationships.*
This session focused on developing effective communication using the DEAR MAN acronym: Describe, Express, Assert, Reinforce, stay Mindful, Appear confident, and Negotiate. Each component was explained using examples from the Child's real-life situations such as feeling judged by hostel mates or wanting more clarity in communication with her parents. Through role-play, the Child practiced using DEAR MAN to assertively express her discomfort and request a change. The therapist modeled the skill and provided feedback on tone, body language, and clarity. Handouts were given to help structure conversations. The Child was encouraged to use DEAR MAN in a real interaction during the week and record the outcome. The session empowered the Child to express needs without aggression or passivity, thereby reducing interpersonal conflict and increasing self-respect.

**Outcome:** Child demonstrates improved ability to express feelings assertively and shows increased confidence in social settings.

**Session VIII: Distress Tolerance – Self-Soothing and ACCEPTS**
**Target:** *Reduce self-harming urges through healthy distraction and self-care.*
Two critical distress tolerance strategies were introduced, Self-Soothing and ACCEPTS. Self-Soothing involves using the five senses (vision, hearing, smell, taste, touch) to create comfort. The Child identified activities for each sense, such as listening to calming music or using scented oils. ACCEPTS stands for Activities, Contributing, Comparisons, Emotions, Pushing away, Thoughts, and Sensations- seven categories of distraction. The therapist worked with the Child to list options for each and integrate them into daily life. She was asked to create a "Soothing Box" or kit with personal items for times of distress. Guided imagery and sensory grounding exercises were practiced in session. Homework including using a minimum of one ACCEPTS skill and one self-soothing activity daily, especially during moments of emotional intensity was given. The therapist helped the Child reflect on how these skills can replace the urge to self-harm with healthier, safer alternatives.

**Outcome:** Child develops a personalized coping toolkit and reports decreased urge to harm herself.

**Session IX: Emotion Regulation – PLEASE Master**
**Target:** *Stabilize daily functioning by addressing physical vulnerability factors.*
The PLEASE Master skill was introduced to help the Child reduce emotional vulnerability by taking care of her physical health. The components- treat PhysicaL illness, balanced Eating, avoid mood-Altering substances, balanced Sleep, and get Exercise were discussed in detail. The Child shared her irregular sleep and eating habits, which are linked to mood fluctuations. Psychoeducation was provided on how biological imbalances increased emotional sensitivity. The therapist helped her design a realistic self-care routine, including

a sleep schedule, hydration reminders, and light physical activity like stretching or walking. The Child was encouraged to track her health habits and emotions side by side in her diary card. This session laid the foundation for holistic emotional regulation and connects mind-body well-being to emotional resilience.

**Outcome:** Child begins sleeping more regularly and experiences fewer physical complaints like headaches and body aches.

**Session X: Mindfulness – Wise Mind Integration**

**Target:** *Strengthen emotional and logical reasoning through Wise Mind.*

The session focused on integrating Wise Mind, the balanced state between Emotional Mind and Rational Mind. Metaphors and visual tools (e.g., Venn diagram and inner "wise self") were introduced to help the Child recognize when she is in one mind state over the other. Guided meditations and journaling exercises were used to facilitate connection with Wise Mind, especially during moments of self-criticism or impulsivity. The Child practiced reframing intrusive thoughts using Wise Mind responses, such as, "It's okay to feel sad, and I can still ask for help." She was encouraged to reflect in her diary card when Wise Mind helped make a decision. This practice helped in reducing black-and-white thinking and fostered emotional balance in overwhelming situations.

**Outcome:** Child develops more balanced perspectives on distressing thoughts and starts challenging self-critical beliefs.

**Session XI: Interpersonal Effectiveness – GIVE and FAST**

**Target:** *Enhance relationships and self-respect in communication.*

The session introduced GIVE and FAST skills to promote relationship health and self-respect. GIVE (Gentle, Interested, Validate, Easy manner) is used for maintaining relationships, while FAST (Fair, Apologies- only when needed, Stick to values, Truthful) supports self-respect. The Child applied GIVE to a hypothetical situation of talking to a roommate and FAST to an imagined conversation with her mother. Role-plays were used extensively, and feedback was given on tone, expression, and phrasing. The therapist helped the Child distinguish between assertiveness and aggression. Homework involving identifying one opportunity to use each skill set during the week was given. These strategies helped her build more respectful, validating relationships without compromising her self-worth.

**Outcome:** Child reports more clarity in expressing her needs and fewer conflicts in relationships.

**Session XII: Building a Life Worth Living**

**Target:** *Shift focus toward future goals and values.*

The therapist guided the Child through a structured values clarification exercise to identify what truly matters to her- education, friendships, personal growth. This led to short- and long-term goal setting. Tools like a "Life Compass," SMART goals, and vision boards were introduced. The Child reflected on how distress and avoidance have prevented her from living a life aligned with her values. She identified actionable steps, such as resuming participation in school events or reconnecting with old hobbies like painting or journaling. The therapist reinforced the DBT principle of working toward a meaningful life despite pain. Homework involved taking one small action each day that supports her values.

**Outcome:** Child starts regaining a sense of purpose and begins participating more in academic and creative activities.

**Session XIII: Managing Setbacks and Generalization**
**Target:** *Prepare the Child to handle future emotional setbacks independently.*
The therapist introduced relapse prevention planning, helping the Child identify personal warning signs of emotional dysregulation. Together, past setbacks were reviewed and analyzed which DBT skills were used or could have been applied more effectively. A worksheet helped map high-risk situations and appropriate coping strategies. Role-plays of possible future challenges (e.g., academic failure or family tension) allowed the Child to rehearse skills like TIPP, Wise Mind, or DEAR MAN. Emphasis was placed on flexibility and self-compassion when things go wrong. A skills toolbox was compiled, summarizing all core skills practiced. Homework involving anticipating one future challenge and planning a DBT-informed response was given. This session boosted the Child's autonomy and reduced fear of regression.

**Outcome:** Child demonstrates confidence in independently using DBT skills and shows reduced emotional reactivity.

**Session XIV: Termination and Consolidation**
**Target:** *Review progress and reinforce gains.*
In the final session, the therapist and Child reviewed the therapy journey, highlighting emotional, behavioral, and interpersonal changes. The diary card was used to reflect on changes in self-harm, mood regulation, and skill use. Gratitude journaling and reflective letters were incorporated to honor growth. The therapist validated the Child's progress and normalized feelings of anxiety around termination. A comprehensive relapse prevention and maintenance plan was prepared, and a folder containing DBT worksheets, a coping plan, and emergency contacts was given. The Child was encouraged to continue daily mindfulness, skills practice, and goal tracking. The session ended with a closure ritual such as sharing affirmations or setting a future check-in date. The Child left therapy with a reinforced sense of agency and tools to maintain well-being.

**Outcome:** Child feels empowered, shows emotional stability, and is prepared to apply skills outside of therapy.

## INTERVENTION DISCUSSION

The 14-session DBT intervention provided a holistic, skills-based framework to address the Child's mixed anxiety and depressive symptoms, self-harm, emotional dysregulation, and interpersonal difficulties. Early sessions focused on mindfulness and distress tolerance, which are core mechanisms by which DBT produces change. Meta-analytic evidence highlights that DBT significantly reduces self-directed violence ($d = -0.324$) and diminishes suicidal ideation in adolescents and adults. These findings align with our Child's marked reduction in self-harm urges after learning techniques like TIPP and ACCEPTS (DeCou et al., 2018).

The emotion regulation and interpersonal effectiveness modules dovetailed with the Child's clinical presentation- ongoing overthinking, low self-worth, social withdrawal, and dysfunctional family dynamics. DBT's focus on emotion labeling and Opposite Action targets emotional avoidance and impulsivity- common features of anxiety and depressive

disorders. The therapeutic outcomes in DBT-adapted programs for generalized anxiety disorder (GAD) support improvements in emotion regulation, attention flexibility, and quality of life, reflecting changes observed in our Child's SSCT and BAI/BDI scores post-intervention.

DBT's structured skills-training approach has now been empirically validated in non-borderline samples. One randomized pilot for GAD showed DBT's superiority over CBT in enhancing executive functioning and symptom reduction. Similarly, DBT group programs for emotional dysregulation in adolescents and adults have demonstrated significant decreases in depressive and anxiety symptoms. These outcomes parallel our Child's improved sleep, reduced somatic complaints, better emotional control, and fewer interpersonal conflicts after skills like PLEASE, DEAR MAN, GIVE, and FAST were introduced (Afshari et al., 2022).

The comprehensive skill set built throughout the intervention including mindfulness, distress tolerance, emotional insight, assertiveness, and values-driven living, countered her chronic invalidation and emotional entrapment stemming from childhood trauma. DBT offered a balance of acceptance and change strategies: she learned to accept her emotions while developing adaptive responses. This dialectical stance actively addressed her self-worth issues and feelings of hopelessness, resonating with core DBT principles and Linehan's biosocial theory (Fassbinder et al., 2016).

The termination sessions, with relapse prevention planning, reinforced long-term resilience. The skill-focused approach and continued diary card use mirror outcomes shown treatment-by-experts trials, where DBT reduced relapse frequency and hospitalization through 1-year follow-up. By integrating a variety of emotional and behavioral tools, DBT equipped the Child with a sustainable self-management system, transcending the immediate therapeutic environment into her daily life (Jobes & Rizvi, 2024).

Post-intervention assessment results indicated significant improvement:

- Reduction in BAI and BDI scores resulting in decreased severity of anxiety and depression.
- Reduction in SSCT scores showing enhanced coping abilities for family, sex, interpersonal relations and self discomfort and disturbance.
- Improvements were observed in Rorschach Psychodiagnostic Test showing better coping abilities, emotion regulation, adequate reasoning ability and reduced factors of psychological distress.

Overall, the intervention demonstrates that DBT's modular structure is not only appropriate but effective for adolescents with mixed anxiety and depressive disorders, especially when self-harm and emotional dysregulation are present. The evidence-based support for adaptable deployment of DBT skills in anxiety/depression, trauma, and non-borderline populations enhances confidence in its clinical utility. Future research should further examine DBT's longitudinal impact in such diagnostic groups, particularly in non-Western contexts where family dynamics and social stigma intersect.

## CONCLUSION

Clinical psychology treatments for mixed anxiety and depressive disorder involve various strategies designed to facilitate recovery. These approaches center on the person's beliefs,

emotions, and behaviors, while also taking into account the larger social environment, such as family relationships and community resources. An integrated method that addresses both personal and contextual factors is crucial for achieving lasting recovery and enhancing overall quality of life.

***Future Plan***

1. Encourage and support medication adherence.
2. Ensure regular follow-up appointments to monitor progress.
3. Engage and motivate family members to actively support the patient, particularly during high-risk periods for relapse.
4. Implement strategies to prevent further relapses and maintain long-term recovery.

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***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:*** Bhatia, M. & Turi, R.K. (2025). Effectiveness of Dialectical Behavior Therapy in a Case of Mixed Anxiety and Depressive Disorder: A Case Study. *International Journal of Indian Psychology*, *13*(3)*,* 021-039. DIP:18.01.003.20251303, DOI:10.25215/1303.003