Efficacy of Cognitive Behaviour Therapy for a Moderately Depressed Client: A Clinical Case Study

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Abstract- The case study illustrates the management of a young female, referred to as "Amrita", who presented with features of depression along with death wishes and decline in her personal, social and occupational performance. Assessments through Beck Depression Inventory (BDI) and Hamilton Depression Rating Scale (HAM-D) revealed features of moderate level of depressive features. Nine sessions of Cognitive-Behavioral Therapy (CBT) was conducted including one follow up session. Amrita's progress throughout the treatment sessions is illustrated in detail in the following case study report. Results corroborate to the previous studies of efficacy of CBT for use with depression. The purpose of the therapy was exploration and resolution of the maladaptive thoughts, feelings and behaviour for a greater sense of autonomy, well being; achieving higher levels of functioning and problem-solving along with developing insight and personality growth. The purpose of the case study report was also exploration of the reasons for discontinuation for the booster sessions.

Index Terms- depression, Cognitive Behaviour Therapy, Beck Depression Inventory (BDI), Hamilton Depression Rating Scale (HAM-D)

I. INTRODUCTION

Depression is thought to be as common as common cough and cold. Depression, a psychological disorder, is a sustained emotional state rather than a temporary, mild mood state. It is an assemblage of experiences of mood, physical functioning, quality of thinking, outlook and behaviours. In contrast to the normal emotional responses to unwanted and stressful events, clinical depression is a mental disorder which, due to its severity, its tendency to recur and its high cost for the individual and for the society, is a medically significant condition that needs to be diagnosed and properly treated. Depressed mood can be differentiated from the other non-morbid emotional reaction of sadness by its intensity, depth, its impact on individual's personal, social and occupational life and its duration.

The clinical features of Depression is illustrated as follows:

Box :1 Depressive Episode: Diagnosis and Clinical Features:

At least two of the following should be present for a minimum 2 weeks:
1. Depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost everyday, largely uninfluenced by circumstances.
2. Loss of interest or pleasure in activities that are normally pleasurable
3. Decreased energy or increased fatigability
B. Additional symptoms, two or more of the following:
1. Loss of confidence and self-esteem
2. Self-reproach or excessive and inappropriate guilt
3. Recurrent thoughts of death or suicide, or any suicidal behavior
4. Diminished ability to think or concentrate
5. Change in psychomotor activity (agitation or retardation)
6. Sleep disturbances
7. Change in appetite with corresponding weight change

References: Adapted from ICD-10: World Health Organisation. The ICD–10 Classification of Mental and Behavioural Disorders. Geneva: WHO, 1992

The diagnosis of depression is based on a set of specific signs and symptoms. (World Health Organization,1992). (Box 1). A clinician needs to have adequate knowledge, skills and expertise to elicit these symptoms. The common symptoms of depression are:

a. a persistently depressed mood;

b. a loss of interest in activities which were earlier considered as pleasurable; and

c. easy fatigability.

Table :1: Chart showing the common symptoms of depression

COGNITIVE	AFFECTIVE	CONATIVE	PHYSIOLOGICAL
"I am a failure" *"I am worthless"* *"its my fault"* *"nothing good happens to me"* *"life is not worth living"*	*Sadness/tearful* *Anxiety* *Irritable* *Frustrated* *Guilt* *Overwhelmed* *Indecisive* *Miserable* *Disappointment*	*Unable to concentrate* *Stopped going out* *Withdrawn from family and friends* *Not participating in previously liked activities* *Relying on alcohol or other substances*	*Tiredness* *Fatigue* *Headache and other muscle pain* *Sleep disturbance* *Loss of appetite/weight gain/loss*

Prevalence studies

Several studies were conducted on the prevalence rates of depression. A study done by Bromet, Andrade, Hwang , Sampson , Alonso , de Girolamo (2011), revealed a lifetime prevalence of depression in about 10-15% of cases and at least 5% as yearly prevalence rate of depression (Murphy et al.,2000) . Another recent large sample survey revealed overall prevalence in Indian context was found to be 15.9% (Poongothai, Pradeepa, Ganesan, Mohan, 2009) indicating an increase in prevalence of depression over few decades (Nandi, Banerjee, Mukherjee, Ghosh, Nandi, and Nandi, 2000) in India also about 21-84% of primary health care settings in India (Pothen, et al.,2003 ;Amin, Shah, and Vankar,1998). Derasari and Shah,(1988) also pointed out that in Indian patients there is a high prevalence of physical and somatic symptoms than in western population. Atleast 50% of individuals having the diagnosis of depression committed suicide indicating a high risk of suicide in depression. (Reddy,2010). Nolen-Hoeksema (1990), conducted a large population-based study in Chennai and found that the prevalence of depression was almost 15.1% among south Indians. A study by Poongothai, Pradeepa, Ganesan, and Mohan, (2009) revealed prevalence of depression was mostly observed to be higher in the low income group and in those with lower level of education compared to those who were better educated. Another study done in Bangalore by Hussain, Creed and Thompson (2000), found that, among young adults attending college, men were found to be more depressed (25%) than women (18%). In the WHO study done in primary care centers by Goldberg and Lecrubier(1995), found that atleast 9.1% of the individuals in Bangalore city was affected with depression.In 1992 in Illinois in USA (Mirowsky and Ross,1992), it was reported that depression reached its lowest level in the middle age at about the age of 45, with a rise in later life [>80 years], reflecting life cycle gains and losses related to marriage, employment and economic well being as the possible causes. Poongothai, Pradeepa, Ganesan, and Mohan, (2009) also cited that major depressive disorder mostly is common among people who does not have close interpersonal relationships, and/ or individuals who are divorced or separated.

Results of previous studies show that depression may last for about 6 months to 1 year without treatment and with treatment, remission occurs within few weeks. However, depression can recur within 5 years and atleast two-thirds of the population suffer from chronic depression (Sadock and Sadock,2007; Remick,2002)

Comorbidity

Major depression frequently co-occurs with other psychiatric problems. According to the 1990–92 National Comorbidity Survey (US) atleast 51% of those with major depression also suffer from lifetime anxiety, and individuals diagnosed with ADHD might develop comorbid depression.(Kessler, Nelson, McGonagle, Liu, Swartz, Blazer 1996).According to a study done by The National Institute of Mental Health (NIMH),(2008), it was suggested that there is a high risk of having alcohol abuse or dependence, panic disorder, obsessive compulsive disorder (OCD), social anxiety disorder and other Axis I disorders as comorbid disorders of depression (Grant,1995).

Theoritical Perspectives:

No single cause can explain the etiological factors for depression. The different schools of thought have explained depression in the following way:

A. **Biological—**

Both heredity and environment has their respective roles to play in causing depression. The Biological theorists explain that depression, unipolar and/or bipolar can be result of a vulnerability or having a predisposition to mood disorder. Findings as obtained from different twin studies and family studies suggested that this vulnerability could be

"polygenetically transmitted". (Harrington,1993). Results from these studies showed a biological vulnerability to dysregulation of the amine system, (Deakin,1986) dysregulation of the endocrine system,(Deakin,1986) dysregulation in the immune system,(Levy and Heiden,1991) dysregulation of the circadian rhythm (Kupfer and Reynolds,1992) and/or seasonal occurrence of depression (Wehr and Rosenthal, 1989), could be inherited factors which can be explained as possible causes for mood disorder.(Carr,1999).

B.Psychological Theories:

According to the Family system model the cause does not lie not within the individual but within the structure and functioning of the family as a system. Depression can result when there is a misbalance in the structure and function of the family which might prevent the individual from performing "age-appropriate developmental tasks". Extreme parental criticism, overprotection, selectively focussing only on the failures than the success might affect the individual's self esteem leading to depression.Also enmeshed relationship among the family members can also cause an hindrance to the proper development of a sense of individuation.(Carr,1991)

From Freud's Psychoanalytic perspective, depression can be explained as anger turned inward, towards the self. When an actual or perceived loss of a loved object or a caregiver occurs, the anger is directed as a part of the self which represent the lost object.(Carr,1999)

Bibring's low self-esteem theory says that often individuals form an unrealistic ideal self on the basis of internalizations of early parental sanctions which were probably highly critical or perfectionistic. As a result a perceived gap between the actual self and the ideal self develops leading to low self-esteem, which in turn can lead to depression.(Blatt and Zuroff,1992).

Blatt's attachment and autonomy theory explains that at times neglecting parenting, overindulgent parenting, critical and punitive parenting can lead a loss of sense of autonomy in the individual. Also loss of attachment relationships can sometimes lead to depression. (Blatt and Zuroff,1992)

Lewinson's behavioural theory explains that depressed people also might lack the necessary social skills for maintaining a "rewarding interactions" from others. They make efforts to avoid situations where they perceive that they might receive "response contingent positive reinforcement (RCPR)" (Lewinsohn et al., 1990)

Reformulated Learned helplessness theory explains that repeated failures of an individual, to effectively deal with the perceived or actual aversive stimuli can lead him to attribute to him/herself as responsible for these failures and unstable attributions to the external factors for success.(Seligman,1981)

As explained by Beck's cognitive theory—early negative learning experiences help in formation of negative assumptions regarding self, world and future. These negative schemas when activated gives rise to negative automatic thoughts and cognitive distortions which maintain the depressed mood.(Beck,1976; Williams,1992; Carr,1999).

Psychotherapeutic Treatment Approach

Earlier studies suggest CBT can be considered as the "first-line psychosocial treatment of choice, at least for patients with anxiety and depressive disorders". (Tolin,2010) A study by Whitfield and Williams (2003), also revealed "extensive evidence for the effectiveness of CBT for depression". "CBT in the treatment of depression is one of the therapeutic modalities with the highest empirical evidence of efficacy, whether applied alone or in combination with pharmacotherapy" (Powell, Abreu, Oliveira and Sudak,2008). Also previous case studies on the use and efficacy of CBT on first onset depression and dysthymia can also be cited here. (Thomas and Drake, 2012).

Going in the same line with the previous studies CBT was chosen to be the treatment approach for the present case of Amrita.

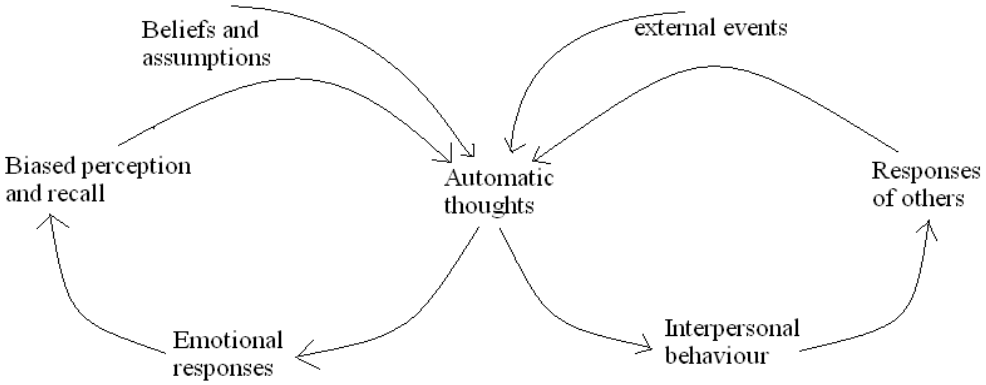
Cognitive Behaviour Therapy (CBT) is an amalgamation of Behavior Therapy with Cognitive Therapy, focusing primarily on the "here and now" principle. The National Institute for Health and Clinical Excellence recommends CBT as the "treatment of choice for a number of mental health problems, including post-traumatic stress disorder, OCD, bulimia nervosa, and clinical depression.."(Driessen, Hollon and Steven 2010). The approach that is followed is "Collaborative Empiricism" or in other words building trust in the client. It is an active learning process, based on open-ended questioning and is highly structured and focused therapy. (Kazantzis, Beck, Dattilio, Dobson, and Rapee 2013).

Cognitive behavior therapy follows a straightforward common sense model stressing on the inter relationship among cognition, emotion and behavior.CBT can be divided into three basic tenets that is Cognitive principle (interpretations or meanings that one draws from the situations) ,Behavioural principle (the actions or the overt behaviours that one does which in turn are highly influenced by thoughts and emotions and vice versa) and the Continuum principle – (mental health problems can be best hypothesized as "exaggerations of normal processes"). (Westbrook, 2011).

Basic Concepts

Automatic thoughts comprise one of the basic premises of CBT. It silhouettes the emotions and actions of an individual in response to any situation. They are immediate, automatic, spontaneous in nature.The perceptions and meanings that one draws from the events are largely prejudiced by the "beliefs, assumptions and schemas" of the individual. The cognitive distortions or logical errors in cognition are highly responsible for formation of flawed deductions. (Beck, 1976) . Cognitive distortions are more accessible in automatic thoughts and are responsible for maintaining the distress that an individual experiences. Common examples of cognitive distortions are dichotomous thinking, overgeneralization, selective abstraction, arbitrary inference etc. (Hawton, Salkovskis, Kirk, and Clark, 2001)

Figure I: Figure showing the role of cognition in psychopathology



Reference: Freeman, Pretzer, Fleming and Simon, 1990.

From the above figure it can be assumed that any individual is susceptible to formation of any kind of dysfunctional beliefs or assumptions regarding self, the world or the future. However, this assumption remains dormant until a situation arises which might activate these dormant negative assumptions. Here the cognitive distortions play a crucial role in contributing to the emergence of negative automatic thoughts. A perpetuating cycle often builds up including the automatic thoughts, cognitive distortions along with the prevalent mood state. Depending upon the content of these automatic thoughts, the dysfunctional automatic thoughts elicit a corresponding mood. This mood again tends to biases most of the past memories and perceptions in a way that the individual experiences some "additional dysfunctional automatic thoughts, intensifying her/his mood". This again tends to bias further memories and perceptions and continues as a vicious cycle. Hence to summarize, cognition plays a crucial role in this vicious cycle and so this cognition is targeted in the intervention.(Freeman, Pretzer, Fleming and Simon, 1990).

Case History

Amrita V, is a 25 year old female, single, a fashion designer by profession, working in a leading multinational company for almost 6 months. She is the second daughter of her parents of a middle class Malayalam joint family in Cochin. She came to Bangalore 6 years ago to study fashion technology and currently was staying as a paying guest in Bangalore. Amrita came with the chief complaints of lonely feeling, fatigue, sadness, feeling like crying all the time, lack of pleasure in everything and feeling that nobody understands her, for last 6 months, with unknown precipitating factor, onset being insidious, continuous course and deteriorating progress.

Family history revealed depression and suicidal attempts of her elder sister who is currently under medication. Educational history revealed, Amrita was an above average performer in her studies and had few friends in school and college. Her parents wanted her to study B.Com but she wanted to study Fashion Technology. Her parents were not happy with her preference for studying fashion technology, as according to them that was not a "good" profession for a "girl" to choose. However, with much difficulty and heated exchanges between her parents and her, Amrita convinced her parents and shifted to Bangalore 6 years back (in 2007) to pursue her studies in fashion technology. Her occupational history revels that Amrita got her first job in Chennai where she worked for 2 months and then she shifted to Bangalore and worked in a leading company for 2 years. However, she was not satisfied with her work profile. As reported by her, Amrita started feeling depressed and had difficulty to concentrate in her work and other daily activities. She used to cry often and felt lonely. She finally decided to resign and observed that her condition improved gradually within few weeks in 2012. Amrita got the present job, 6 months back in a leading fashion organization and was happy with her profile. However, she observed that she was not able to "connect" with her present colleagues and/or other people. She felt lonely often, cried often, and also felt, that she was not capable of doing anything. Amrita's premorbid personality revealed that she was shy yet responsible, motivated and had social relationships with friends and family. However, she had a distant relationship with her parents, as according to Amrita, her parents were very "dominating" and they always wanted to take all the decisions of her life. The relationship became more distant with her parents when she chose to shift to Bangalore for studying fashion technology instead of what her father wanted her to study.

Mental Status Examination (MSE) revealed appearance being well kempt and tidy, eye contact maintained, rapport could be easily established as attitude towards the examiner was cooperative, speech was spontaneous, relevant, coherent and goal directed. Cognitive functions revealed, attention could be easily aroused and sustained for an appreciable period of time, subjective and objective affect was depressed. Thought content revealed death wishes, helplessness and worthlessness with Grade VI (emotional insight) level of insight. Based on the chief complaints and Mental Status Examination, the provisional diagnosis of Moderate Depressive Episode with Somatic Syndrome (F32.11) was given (World Health Organization,1992).

Investigations and Assessments

Amrita first consulted the Psychiatrist for help, who referred her to a psychologist for psychotherapy. She was not given any medicines. Initially for the baseline assessment, Beck Depression Inventory (BDI) and Hamilton Depression Rating Scale (HAM-D) was given to Amrita. In both BDI and HAM-D the scores were in the moderate category. The Negative Automatic Thought (NAT) rating scale was also given for assessing the level of severity of her negative automatic thoughts. The score was found to be in the above average range.

Therapeutic program

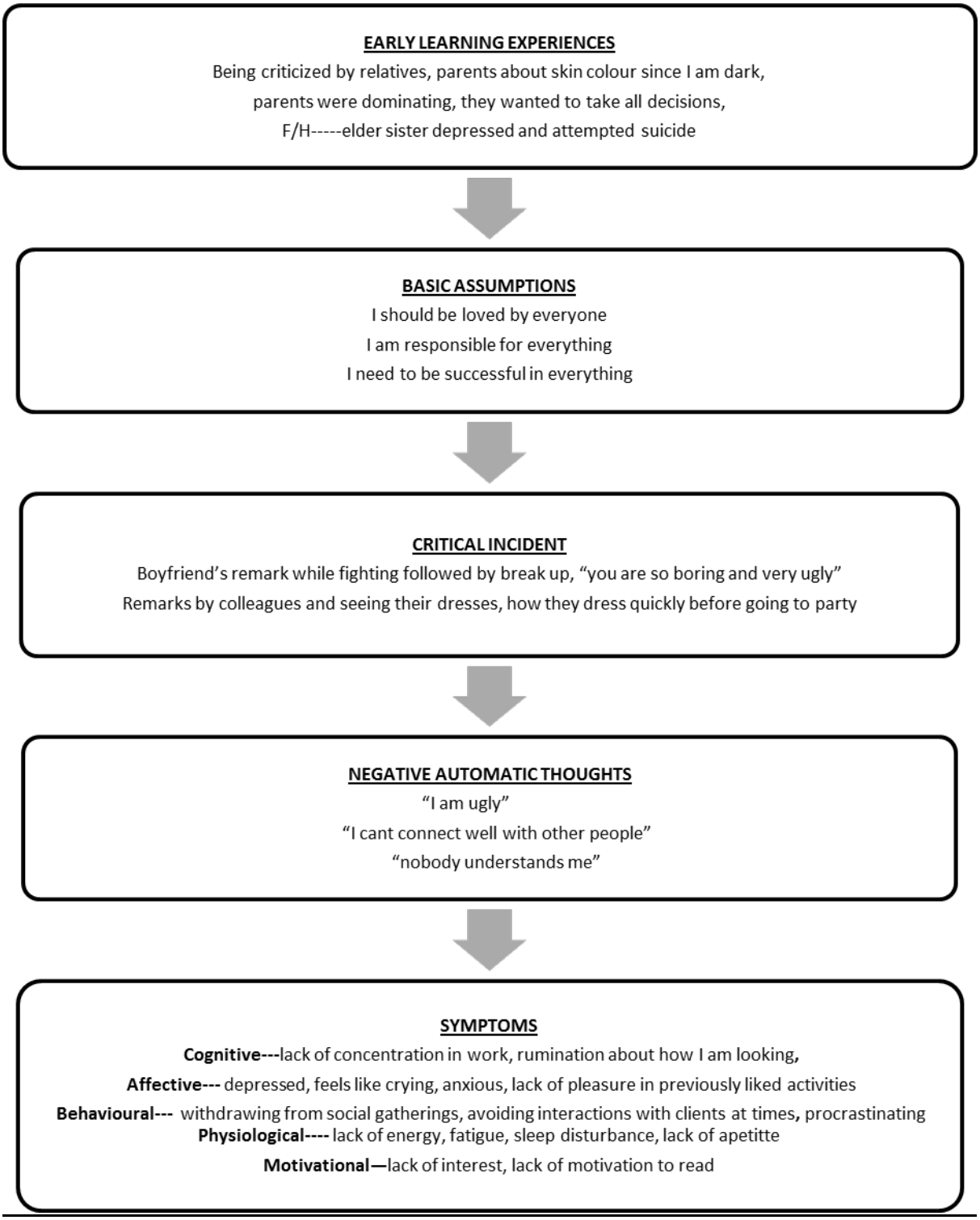
Cognitive Behaviour Therapy (CBT) was followed for Amrita. As mentioned earlier, that research shows the effectiveness of CBT in treatment of depression. The total number of session conducted were 9 with one hour duration of the sessions, once a week.

The goals of therapy were, to help Amrita in counteracting the negative cognitive biases, and develop a more balanced view of herself, the world, and the future. Target was also to restore the activity levels, by engaging her actively, as she mentioned that she had lost interest in previously liked activities of pleasure or achievement and help her in problem solving and decision making. The first task was to prepare a problem list and prioritise according to the severity, intensity and duration of the symptoms. Then it was to be followed by introducing the cognitive model and how the thoughts, feelings and behaviours are interconnected. The behavioural techniques were to be used for reducing of the symptom severity and then followed by the cognitive techniques. Further, the Thought diary for identifying and challenging the Negative Automatic Thoughts and followed by relapse prevention to be followed.

Psychopathology Formulation:

Based on the case history, MSE and self-reports of Amrita, the psychopathology formulation was done which is illustrated as follows—

Figure 2: Figure showing the Psychopathology Formulation:



Reference: Based on Beck's Cognitive Model of Depression.(Beck,1967,1976).

Initial phase---

A visual analogue scale ranging from 0 to 10 (with 0 indicating minimum distress and 10 indicating maximum distress) was used to assess the subjective level of distress of Amrita. This was used in every session, in order to obtain an idea regarding Amrita's affective condition. In the initial sessions, the presenting complaints were reviewed, and the goal of the therapy were discussed, along with psycho-education regarding the nature of complaints, the source and course of the symptoms and its various manifestations. An overview of psychotherapy was presented, and the focus of therapy was explained. Also, the

nature of the sessions and the basic structure of sessions were discussed.

Amrita reported that she was unable to concentrate in her work as she tends to spend most of the day in ruminating about the distressing incidents. In order to cope with that, initially some distraction techniques like focussing on an object, sensory awareness, mental exercises and counting thoughts were briefed to Amrita. It was also briefed that these might act as a temporary way of distracting herself from thinking repeatedly about the incidents which were leading to increased distress rather than focussing on problem-solving. (Hawton, Salkovskis, Kirk, and Clark, 2001)

Amrita also reported that, since she spent most of her time in ruminating about the past and other distressing situations, she was having difficulty in engaging herself into any constructive work. As a result her performance in her work was also deteriorating day by day. Certain behavioural strategies were used in order to engage Amrita into some "mood-elevating" activities. This in turn would be helpful in challenging the negative automatic thoughts which in turn are forming as major obstacle in her engagement top any productive work. Amrita was asked to follow activity scheduling and mastery pleasure rating along with graded task assignment as homework. As a part of feedback in the following sessions, Amrita reported that these homework assignments helped her throughout the week to engage in something productive rather than simply sitting and ruminating about what happened. She also reported that she has improved a lot from before which was also depicted from the reassessments done and her subjective level of distress rating.
Amrita expressed great happiness, and said that she felt almost fully cured. She was also praised at work for improvement in quality and was extremely happy.

Middle phase---

Since Amrita's condition improved from before, now the treatment sessions and homework assignments were directed towards teaching her to identify, question and test the negative automatic thoughts which form the core of cognitive therapy. This is also used to reduce the symptoms specific to the individual and later to help to cope with the distressing situations and engage in more constructive problem-solving.(Hawton, Salkovskis, Kirk, and Clark, 2001)

Amrita was explained how the negative automatic thoughts are a result of errors in processing of information. She was also briefed about how the perceptions and interpretation of the events, situations or experiences are distorted. Some of the cognitive distortions of Amrita, that were identified were overgeneralization, selective abstraction, personalization, dichotomous reasoning and arbitrary inference.(Hawton, Salkovskis, Kirk, and Clark, 2001)

The continuing relationship between thought, emotion, physiology and behavior was discussed with her. Examples were generated from her own experiences, to strengthen the understanding of the cycle.

This was followed by the introduction of the Dysfunctional Thought Record through homework, in order to help her in eliciting the Negative Automatic Thoughts (NATs) which might be causing the particular emotion and/or behaviour in her.(Hawton, Salkovskis, Kirk, and Clark, 2001)

Initially Amrita had difficulty in identifying the thoughts and differentiating them with her feelings. She could initially only identify the feelings and situations rather than the thoughts. However, she was helped during the therapy sessions. Guided discovery and Socratic questioning were followed in order to identify and challenge the negative automatic thoughts. (Hawton, Salkovskis, Kirk, and Clark, 2001) She was then able to identify herself and also was able to write the alternative thoughts for the negative thoughts.

Terminal phase of therapy----

In the terminal phase of the therapy, the reduction for the risk of relapse (De Maat, Dekker, Schoevers, & De Jonghe, 2006; Cuijpers et al., 2011a; Spielmans, Berman, & Usitalo, 2011) was aimed. CBT is also thought to be decreasing the vulnerability to future episodes by undermining the underlying assumptions on which depressive thoughts are based.

Identifying dysfunctional assumptions –

Amrita was in the stage of skilfully identifying and challenging the negative automatic thoughts so the focus of therapy was now shifted to dealing with the underlying dysfunctional assumptions. She was able to identify that whatever thoughts she was having are not reality and reported that " *I realized that there is something wrong in my thinking like this*". Downward arrow technique (Hawton, Salkovskis, Kirk, and Clark, 2001) was used to identify her dysfunctional assumptions as *" I should be loved and liked by everyone" , "I need to succeed in everything" and " I should be strong" etc.* This identification made her realize the reason behind avoiding people, as she feared rejection from people. She was always striving towards meeting other people's expectations and also fear of failure and criticisms.

Challenging the dysfunctional assumptions was done by questioning and some behavioural experiments. According to Amrita the dysfunctional assumptions that were identified were not much helpful and illogical in nature. These were making her more sad and depressed and she is the one who is "suffering". Further questioning revealed that, these assumptions mostly came from her experiences in childhood where she was constantly "taught" to please others by "behaving properly". She also remembered, that in order to please others and be accepted by others she needs to be "fair" and "have an "attractive body built", which according to her family members she did not have. She was criticised for her "darker skin tone" and a "slim body built".She was oten compared with her cousins and friends and was often told that she might not get a good groom if she does not have the "appropriate body and skin". In order to challenge the assumptions Amrita was asked to formulate an alternative for these assumptions and write on flash cards for reading it repeatedly until acting in accordance with the alternative assumptions become as a habit for her.Also behavioural experiments were given as homework assignments, like, to gather information about other people's standards, observing what other people do and acting against assumptions and observing the consequences and testing out e new rule in action. (Hawton, Salkovskis, Kirk, and Clark, 2001)

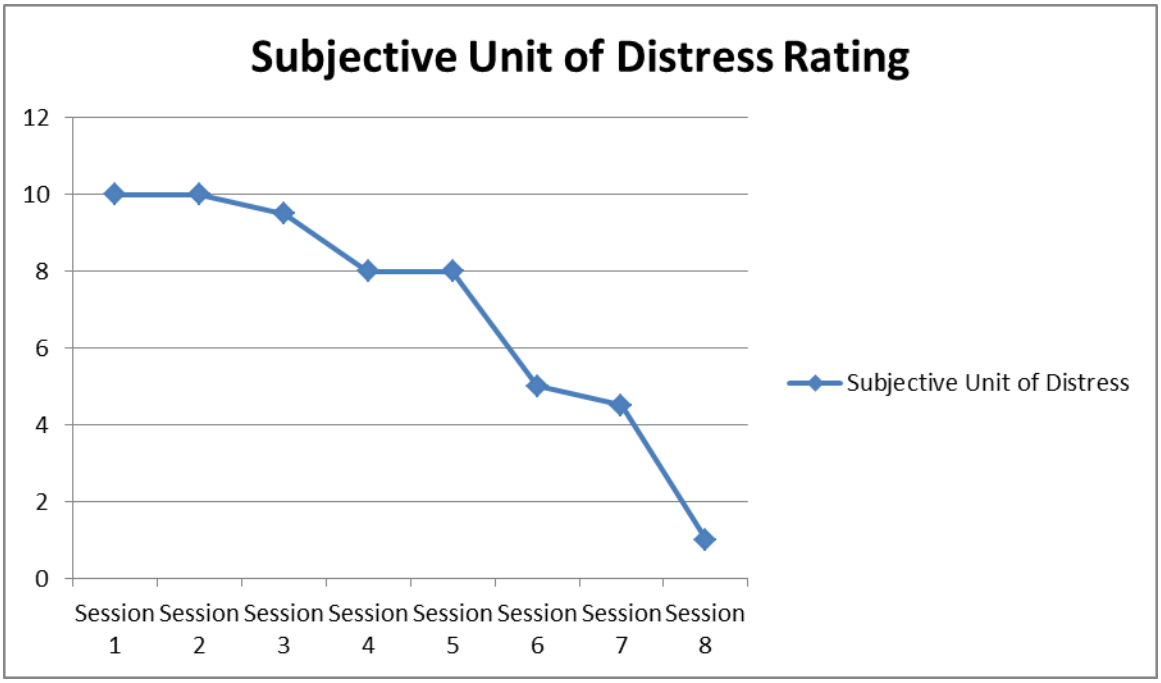
Reassessments corroborated with the reports of Amrita that she was feeling "better" and "good" She also said that she was

confident now to deal with the situations which she was finding it difficult before. She wanted to discontinue the therapy. However, she was reminded of follow up sessions and not to terminate the therapy abruptly. Though she agreed to turn up for the follow up sessions but did not turn up for them later, except for one follow up session.

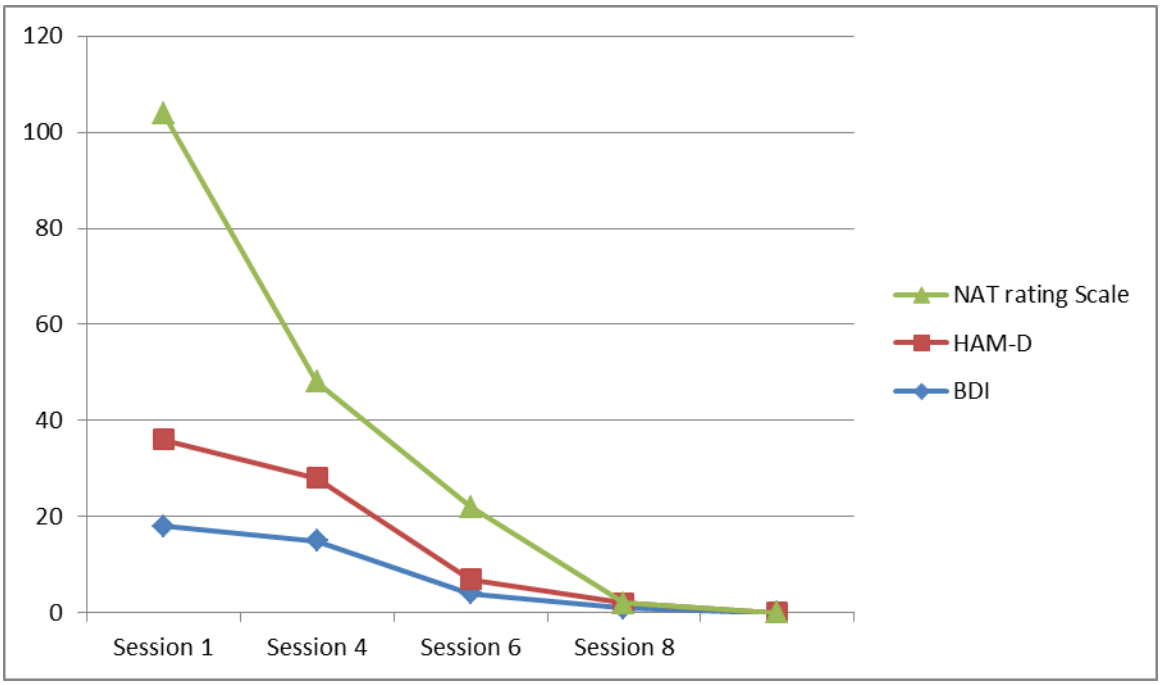
Outcome

The ratings given subjectively by Amrita, in each session, has been graphically represented below, to identify the alterations in the affect and experience of distress. The following graph represents the same:

Graph I: graphical representation of improvement of the client as assessed by visual anologue scale:



Graph II: Graphical representation of improvement through sessions as assessed by BDI, HAM-D and NAT rating Scale:



Therapist's Reflections

To reflect from a therapist's point of view, Amrita's level of insight and motivation was a great advantage; this evidently, is what brought her back to each session, in spite of her unsteady emotional states. Amrita also had the ability to identify & describe her negative thoughts vividly. With the progression of the therapy sessions, the awareness of her own negative emotions and thoughts was evident from the Dysfunctional Thought Record. She was also able to differentiate between her emotions and thoughts easily after a little support from the therapist.

Amrita's insight into her automatic thoughts, her ability to identify and distinguish her emotions from these thoughts along with her understanding regarding the use of her avoidance behaviour to cope with the situations, could be said to be the key features that helped in her progress. Her ability to focus and her optimism, about the outcome of the therapy truly helped in improvement in her condition. Her acceptance, that she must take the responsibility for change was evident in her verbal reports and her behaviour. She actively participated in the therapy sessions and her commitment could be inferred from the way she followed every single technique and completed her homework assignments. This also corroborates with the findings of a study done by Renaud, Russell and Myhr (2014), saying that a greater reduction in the illness symptoms was highly associated with clients having a greater capacity for participation in CBT. Also those patients who have the greater capacity to identify and articulate their thoughts and feelings and to share them in a "nondefensive, focused way" benefit most from CBT. (Renaud, Russell and Myhr,2014).

The therapeutic relationship or the bond that was formed could be said to have had its impact on her engagement in her tasks and be focussed on the therapeutic goals. These also might have enabled her to feel "safe" with the therapist.The trust that she had with the therapist was often verbalized by her-*" I am speaking to my heart's content after a long time…" "I am also not close to anybody in my family with whom I can talk or discuss.."*

The empathy from the therapist's side, also might have played its role in the improvement of her condition, corroborating with the findings of a study done by Burns and Nolen-Hoeksema (1992). The study stated that therapeutic empathy and homework compliance especially structured by experienced therapists had a moderate-to-large causal effect on recovery from depression (aged 18–75 years) treated with cognitive-behavioural therapy (CBT). The therapeutic alliance is also a significant factor with significant influence on outcome.(Krupnick, Sotsky, Simmens, Moyer, Elkin, Watkins, and Pilkonis, (1996).

If reflected on the first two sessions Amrita had weeping spells. However, in the third session she did not cry. However, by that time, no formal introduction of cognitive restructuring was done. This betterment in her condition in such an early stage of the therapy, might be explained in the following way. As inferred from the findings of previous studies, that many "nonspecific" factors like treatment rationale and the assignment of homework, play a significant role in ameliorating the patient's negative feelings, especially hopelessness, in the initial phase of the treatment sessions. These factors often "catalyse" the improvement across the depressive symptoms. Thus, before any proper introduction of formal cognitive restructuring occurs, improvement in intensity, frequency and duration of symptoms occurs in most of the cases. (Ilardi and Graighead,1994).

Though she was psycho educated in the very first session about the booster or follow up sessions, she did not turn up for more than one session. She was given a call from the clinic but she did not pick up the call. She also did not call back the clinic, which she usually did whenever; she missed a call from the clinic. In the terminal phase of the treatment sessions, she mentioned that her office was about to shift to a different place which was quite far from the clinic. Previously both her office and her house were very near to the clinic. May be that prompted her to discontinue, as it might have had become difficult for her to travel or manage time. If reflected on other reasons about her discontinuity to the booster sessions, could be, that she was able to "manage" herself and she has become "confident" to handle the stresses or the situations were not perceived to be so "stressful" as before; which could be due to the way she has learned to reconstruct her thoughts.

Though Amrita terminated the therapy sessions prematurely, was quite compliant on the homework assignments and other self-help tasks. This is unlike other studies which stated that patients who terminated therapy prematurely were less likely to complete the self-help assignments between sessions.(Burns and Nolen-Hoeksema (1992). However, previous literature suggests that psychotherapy when compared to pharmacotherapy has superior results and lower relapse rates. (De Maat, Dekker, Schoevers, & De Jonghe, 2006; Cuijpers et al., 2011a; Spielmans, Berman, & Usitalo, 2011). "Psychotherapy had a significantly lower rate of relapse (26.5%) than did pharmacotherapy (56.6%). Additionally, when examining attrition from pharmacotherapy (n = 182) and psychotherapy (n = 140), the drop-out rate was 28.4% for pharmacotherapy versus 23.6% for psychotherapy. This difference was statistically significant, indicating dropout rates are significantly lower in psychotherapy than pharmacotherapy." (Hunsley, Elliott, and Therrien, 2013).

II. Conclusion

Keeping in line with the previous literature, in the present case study also, Cognitive Behaviour Therapy proved to be an effective treatment of depressive symptomatology. However the question of premature termination or drop out of the client for the follow up sessions remains unanswered. So, is it the efficacy of the of the treatment sessions; was the sessions sufficient enough to make her insightful that she did not turn up or that made her confident enough that she is able to deal with the demands of the situations and/ or is it that the symptoms have subsided and are not manifested as yet to seek help?

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REFERENCES

[1] Amin, G., Shah, S. and Vankar, G.K.(1998). The prevalence and recognition of depression in primary care. Indian J Psychiatry,40,364–39.

[2] Beck, A.T. (1967). Depression: Clinical, experimental and theoretical aspects. Harper and Row, New York.

[3] Beck, A.T. (1976). Cognitive Therapy and the Emotional Disorders. New York: International Universities Press.

[4] Beck, A.T., Rush, A.J., Shaw, B.F. and Emery, G. (1979). Cognitive therapy of depression. Guilford Press, New York.

[5] Blatt, S. and Zuroff, D. (1992). Interpersonal relatedness and self definition: Two prototypes for depression. Clinical Psychology Review,12, 527-562.

[6] Bromet E., Andrade L.H, Hwang I., Sampson N.A., Alonso J. and de Girolamo G., et al. (2011) Cross-National Epidemiology of DSM-IV Major Depressive Episode, BMC Med, 9, 90.

[7] Burns, D. D. and Nolen-Hoeksema, S. (1992). Journal of Consulting and Clinical Psychology, Vol 60(3), 441-449.

[8] Carr, A.(1991). Milan Systemic Family Therapy: A review of 10 empirical investigations. Journal of Family Therapy, 13,237-264.

[9] Carr, A. (1999).The Handbook of Child and Adolescent Psychology:A contextual Approach. Brunner-Routledge. New York.

[10] Cuijpers, P., Andersson, G., Donker, T., & Van Straten, A. (2011a). Psychological treatment of depression: Results of a series of meta-analyses. Nordic Journal of Psychitary, 65, 354-364.

[11] De Maat, S., Dekker, J., Schoevers, R., & De Jonghe, F. (2006). Relative efficacy of psychotherapy and pharmacotherapy in the treatment of depression: A metaanalysis. Psychotherapy Research, 16, 566-578.

[12] Deakin, J. (1986). The Biology of Depression.London:Royal College of Psychiatry.

[13] Derasari, S. and Shah, V.D.(1988). Comparison of symptomatology of depression between India and U.S.A. Indian J Psychiatry,30,129–34.

[14] Driessen, E., Hollon and Steven, D. (2010). Cognitive Behavioral Therapy for Mood Disorders: Efficacy, Moderators and Mediators. Psychiatric Clinics of North America 33(3), 537–55.

[15] Freeman, A., Pretzer, J., Fleming, B. and Simon, K.M. (1990).Clinical Applications of Cognitive Therapy.

[16] Goldberg, D.P. and Lecrubier, Y. (1995). Form and frequency of mental disorders across centers. Mental Illness in general health care: An international study. In: Ustun TB, Sartorius N, editors. Chichester: John Wiley and Sons on behalf of the World Health Organization. pp. 323–34.

[17] Grant, B.F. (1995). "Comorbidity between DSM-IV drug use disorders and major depression: Results of a national survey of adults". Journal of Substance Abuse, 7 (4), 481–87.

[18] Harrington, R. (1993). Depressive disorder in childhood and adolescence. Chichester:Wiley.

[19] Hawton, K., Salkovskis, P.M., Kirk, J. and Clark, D.M.(2001). Cognitive Behaviour Therapy for Psychiatric Problems: A practical Guide. Oxford University Press.

[20] Hunsley, J., Elliott, K. and Therrien, Z. (2013). The Efficacy and Effectiveness of Psychological Treatments.University of Ottawa. Canadian Psychological Association.

[21] Husain N, Creed F, Thompson B. (2000). Depression and social stress in Pakistan. Psychological Medicine.Vol 30, 395–40235.

[22] Ilardi, S.S. and Craighead, W.E. (1994).The Role of Nonspecific Factors in Cognitive-Behavior Therapy for Depression.Clinical Psychology: Science and Practice.Vol 1, (2), 138–15.

[23] Kazantzis, N., Beck, J.S., Dattilio, F.M., Dobson, K.S. and Rapee, R.M. (2013). Collaborative Empiricism as the Central Therapeutic Relationship Element in CBT: An Expert Panel Discussion at the 7th International Congress of Cognitive Psychotherapy. International Journal of Cognitive Therapy: Vol. 6, No. 4, pp. 386-400.

[24] Kessler, R.C., Nelson, C.B., McGonagle, K.A., Liu, J., Swartz, M. and Blazer DG (1996). "Comorbidity of DSM-III-R major depressive disorder in the general population: results from the US National Comorbidity Survey". British Journal of Psychiatry. 168 (suppl. 30), 17–30.

[25] Krupnick, J. L., Sotsky, S.M., Simmens, S., Moyer, J., Elkin, I., Watkins, J. and Pilkonis, P.A.(1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Journal of Consulting and Clinical Psychology, Vol 64(3), 532-539.

[26] Kupfer, D. and Reynolds, C. (1992). Sleep and affective disorders. In E.Paykel (ed.), Handbook of Affective Disorders (second edition, pp. 311-323), Edinburgh: Churchill Livingstone.

[27] Levy, S. and Heiden, L. (1991). Depression, distress and immunity: Risk factors for infectious disease. Stress Medicine, 7,45-51.

[28] Lewinsohn, P., Clarke, G., Hops, H. and Andrews, J. (1990). Cognitive behavioural treatment for depressed adolescents. Behaviour Therapy, 21, 385-401.

[29] Mirowsky, J. and Ross, C.E. (1992). Age and depression. J Health Soc Behav. 33, 187–205.

[30] Murphy, J.M., Laird, N.M., Monson, R.R., Sobel, A.M. and Leighton, A.H. (2000). A 40-year perspective on the prevalence of depression: The Stirling County Study. Arch Gen Psychiatry, 57, 209-15.

[31] Nandi, D.N., Banerjee, G., Mukherjee, S.P., Ghosh, A., Nandi, P.S. and Nandi, S.(2000). Psychiatric morbidity of a rural Indian community changes over a 20 year interval. British Journal of Psychiatry, 176, 351–6.

[32] Nolen-Hoeksema, S. and Stanford, C.A. (1990). Sex Differences in Depression. Stanford University Press.

[33] Poongothai, S., Pradeepa, R., Ganesan, A., Mohan, V.(2009). Prevalence of depression in a large urban South Indian population - The Chennai Urban Rural Epidemiology Study (CURES-70). PloS One, 4, E7185.

[34] Pothen, M., Kuruvilla, A., Philip, K., Joseph, A. and Jacob, K.S.(2003). Common mental disorders among primary care attenders in Vellore, South India: Nature, prevalence and risk factors. Int J Soc Psychiatry,49, 119– 25.

[35] Powell, V.B., Abreu, N., Oliveira, I.R. and Sudak, D. (2008). Cognitive Behaviour Therapy for Depression. Brazillian Journal of Psychiatry. 30,(2).

[36] Reddy, M.S.(2010). Depression: The disorder and the burden. Indian Journal of Psychological Medicine, Vol 32, No.1,1-2.

[37] Remick, R.A.(2002). Diagnosis and management of depression in primary care: a clinical update and review. CMAJ, 167,53-60.

[38] Renaud, J., Russell, J.J. and Myhr, G. (2014). Predicting Who Benefits Most From Cognitive-Behavioral Therapy for Anxiety and Depression. Journal of clinical psychology.

[39] Sadock, B.J. and Sadock, V.A.(2007). Mood disorders. In: Kaplan & Sadock's Synopsis of Psychiatry. Lippincott Williams & Wilkins. 10(Ed), 527-78.

[40] Seligman, M. (1981). A learned helplessness point of view. In Rehm (ed.),Behaviour Therapy for Depression. New York: Academic, pp.123-141.

[41] Spielmans, G. I., Berman, M. I., & Usitalo, A. N. (2011). Psychotherapy versus second-generation antidepressants in the treatment of depression: A meta-analysis. The Journal of Nervous and Mental Disease, 199, 142-149.

[42] Thomas, M. and Drake, M. (2012). Cognitive Behaviour Therapy Case Studies. Sage Publications Inc.

[43] Tolin, D.F. (2010). Is cognitive-behavioral therapy more effective than other therapies? A meta-analytic review. Clinical Psychology Rev. 30 (6), 710-20.

[44] Wehr, T. and Rosenthal, N. (1989). Seasonality and affective illness. American Journal of Psychiatry, 146,829-839.

[45] Westbrook, D., Kennerley, H. and Kirk, J. (2011).An Introduction to Cognitive Behaviour Therapy: Skills and Applications, (second edition), Sage Publications Ltd.

[46] Williams, J. (1992). The Psychological Treatment of Depression:A guide to the Theory and Practice of Cognitive Behaviour Therapy (second editon). London: Routledge.

[47] Whitfield, G. and Williams, C. (2003).The evidence base for cognitive–behavioural therapy in depression: delivery in busy clinical settings. Royal College of Psychiatrists. B.J. Psych Advances. 9,(1).

[48] W.H.O: World Health Organization. The ICD–10 Classification of Mental and Behavioral Disorders. Geneva: WHO, 1992.

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