Cognitive-Behavioral Therapy for an Indian Adolescent With Depression: A Clinical Case Study
Roshni Sondhi, Shagun Gulgulia and Vandana Shriharsh

Clinical Case Studies 2013 12: 157 originally published online 10 January 2013
DOI: 10.1177/1534650112470741

The online version of this article can be found at:
http://ccs.sagepub.com/content/12/2/157

Published by:
SAGE
http://www.sagepublications.com

Additional services and information for Clinical Case Studies can be found at:

Email Alerts: http://ccs.sagepub.com/cgi/alerts

Subscriptions: http://ccs.sagepub.com/subscriptions

Reprints: http://www.sagepub.com/journalsReprints.nav

Permissions: http://www.sagepub.com/journalsPermissions.nav

Citations: http://ccs.sagepub.com/content/12/2/157.refs.html

>> Version of Record - Feb 26, 2013
OnlineFirst Version of Record - Jan 10, 2013

What is This?
Cognitive-Behavioral Therapy for an Indian Adolescent With Depression: A Clinical Case Study

Roshni Sondhi¹, Shagun Gulgulia¹, and Vandana Shriharsh¹, ²

Abstract
This case study describes the treatment of an adolescent male, referred to as ML, who presented with a significant decline in academic performance coupled with a difficulty in coping with parental pressure. A formal assessment revealed the signs of moderate depression with anxiety features, especially on the dimensions of tension and guilt proneness. He was treated with 12 sessions of cognitive-behavioral therapy (CBT) along with group sessions of family therapy and interpersonal therapy. ML's progress throughout treatment is detailed in this case study report. Results lend support to the body of case series studies attesting to the efficacy of CBT for use with adolescents with depression and anxiety, further implicating the importance of the role played by the parents in the conceptualization, maintenance, as well as treatment of the adolescent.

Keywords
academic decline, adolescent depression, cognitive-behavioral therapy, India, parental pressure

I Theoretical and Research Basis for Treatment
Depression and anxiety, together with substance use disorders, are the most common mental illnesses in young people (National Health and Medical Research Council, Australia [NHMRC], 2011). In India, epidemiological studies of children and adolescent disorders undertaken in Bangalore found a prevalence rate of 0.5% (Srinath et al., 2005). Studies that specifically assessed depression reported a prevalence of 3% in 13- to 19-year-old school going adolescents (Nair, Paul, & John, 2004) and found that 15.2% of the adolescents had evidence of distress and 18.4% were found to be depressed (Bansal, Goyal, & Srivastava, 2009). The number of children and adolescents with depression is growing, with an estimated 5% affected at any one time (Rosenbaum & Covino, 2005) as a recent study in India found a prevalence of 23.7% adolescents with moderate to severe depression (Mohanraj & Subbaiah, 2010).

The mother of an adolescent was quoted as saying, “Isn’t it sort of the norm for adolescents to be depressed and anxious? Most teenagers I know, my kids included, seem to experience mood swings a lot during this time of their lives” (Karnani & Pomm, 2006, p. 41).

Adolescence is a time of great change and also often a stormy time of developmental turmoil and conflicting emotional states. There are many myths about depression and anxiety in young

¹Amity University, Noida, Uttar Pradesh, India
²Rehabilitation Council of India, New Delhi, India

Corresponding Author:
Roshni Sondhi, Amity University, B-133, Sector-30, Noida 201301, Uttar Pradesh, India
Email: roshnisondhi@yahoo.com

http://ccs.sagepub.com
people, but mood and anxiety disorders are not a “normal” consequence of this stage of life. Although most teenagers emerge from this turbulent period unscathed by clinical depression or anxiety, there are also a significant number who are affected.

Despite improvements in the understanding of mental health of young people, conditions such as these disorders are alarmingly underrecognized and untreated in this age group, despite its poor long-term outcomes, including risks for suicide (Stein, Zitner, & Jensen, 2006) and impairment in academic, occupational, and interpersonal functioning, due to which many adolescents may not be getting the care they need (Karnani & Pomm, 2006).

Adolescent depression is a disorder that affects teenagers, leading to sadness, discouragement, and a loss of self-worth and interest in their usual activities (Adolescent Depression, 2012).

Depression in adolescence may manifest as increased irritability rather than feelings of sadness, sometimes manifested by negativism, antisocial behavior, and a feeling of being misunderstood. Social and cognitive factors that have been demonstrated to characterize depressed adolescents include higher levels of critical self-referent attributions (Prinstein, Chea, & Guyer, 2005), low levels of self-perceived competence (Tram & Cole, 2000), perfectionistic expectations and a need for social approval (Ginsburg et al., 2009), and more negative automatic thoughts about self and others than nondepressed adolescents (Greening, Stoppelbein, Dhossche, & Martin, 2005).

Adolescence represents a phase wherein cognitive vulnerability is likely to become apparent, with cognitive vulnerability factors, including attributional style, dysfunctional attitudes, and self-perception being associated with depression among youth (Jacobs, Reinecke, Gollan, & Kane, 2008). An integrated model of affective (emotional reactivity), biological (genetic vulnerability, pubertal hormones, pubertal timing and development), and cognitive (cognitive style, objectified body consciousness, rumination) factors as vulnerabilities to depression, in interaction with negative life events, heightens rates of depression beginning in adolescence. In addition, social factors are integral to the model insofar as the negative life events that interact with the vulnerabilities often come in a social, interpersonal form—whether peer’s sexual harassment, parents’ marital discord, or a troubled relationship with parents (Hyde, Mezulis, & Abramson, 2008). Maturational differences have also been identified in the neurobiological correlates of depression. Specifically, hypersomnia shows a developmental trend with a higher prevalence in depressed adolescence, with somatic complaints and behavioral problems being more common during this developmental period (Rao & Chen, 2009).

Cognitive-behavioral therapy (CBT) is perhaps one of the most frequently used psychotherapeutic orientations, with considerable research supporting its effectiveness for treating depression and anxiety and adaptability in clinical practice. It has its theoretical origin in the work of Aaron Beck, who argued that maladaptive cognitions create negative mood states and dysfunctional behaviors (Beck, Rush, Shaw, & Emery, 1979). Based on the adult literature, CBT is seen as effective for adolescents also as it has been found that all cognitive coping strategies reported by adolescents are the same but of a significantly lesser extent than those reported by adults (Garmešík, Legerstee, Kraaij, Van den Kommer, & Teerds, 2002). Prior studies have shown that CBT provides a scientifically proven tool for adolescent depression as CBT enhances self-control, perceptions of personal efficacy, rational problem-solving skills, social skills, and participation in activities and physical exercise that bring the adolescent a sense of pleasure or mastery (Clabby, 2006).

The individual CBT for adolescent depression places great emphasis on collaborative empiricism, the establishment of a trusting, open, and collaborative relationship between the therapist and the adolescent (Brent & Poling, 1997). In the context of this relationship, depressive cognitions can be identified, questioned, and challenged. The Treatment for Adolescents With Depression Study (TADS) manual for CBT incorporates the focus on specific and current actions and cognitions as targets for change, structured intervention sessions, repeated practice of skills, use of rewards and contracts, and a relatively small number of therapy sessions (Curry et al., 2005).
In addition, research has demonstrated that lack of family support may indirectly influence suicidal behaviors for male and female teens (Thompson, Mazza, Herring, Randell, & Eggert, 2005). A broad array of parental and family factors is associated with a risk for youth depression, ranging from parental pathology to parental cognitive style to family emotional climate. Moreover, parent–child relationships, the interactions of child temperament and child coping with family environment, parent pathology, and the impact of situational and environmental stress on the family system have been found to be contributing factors to youth depression (Sander & McCarty, 2005), thereby implicating the role of including family in the therapy for adolescent depression. This need is of manifold significance, especially in India, which being a collectivist society emphasizes family integrity, family loyalty, and family unity. Unlike the West, most Indian families prefer to be meaningfully involved in all aspects of care of their relatives despite it being time-consuming, because of the Indian tradition of interdependence and concern for near and dear ones in adversities (Avasthi, 2010). More specifically, collectivism is reflected in greater readiness to cooperate with family members and extended kin on decisions affecting most aspects of life, including career choice, mate selection, and marriage (Hui & Triandis, 1986; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988).

The unique aspects of Indian family life have significant cross-cultural implications, which need to be incorporated in the traditional therapeutic approaches. In spite of the numerous changes and adaptations to a pseudo-Western culture and a move toward the nuclear family among the middle and upper classes, while the family is assuming global, national, cosmopolitan, Western, and modern forms in some quarters, many functional extensions of the traditional joint family, especially family ties, have been retained in contemporary India (Chekki, 1996; Patel, 2008).

Adolescence and young adulthood are particularly stressful and traumatic stages in the lives of Indian youths. Developmentally, youth are known to have close ties to their families of origin (Steinberg, 2005). In one way, they desire emancipation and liberation from family but residing in the matrix of the extended family makes it difficult for them to assert themselves and exhibit any independence in thought, action, or behavior. In the traditional Indian family, communication between parents and children tends to be one-sided. Children are expected to listen, respect, and obey their parents. Furthermore, sex and sexuality issues are not openly discussed, sex education is not readily available, interrelationships with the opposite sex are discouraged, and pre-marital sex is frowned upon. Generally, adolescents do not share their personal concerns with their parents because they believe their parents will not listen and will not understand their problems (Medora, Larson, & Dave, 2000).

As it appears that depression and anxiety affect not only the patient but also every member of his or her family, and an adolescent patient will fare much better over time if the entire family system is involved in the patient’s treatment (Karnani & Pomm, 2006, p. 45), the significance of adapting the traditional CBT approach to include not just an individual but the entire family increases manifold in consideration of the Indian culture.

2 Case Introduction

ML, a 16-year-old Indian male, belongs to a nuclear family from a middle socioeconomic status and resides in an urban district near Delhi. He is of a shy and quiet temperament, has always been an average student, and has been an active participant in extracurricular activities and sports throughout high school.

3 Presenting Complaints

At the time of presentation at the clinic, ML was pursuing Class XII. He presented at the clinic at the behest of his mother, who complained of a significant decline in his academic performance,
expressing her concern about ML’s diminished ability to concentrate, attributing his decline to the alleged influence of bad company, especially girlfriends, and her expectation of desiring ML to model her elder son. She also complained that ML had become very reclusive, preferring solitude most of the time, keeping things to himself.

ML himself complained of high parental pressure, especially his mother’s excessive suspicious and restrictive nature, and her constant nagging, which made him feel frustrated and angry. He also reported feeling lonely most of the time.

After clinical interviews, it was revealed that ML’s symptomatology began around 3 years prior to the onset of the treatment described in this case report. He first experienced some signs of anxiety and low mood when his academic performance failed to meet his parents’ expectations. He had difficulties in coping with the fast pace of his teachers and tutors in Class VIII. His anxiety manifested in the form of somatic complaints, mostly related to the abdomen. By the end of Class IX, his ability to concentrate had diminished. He lost interest in previously enjoyed activities and sports, and would instead prefer to sit solitarily in darkness for hours at a stretch. His energy levels reduced as he fatigued easily. There was a significant weight loss accompanied by refusal to eat food or carry tiffin, and his daily sustenance went unexplained as he did not have access to any pocket money. He became reclusive, hiding details of his marks, school tests, and whereabouts from his parents. By the end of 2 years, unable to cope with severe parental restrictions, he began to rebel, shouting back at the parents, threatening to run away when verbally or physically abused. His parents suspected him of being deceptive and stealing as he began playing truant after his coaching classes in a bid to stay away from parents, and he was also found to be procuring mobile phones from unaccountable sources. Upon presentation at the clinic, subjective accounts of loneliness, worthlessness, and suicidal ideation were elicited, and he experienced feelings of hopelessness regarding his future.

4 History

Family History

ML resided with his parents and sibling in a nuclear family in an urban district near Delhi. He was the second child, 6 years younger to his brother, who worked as a mechanical engineer. ML’s father was a Superintendent and his mother (formerly a teacher) was a housewife. Being a traditional Indian family, various cultural factors discussed in the theoretical and research basis above could have played a role in encouraging ML’s dependence on his parents. Despite their efforts to adapt to the pseudo-Western culture, there was a communication gap in the family, which prevented ML as an adolescent from sharing his personal concerns with his parents. ML complained of a strained relationship with his mother. He also had an inferiority complex with his elder brother as his parents were habitually drawing comparisons and citing examples of the elder brother as a role model to compete with. ML and his father enjoyed a close and mutually supportive relationship, though they were unable to spend much time together.

Educational History

ML was studying in Class XII in a local private high school. He had been in this current school for the past 2 years, his prior school being provisioned only up to Class X. Before the onset of the symptoms reported in this case report, ML was doing quite well academically till Class IX, obtaining mainly first division. He had been highly involved in his school and, in particular, enjoyed participating in basketball. He had always been a popular student and had often been voted for by his peers to be a school representative, but his mother restrained him from accepting the responsibility expressing concern about neglect of his study time. By Class VIII, ML began having difficulties with subjects such as physics and mathematics, and his subsequent
inability to cope coupled with parental pressure over 2 years reached its peak by Class X. Despite his apparent difficulties and his inadequate performance in Class X, his parents secured him a seat in the science stream. In the current school, he had developed an inferiority complex with his peers, who belonged to a much higher socioeconomic status.

**Social History**

ML was a socially popular boy with several friends. He enjoyed socializing and despite unreasonable parental restrictions (especially his mother’s belief of his falling prey to wrong company and her suspicion of his being involved in relationships with the opposite sex) would spend time with his friends after the coaching classes. He first dated a girl in Class X (without any sexual involvement), but the relationship ended mutually after they left the school. He was not involved in any illegal behavior, such as substance use or other delinquent behaviors. Since the onset of his symptoms, he showed a preference for being solitary in a dark room for hours at a stretch, maybe as an escape from his mother’s constant nagging. He also lost interest in previously enjoyed extracurricular activities.

**Medical and Mental Health History**

ML had never experienced any major medical illness nor was there a history of major medical illness in his family. He had an insignificant medical history until the onset of the symptoms reported in this case report. One month prior to his presentation at the clinic, stones in his kidney had been detected, for which a parallel treatment had been sought, though the treatment had not shown effects. After the assessment, ML was advised medication for his depression, but his parents expressed their preference and faith in homeopathic medication instead. Prior to the beginning of the treatment described in this case report, ML visited a doctor who, in consultation with the therapist, prescribed homeopathic medication for his depression as well as his somatic symptoms. This medication was continued till the 1st month of therapy, by which period the stones in the kidney had dissolved, though ML’s anxiety and depressive symptoms still persisted.

**5 Assessment**

A multimodal psychological assessment was done using clinical interviews as well as psychometric tests. The information presented in the previous sections regarding ML’s presenting problems was obtained through semistructured clinical interviews with ML and his parents. In particular, for the first three sessions, ML and his mother engaged in separate clinical interviews during which the reliability of their subjective reports was tallied and assessed, suggesting a concordance between the parent and ML’s reports.

The information obtained through clinical interviewing as well as ML’s mental status examination suggested the presence of depressive and anxiety symptoms, though further structured diagnostic assessment was indicated to assess whether ML met the diagnostic criteria for moderate depressive episode with somatic syndrome (coded as F32.11 in the International Statistical Classification of Diseases and Related Health Problems–Tenth Revision [ICD-10]) based on the parameters set forth in the ICD-10 (World Health Organization, 1994).

The structured assessment began with a formal diagnostic evaluation, for which ML completed two self-report measures.

**Beck Depression Inventory (BDI)**

It is a 21-item self-report inventory measuring characteristic attitudes and symptoms of depression, which is widely established as a reliable and valid tool to screen for depressive illness and
assess symptom severity, designed for individuals aged 13 years and above (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Groth-Marnat, 1990). ML’s baseline measure on the BDI met the criteria for moderate depression in the pretreatment phase.

**State Trait Anxiety Test (STAT)**

It is a standardized test (Vohra, 1997) that measures anxiety levels on five dimensions: guilt proneness, tension, maturity, suspiciousness, and self-control. In the pretreatment assessment, ML’s scores for the dimensions of tension and guilt proneness were elevated, clearly suggesting a high level of general anxiety. The results also suggested that ML had an average self-control on his behavior and emotions, along with low suspiciousness and maturity levels.

Second, a pretreatment assessment of ML’s intellectual functioning was made to obtain a baseline measure, even though an adverse influence of his depressive and anxiety symptoms was anticipated. The following tests were administered to measure ML’s performance quotient (PQ) and verbal intelligence, respectively.

**Bhatia’s Battery of Performance Intelligence Tests (BPIT)**

It is a battery of individual performance tests (Bhatia, 1955) for the age group of 11 to 16 years standardized for the Indian population. It comprises five subtests, namely, Koh’s Block Design Test, Alexander Pass-Along Test, Pattern Drawing Test, Immediate Memory Test, and Picture Construction Test, revealing an intelligence quotient (IQ) as well as a PQ with separate normative data for interpretation. The baseline measures of IQ and PQ suggested that ML’s intellectual functioning was below average based on normative data.

**Verbal Adult Intelligence Scale (VAIS) Subtest of the PGI-Battery of Brain Dysfunction (PGI-BBD)**

PGI-BBD (Pershad & Verma, 1990) is a compilation of individual tests of memory, intelligence, and visual perception that are standardized on the Indian population, comprising five subtests, namely, PGI Memory Scale, Bhatia’s Short Battery of Performance–Revised, VAIS, Bender–Gestalt Test, and Nahor–Bensen Test. ML’s scores on this test revealed an average intellectual functioning with the absence of brain dysfunction.

Subsequently, in consideration of the observed discrepancy between ML’s scores on the PQ and verbal IQ functioning, the following test of visual-motor coordination was administered to assess for its possible role underlying ML’s below average performance on the PQ of intellectual functioning.

**Bender–Gestalt Visuo-Motor Test (BGT)**

It is an individually administered pencil-and-paper test (Bender, 1938; Bhargava & Sandhu, 1987) used to evaluate visual-motor functioning and visual perception skills, including visual maturity, visual-motor integration skills, style of responding, reaction to frustration, ability to correct mistakes, planning and organizational skills, and motivation, in children and adults. It is widely used to identify possible organic brain damage and the degree maturation of the nervous
system. ML’s performance on this test suggested adequate visual-motor coordination, with an absence of any brain dysfunction.

Hence, the discrepancy in ML’s results on the PQ versus verbal IQ assessed above can be attributed to the inevitable influence of his emotional state at the time, especially in the case of the performance tests. In consideration of ML’s previous academic functioning as well as clinical observations, his scores strongly indicate the anticipated adverse influence of ML’s depressive and anxiety symptoms on his performance in the intellectual assessment of the pretreatment phase, thereby indicating the need for a posttreatment assessment.

Finally, the possible role of any repressed needs, drives, emotions, and unconscious dynamics in explaining the nature of ML’s somatic complaints was assessed using a projective assessment tool.

**Thematic Apperception Test–Indian Adaptation (TAT)**

It is a projective test (Mehrotra, 1997) of personality, in which a set of pictorial cards were selected keeping in mind the suitability of the card content, ML’s age and sex, and his responses were analyzed at the levels of form, content, dynamic structure, and other dynamic clues.

ML’s responses, comprising complete and well-structured stories, reflected an adequate verbal ability and expression of his thoughts. In a majority of his responses, ML identified himself with the main or the secondary male hero, though usually ending with a negative outcome. ML’s ego structure was indicated to be weak, mostly dominated by guilt, anxiety, and depression in his inner dynamics. Intracpection (processing the world primarily through feelings/emotions), endocathexion (preoccupation with one’s own thoughts or inner activities and withdrawal from external and practical pursuits), and anxiety were revealed as the basic traits of his personality.

Some of ML’s stories revealed the presence of suicidal ideation, though in subsequent sessions ML admitted that these were fleeting thoughts that occurred occasionally in face of parental pressure but did not sustain.

Most of ML’s stories were indicative of many needs that were usually not being supported by an adequate press, as symbolized by the parents of the main or secondary hero. The dominant needs included those of autonomy, nurturance, affiliation, acquisition, aggression, intragression, achievement, and infavoidance. The analysis of his responses revealed significant conflicts between his needs for nurturance (help someone in need) versus rejection, needs for infavoidance (to quit embarrassing situation) versus achievement, and needs for autonomy versus restraint.

His personal adjustment, as indicated by the outcome of the main and secondary hero in most of his stories, was evidently not adequate as his responses projected negative emotions such as guilt, anger, frustration, grief, remorse, dejection, loneliness, regret, and inferiority dominate the inner dynamics of his personality.

ML’s stories suggested an inadequate social adjustment as the projected relations of the identified heroes with their parents, especially with the mother were conflictual and strained, though love and deference for the father was strongly projected in few stories. He experienced an inferiority complex to his elder brother as well as some of his peers coming from a higher socioeconomic background.

The main defense mechanisms used repetitively in his stories were isolation, inhibition, and compensation. ML’s emotional maturity appeared to be slightly lower than that expected in accordance to his age, though his emotional life had developed with time and experience.
There are several variables contributing to the onset and the maintenance of ML’s experiences of low mood, loneliness, loss of interest in activities, suicidal ideation, rebellion, and refusal to eat food. Data from the initial assessment suggested that ML’s symptoms were best attributed to depression resulting from anxiety on dimensions of guilt proneness and tension about coping with unreasonably high parental pressure.

As illustrated in Figure 1, the onset of ML’s symptoms could be conceptualized as being precipitated by ML’s difficulty in coping with his tight schedule of school and coaching classes, along with the pressure of an accumulated backlog, subsequently leading to a significant decline in his academic performance, coupled with the pressure to meet parental expectations. His parents attributed ML’s decline to the negative influences of his peer group and of his alleged girlfriends, though ML strongly resisted these accusations, arguing that his...
academic decline had commenced when he was in Class VIII itself, whereas he first dated a girl in Class X only. Despite ML’s insistent attributions to difficulty in understanding subjects, his parents, especially his mother, began restricting his socialization and other activities, prohibiting his possession of mobile phone/pocket money, constantly nagging him to study, even beating with a stick occasionally and constantly comparing him with his elder brother, giving rise to an inferiority complex.

These high levels of unreasonable parental pressure, suspiciousness, and restrictions amounted to extreme frustration, which led ML to rebel by shouting back at the parents, threatening that instead of being scolded and hit, he would be better off if he ran away from home and went to work in a tea shop. Due to his mother’s unreasonable restrictions, he found his own means of procuring mobile phones from unaccountable sources and played truant for hours after his coaching classes in efforts to stay away from home, thereby reinforcing his mother’s suspicions. As a result, he became reclusive and hid details of his marks, school tests, and whereabouts from his parents. As a reaction to his mother’s extreme insistence on eating only homemade food, ML developed a strong preference for junk food, and refused to carry tiffin, and as he had no pocket money to buy food, his daily sustenance went unexplained. Moreover, his parents had imposed their ambition onto ML by using their influence to secure his admission to the science stream despite his inability to cope, as they expected him to become an engineer like his older brother. As a result, ML himself had never even got the opportunity to decide his career choice, leading to a feeling of hopelessness toward the future.

7 Course of Treatment and Assessment of Progress

A rapport between ML and the therapist had already been achieved during the initial sessions of clinical interviewing as well as assessments. He was willingly relying on the help of the therapist, feeling helpless and seeking a dependency.

Psychoeducation

Educating ML and his parents about the cognitive-behavioral conceptualization of depression (Beck et al., 1979), associated features of the disorder, and treatment options was accomplished during the first therapy session.

As the presence of suicidal ideation had been revealed, ML’s parents were warned of the risk and were advised to take precautions such as being vigilant and removing potentially harmful objects from his environment.

After psychoeducation, ML and his parents indicated feeling more confident about the course of treatment. Although the majority of psychoeducation was provided in this first session, the therapist supplemented the educational information throughout treatment, especially when implementing the cognitive restructuring interventions.

Goal Setting

After ML was socialized into CBT, the agenda for each session was decided upon. Next, ML was asked to review his presenting problems, while the therapist then turned ML’s attention to identifying his specific problems, logically helping ML to turn these problems into goals to work on in therapy. These goals were then refined and classified further. The major goals that were agreed upon included the following:
Short-term goals

- To be able to concentrate on studies;
- To reduce worrying about examinations;
- To cope with coaching classes effectively;
- To increase appetite; and
- To socialize with friends.

Long-term goals

- To improve academic performance;
- To reduce strain in relationship with mother; and
- To restore previous levels of functioning.

ML’s primary expectations from therapy were to improve academic performance and to develop effective mechanisms of coping with parental pressure.

Cognitive Restructuring Interventions

As suggested by Beck et al. (1979), individuals with depression tend to engage in cognitive errors such as negative automatic thoughts that lead to depressed feelings and in turn lead to dysfunctional behavioral response patterns. For ML, it was apparent that he engaged in negative automatic thoughts primarily about himself, which activated his helpless core beliefs. As with any cognitive restructuring techniques, it was first important to educate ML about what automatic thoughts were and how they became automatic.

To socialize ML into the cognitive therapy model, the therapist explained the common interplay of thoughts, behavior, and emotions that seemed to perpetuate his depressive cycle. In particular, the therapist conveyed that often, the cycle of depression involved individuals having negative thoughts, which led to perceptual biases, which in turn created excessive negative emotions, thereby leading to dysfunctional behavioral and somatic response patterns. Diagrammatic illustrations were used to derive the specific cognitive conceptualization of ML’s symptoms, as previously shown above (Figure 1). The therapist and ML went on to further discuss the specific interplay of thoughts, behaviors, and feelings in his life, in a sense to tailor the depressive conceptualization to ML’s specific experiences. For instance, ML identified that his negative thoughts (“I am incapable”) lead to depressive feelings, lack of activity, and tiredness/loss of appetite, which are in turn reinforced by each of these symptoms. These symptoms also interact with each other in vicious cycles, as feelings of depression lead to a loss of appetite, while lack of

![Figure 2. Illustration of ML's depressive cycle](image-url)
proper nutrition is likely to increase the vulnerability to feelings of depression. This relationship could be demonstrated diagrammatically as in Figure 2.

Hence, ML’s negative automatic thoughts could arise out of assumptions such as “If I fail in an exam, it means I can never succeed” and “Even if I study, I get poor marks,” triggered by a current situation of failure in the examination. These assumptions could in turn arise out of a core belief such as “I’m incapable” rooted in ML’s early (or later) experience of being treated as incapable, or being told that he was incapable. His assumptions could lead him to avoid studying, or trying too hard to study, juggling between teachers and tutors (compensatory strategies), either of which are likely to increase his chances of failure, thus feeding back to reinforce his assumptions.

This cognitive restructuring component specifically addressed ML’s negative automatic thoughts and distortions, including selective abstraction, dichotomous thinking, overgeneralization, and disqualifying the positive. Multiple examples of ML’s distortions could be cited. For example, ML thought “Because I failed in mathematics and physics, it means I am a total failure,” focusing on the failure in two subjects and overlooking the number of subjects that had been cleared with a first division, thus disqualifying the positive and selectively abstracting the negative from his performance. He often overgeneralized his failure, thinking “If I fail in an exam, it means I can never succeed,” concluding the impossibility of his success despite having succeeded a number of times in the past. ML’s dichotomous thinking was occasionally voiced in his belief that one is either a success or a failure and that anything short of a performance meeting the parental expectations is a total failure.

A self-awareness component was subsequently added in which ML was asked to begin monitoring some of his thoughts. Exercises (e.g., thought bubbles) borrowed from evidence-based child cognitive treatments such as the Coping Cat (Kendall & Hedtke, 2006) were used. ML was assigned homework tasks such as jotting down his thoughts when his mood changed. This served as the basis of identifying ML’s negative automatic thoughts in the next sessions.

Behavioral techniques such as role-playing and recall were additionally used to elicit problematic situations and their associated negative automatic thoughts were arrived at through the downward arrow technique. Using the same example of his belief “I am incapable,” ML’s confidence in this statement began to decrease as he engaged in Socratic questioning, finding evidence for and against his thoughts, and evaluating them. Toward the end of the treatment, ML’s thought became more like “If I concentrate, I am capable of accomplishing more than I have in the past.” Once ML’s thought awareness increased, the therapist helped him learn how to modify his automatic thoughts. The therapist often used dolls to behaviorally demonstrate the use of the modified balanced thoughts during the session, and ML would model and rehearse them in the session itself.

Other cognitive and behavioral techniques such as guided discovery (asking a series of questions designed to guide ML toward the discovery of his cognitive distortions, for example, “What would it mean to you if you failed in an exam?”), cognitive rehearsal (imagining a problematic situation ML has encountered in the past, and rehearsing a coping mechanism for future confrontations with similar situations, for example, practicing breathing exercises when unable to concentrate on studies), and role-playing and modeling (acting out or demonstrating appropriate reactions to different situations for ML to model, for example, two dolls assuming the roles of ML and his mother, respectively, acting out a situation of the mother’s constant nagging, and ML’s appropriate response) were also implemented throughout the treatment.

These cognitive restructuring exercises helped ML make internal attributions regarding the impact of his own effort and new skill development on reducing depression.
Behavioral Techniques

In the initial sessions itself, techniques such as activity monitoring and scheduling were used with the goal of behavioral reactivation. ML’s daily routine was charted and modifications were brought, which were to be implemented and monitored throughout the week and then reviewed in the next sessions. Time management strategies were included in graded task assignments, especially related to study goals, to increase ML’s productivity, and constructive activities were suggested. In leisure hours, sports activities he was previously interested in were encouraged, in contrast to television or other solitary activities, in efforts to increase his socialization as well as to increase his energy levels. Throughout his treatment, techniques such as progressive muscle relaxation were used to reduce ML’s anxiety levels during the sessions. He also practiced the breathing exercises outside the sessions and reported a positive feedback. He was also assigned a variety of homework tasks, including thought recording as well as using dolls to role-play the rehearsed balanced thoughts.

Problem-Solving Strategies

In addition to his dysfunctional thoughts, ML also had real-life problems, which were dealt with using problem-solving techniques parallel to the cognitive techniques. For instance, ML was helped in working out better time management strategies to help cope with tutors, and he was given study tips as well. He had difficulty concentrating when he was studying. The therapist suggested several practical ideas for him to try such as starting with the easiest topic first, reviewing relevant class notes before reading the textbook, writing down questions when he was unsure of his understanding, and pausing every few minutes to rehearse mentally what he had just read. It was agreed that he would try these strategies as experiments to see which, if any, facilitated his concentration and comprehension.

Other problems related to his environment were also dealt with, such as the provision of a separate room for studying without any distractions, the positioning of the study table, and so on.

Parent Training

As parental pressure played a major role in maintaining ML’s symptoms, parental training was additionally a significant component in ML’s case. The psychoeducational component of parent training was implemented during the first session itself, including the warning about the precautions to be taken due to the risk of suicide, and the education about the disorder, conceptualization, and therapy process. Following this session, the therapist would meet with ML’s parents at the beginning of each subsequent session for about 10 minutes. This 10-minute period was used to discuss ML’s exposure homework and treatment progress and to discuss their progress in refraining from engaging in any behavior that would pressurize ML. The therapist praised the parents’ effort to help ML by providing a more supporting and conducive environment. Besides this, ML had a strained relationship with his mother as she was unreasonably suspicious and restrictive. Hence, separate therapy sessions were allotted for her to reduce her anxiety levels about her son. However, ML’s father was advised to spend more time with his son, especially to help in building the bridge between ML and his mother. ML’s elder brother was also included in the sessions, whose behavior often served as a maintaining factor for ML’s inferiority complex. The therapist also helped ML’s parents process any negative feelings toward implementing the intervention (e.g., feeling guilty or anxious themselves seeing their child in distress) by empathizing with them and reminding them of their role in
reducing the parental pressure. ML’s parents were quick to implement this component of treatment as they no longer nagged ML, and instead encouraged and supported him. ML’s father made a conscious effort to take out time from his routine to spend with ML, assisting with his studies and supporting him.

**Termination and Posttreatment Assessment**

In the last two sessions, ML was prepared for termination, and he was self-reliant. He was following a systematic regimen for his studies, with a minimal interference of his mother. The final treatment session involved a review of ML’s progress, generalization of his gains to other problematic situations, and a discussion of how to prevent relapse. He was advised follow-up sessions to be spaced at not more than 2 months.

The posttreatment phase of assessments was conducted. ML’s score on the BDI showed the presence of a very mild depression. His scores on STAT were significantly lower than the pretreatment assessment, especially on the dimensions of guilt proneness, tension, and self-control. The posttreatment intellectual assessment showed a consistency between ML’s scores on the PQ and verbal quotient. His performance on the BPIT was significantly better than the pretreatment assessment, indicating an average level of intellectual functioning, thereby confirming the influence of his emotional state at the time of preassessment to be attributable for the discrepancy between his PQ and verbal quotient, whereas his scores on the VAIS showed little or no improvement, showing a constancy of an average intellectual functioning.

Besides the posttreatment assessment of the clinical symptoms and intellectual functioning, an assessment of ML’s specific aptitude was additionally conducted in alignment with ML’s request to help his choice for admissions in a career of his own interest after Class XII.

**Differential Aptitude Test: Form A (DAT)**

It is a standardized test (Bennett, Seashore, & Wesman, 1990), measuring aptitudes in eight specific areas: verbal reasoning, numerical reasoning, abstract reasoning, space relations, mechanical reasoning, clerical speed and accuracy, language usage–spelling, and language usage II–sentences. The scores suggested that ML has a moderate high ability in language usage. His aptitude for clerical speed and accuracy, including his speed of perception, momentary retention, and speed of responses, also seemed to be significantly better than his aptitude for other areas.

**Treatment Outcomes**

The treatment over a period of 6 months led to significant improvements. A follow-up revealed that ML was able to study well for his Class XII boards and secured a first division. ML was successful in convincing his parents to change his stream to the area of his interest in spite of getting through a reputed engineering college as per his parents’ aspirations. ML subsequently secured admission for a Law program in a highly reputed Indian university, securing a fourth rank from among 45 applicants.

**8 Complicating Factors**

The only apparent complicating factor in this case was the unreasonable amount of parental pressure, and the mother’s overanxious and suspicious nature, which made her quite resistant
toward the treatment initially. It was only after observing some improvement in her son’s condition by the fourth session that her resistance to treatment reduced. Another complicating factor was the scheduling of ML’s sessions, as he had difficulty in managing his time with schooling and coaching classes, along with an accumulation of pending work, but this factor was overcome by adjusting the timings of the sessions flexibly.

9 Access and Barriers to Care

There were no major barriers to care in this case, with an exception of the somatic symptoms. The detection of stones in his kidney was a cause of concern, but a 2-month period of homeopathic treatment successfully dissolved the stones by the first month of the therapy reported in this case report, after which no further medical treatment was taken.

10 Follow-Up

ML participated in two follow-up sessions, each spaced at 1 month and 2 months post-treatment, respectively. At each follow-up session, ML identified times of stress, which in the past may have led to triggering depressive symptomatology, and articulated how he utilized his CBT tactics to prevent the symptoms. At the first follow-up session, ML reported a major stressful event, the death of his close friend during the preparation for his final Class XII board examinations. Although such an event would have previously led to severe pressure accompanied by depressive symptoms and dysfunctional behavior patterns as identified by ML, he was able to cope with the stress effectively by using his reinforcing behavioral and cognitive restructuring tactics.

11 Treatment Implications of the Case

Multiple implications can be derived from this case study, considered in the context of other related research. First, this case study provides further support for the utilization of CBT for adolescents with depression, corroborating further case series studies with adolescents (i.e., Chafey, Bernal, & Rosselló, 2008; Curry, 2001; Kaslow & Thomson, 1998) and studies done with adult samples (i.e., Roth & Fonagy, 2005). Moreover, the cross-cultural implications of the unique aspects of Indian family life need to be established and incorporated in the adaptation of the traditional therapeutic approaches. It is important to build the body of literature on effective treatment interventions for adolescents with depression given the severity this disorder may assume.

Second, this case implicates the importance of including the patients in the process of therapy, as an adolescent patient will fare much better over time if the entire family system is involved in the treatment. Moreover, the parents themselves could be unwittingly serving as a maintaining factor for their adolescent, as was in this case report. It is necessary for the parents not only to be psychoeducated but also to be trained to provide such a supportive and conducive environment that could help in overcoming the adolescent’s symptoms. Thus, it might be appropriate to say that there are not only “problem children” but there may also be “problem parents” sometimes.

12 Recommendations to Clinicians and Students

Often, a case presents itself as simple, clear, and straightforward as its face value. Especially in the case of an adolescent, if the parents and the adolescent present opposing points of view, blaming each other, most often the parents’ complaints regarding the adolescent’s behavior are
to be taken seriously as adolescence is a phase of dilemmas during which adolescents usually do face turbulence, and often the behavior of the adolescent needs to be the target of the therapy. However, it is vital to be very sure of making such judgments only after a complete and unbiased appraisal of the situation, without any haste in jumping to conclusions. As seen in this case report, the initial presentation of the case could appear to be regarding the adolescent’s academic performance, attributed to his behavioral problems. However, a thorough appraisal of the situation would reveal other factors at work behind the curtain that are contributing to the problem. Hence, this case illustrates the importance of involving the parents of the adolescent in the entire process of assessments as well as therapy, as the parents could play a major role in not just helping in the treatment of the adolescent but also in the prevention of such problems in the future. Finally, this case reiterates the importance of parental awareness and training, especially in India, to prevent such cases of adolescent depression in the future.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) received no financial support for the research, authorship, and/or publication of this article.

References


**Bios**

**Roshni Sondhi** is a research scholar and postgraduate in clinical psychology as well as psychotherapy. She has had more than 2 years of supervised training in clinical settings. She has also completed a junior level training in cognitive-behavior therapy. Her areas of interest include gerontology and social and cognitive psychology.

**Shagun Gulgulia** is a research scholar and a postgraduate in clinical psychology. She has had 2 years of supervised training in clinical settings and 2 years experience with the Department of Child Safety (Australia) assessing cases of harm to children. Her areas of interest include child and adolescent psychology.

**Vandana Shriharsh** is a rehabilitation psychologist registered with the Rehabilitation Council of India. She is as an assistant professor at Amity Institute of Behavioural Health and Allied Sciences. She has more than 12 years experience in clinical and rehabilitation psychology. Her areas of interest include psychodiagnostics and cognitive-behavior therapy.