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**Cognitive- Behavioral Interventions
in Depressive-Anxiety Disorder. Case Study**

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Abstract: In this paper I used methods specific to cognitive-behavioural psychotherapy in solving a case of *depressive-anxiety disorder with panic attacks*. Cognitive-behavioural therapy (CBT) is a form of problem-focussed psychotherapy, with obvious results centred on ameliorating or curing neuropsychotic (nervous diseases) or psychosomatic symptoms (relating to the mental origin of certain diseases). After a nine-seat sessions, the patient's condition is greatly improved, panic attacks decreased as frequency and intensity. I have noticed in my patient's evolution that depressive symptomatology has been reduced by reducing the anxiety symptoms. I told him that there might be panic attacks, but that this is irrelevant to the idea of reoccurrence of the anxiety disorder. It is good to interpret the possible panic attack as an event from which to learn something - to analyze it, to think about what it has caused.

Keywords: Depression; anxiety; panic attacks; rational/irrational beliefs; cognition; behaviour; self-confidence

Introduction

Psychotherapy is based on the assumption that, even in the case of a somatic pathology, the way the individual will perceive and evaluate his condition as well as the adaptive strategies he uses, plays a role in the evolution of the disorder, and these strategies will need to be modified if we want the disease to evolve favourably. Based on any psychotherapy is the belief that people with psychological problems have the ability to change by learning new strategies to perceive, evaluate and behave.

According to psychology specialists, Cognitive-Behavioural Therapy (TCC) is a problem-focused form of psychotherapy with obvious results centred on alleviating or curing neuropsychological (nervous diseases) or psychosomatic symptoms (on the mental origin of some diseases).

This psychotherapeutic school combines two therapies: *cognitive* and *behavioural*.

In the cognitive-behavioural therapy, special emphasis is given to cognitive and attitude restructuring techniques. The basic principle of therapy starts from the fact that the way a person behaves is determined, first of all, by the way that person interprets the immediate situations. I will present a case study in which I have used methods and techniques in the field of cognitive-behavioural psychotherapy.

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Case Study

Case M.M. – *Depressive-anxiety disorder with panic attacks*

Session. I. Brief description of the problem:

M.M. is a sales agent, aged 39, higher education. The diagnosis I have identified is depressive-anxiety disorder.

Description of symptomatology

Depressive-anxiety symptomatology:

- *palpitations*;
- *dizziness*;
- *feeling faints* (I feel I'm going to fall on the street);
- *general malaise*;
- *insomnia* (constant and they consist in falling asleep and early awakening, unassuming sleeping);
- Feeling of chronic fatigue and drowsiness ("I do not have strength to do anything");
- *moments of sadness* (weekly occurrence);
- *idea of personal devaluation* – the patient is convinced that "the end is near", saying "I do not think I will live much longer, I no longer have a lifetime, no longer use to anyone";
- Inability to focus attention (patient cannot concentrate enough, gets tired very quickly);
- lack of hope (by going to a lot of specialists and not solving the problem, the patient has come to assess the present situation as being out of the solution).

The **onset of the disease** is about 2.5 years ago.

The frequency of panic attacks: Panic attacks occurred every two days, which caused him to isolate himself at home for fear of "not getting ill" or not having a heart attack. Isolated in the house and avoiding to go out alone (even at shopping), the incidence of panic attacks has dropped to 1-2 times a week. But in the last two or three months, they began to appear in the house as well. From the point of view of the level of activism, the following important aspects can be highlighted in the dynamics of therapy: *loneliness, apathetic-passive social withdrawal, lack of social contacts; excessive centering of the person on his/her own health problems; non-involvement of the person in other activities.*

Avoidance behaviours:

-To the question, "What did you quit to do or where you've stopped going because of your problem," the patient replies, "I'm not doing anything anymore, I'm not going anywhere, or going to clubs, discos." The patient has adopted a social withdrawal, has given up any exit to avoid a recurrence of a panic attack. He tries not to make an effort, not to leave the house, not to get tired in the idea that he is "sick of heart" ("I'm afraid to have intimate relationships for fear of not having a heart attack"), this way he was actually trying to protect himself.

Medical and psychiatric history: In the past year, several cardiac examinations have been performed (each time the ECG has gone good), and no cardiologist has been given a specific treatment, the patient fails to explain this and tends to put all his health problems on account of a "heart disease".

Beliefs about problems: As to the patient's belief about his problem and the possible causes of the problem, the patient can not explicitly formulate a particular cause, rather making a vague reference to a cardiac affection.

Engagement, motivation: The level of self-knowledge is weak, verbalization is poor, and identification of the main stressors is poor. This is a state of confusion about the state of illness. The patient declares to be very motivated to get rid of this problem.

At the end of this first session, I considered very important that the *diagnosis be clearly formulated and explicitly communicated*. Thus, the confusion of the patient (fed by the belief that it is a „very special” problem will be reduced.) Moreover, for the success of the therapy I considered very important the clear communication of the costs of the therapy and of a positive prognosis (to motivate the patient and anchor him positively), which could result in greater involvement in the therapeutic process and avoidance of a passive attitude towards the therapeutic process. I communicated the results of the psychological evaluation and diagnosis established at the end of the first session and I told the patient that it was an anxiety disorder, which it was not about “heart problems” but about panic attacks, in which case I proposed the following:

Reducing panic attacks

- by approaching them on the following sessions (implicitly a reduction in the degree of cognitive and affective dissonance, by explaining anxiety and panic attacks);
- identifying and modifying negative cognitions and negative automatic thoughts;
- providing tools to fight panic attacks (a complex of physical exercise, breathing and relaxation, a well-established and respected program);
- inducing better body and affective/emotional control;

Addressing depression reactions

- organization of the patient's social context (currently lacking positive reinforcements);
- assertive training;
- a program of sustained daily activities (to reduce retirement and isolation trends).

Improving self-image and increasing self-confidence by suggestive techniques (the Schultz exercise at the end of each session, and in this exercise I also included organospecific formulas for better body control)

Session no. 2

First, in this session I chose to make the patient differentiate panic attacks from heart attacks.

The objectives of this session were the following:

- Awareness of mechanisms involved in panic attacks;
- Setting strategies to deal with panic attacks;
- Identifying the automatic thoughts, evaluations that trigger panic attack

The first step in this session was to explain to the patient what was happening physiologically during a panic attack, to emphasize that it is not an “irreversible” heart rhythm disorder (it is not a cardiac disease), but a reversible one (as in situations where we feel a strong fear or we are very tired).

I explained that the panic attack cannot cause a heart disease or a heart attack, especially considering that all cardiac examinations did not detect any cardiac condition (this was a great benefit in therapy), meaning that he has got a healthy heart (I emphasized this idea). He denied, but yet he said he was so dizzy that he felt he would faint. I have denied this dysfunctional assessment by telling him that the physiological processes involved in fainting are exactly opposite to those in the states he was experiencing.)

I explained the patient that during a panic attack, the heart beats faster, which is why the blood flow is accelerated, while in the faint states the opposite happens, the blood pressure decreases. There will not be a fall in the legs and will not hinder the movement, although he feels that this would happen feeling the soft feet and dizziness. I told her that he felt that way because a large amount of adrenaline was discharged into the body, causing limb vasodilatation to produce a feeling of muscle weakness (I compared it with intense fears).

I told my patient that panic states are alert states in which our body enters when we are in a dangerous situation, and adrenaline discharges have the potential to give us a “surplus of energy” to overcome the danger. It is only in the panic state that there is no real, objective danger, but rather a mistaken assessment - such as “I’m going to infarct” or “I’m going to fall away.

On this session, I set out the tasks to be done daily the following week:

- *Daily walks in the park (monitoring the states that the patient would feel)*
- *To accomplish a program of daily activities* (through which I aimed to install an anxiolytic effect - to reduce the impact and incidence of unexpected events and to imprint a steady rhythm to avoid the occurrence of agitation:
- Clear definition of daily goals and priorities;
- Establishing an order in performing the tasks;
- Fulfilling one task at a time and trying to complete it before the start of another;
- gap between activities;

At the end of the day I asked the patient to remember how many problems he had solved and to provide himself a reward;

Program organization in such manner to exclude the passivity periods.

I suggested the patient to eliminate the passivity hours in which he remained inactive, doing nothing, thinking about his health and what he could do on that day, told him to think that his disorder was psychological, and these periods of inactivity will feed him endlessly and that we have to break this “vicious circle.” We ended this session with a relaxing Schultz exercise, at the end of which we introduced suggestions for the strengthening of the Ego as well as organospecific and intentional formulas – “my heart is healthy, my heart works by itself, I will overcome these states, it’s nothing but anxiety, which I will manage to overcome”). My patient responded very well to this exercise, entering the relaxation state. Asking him how he felt, he responded that he felt very good. I told him that from now on he would feel better and better, it is just a matter of time until panic states disappear

Session no. 3

During previous sessions, I noticed a type of high breathing (clavicular) on my patient, suggesting him that on this session I would make him aware of this fact and cause him to “reeducate” in this regard. On this session I planed to explain the importance of breathing and relaxation in reducing the intensity of

anxiety states and reducing panic attacks. My attempt is to empower my patient and to induce him an anxiolytic exercise system - a type of breathing (relaxing) and also relaxing method that can also be enjoyed outside of psychotherapy sessions.

Starting with this session, I told my patient that he would have tasks to perform like abdominal breathing (diaphragm) and progressive muscular relaxation exercises (Jacobson). The exercises' frequency will be 2 times a day. Asking him how he felt in the previous week, he replied, "I guess, I felt more peaceful!"

I started this session evaluating the tasks my patient had to accomplish in the previous week. He told me he walked, but only twice, because he was afraid something could happen. I asked him what could happen? He replied "It scares me that my heart is starting to beat faster, I'm afraid something could happen when I'm moving!" "It's natural to beat faster, just make physical movement", "And if I do a heart attack?", "Physical movement does not hurt anyone, but it strengthens the body. Cardiac patients, daily walk, a set of daily exercise are recommended. I tell you this though you are not cardiac, the more these exercises cannot hurt you. Your problem is not organic, it is psychologically conditioned! Physical movement will only help tone your body and strengthen your immune system!". "For your healing, it is important to realize that this is a misinterpretation of a physiological reaction that has no relevance in terms of affecting your longevity or health!"

We continued the session by doing an exercise of abdominal breathing (telling him this would have a relaxing effect), teaching him to do abdominal breathing exercises as many times a day as possible with a time limit (minimum 10 minutes) and also a Jacobson exercise.

We did a Jacobson relaxation exercise, watching how each body segment tightens and relaxes, and I told him he had to do this exercise three times a day after the breathing exercises. For better patient motivation, I told him that these two exercises are essential in combating panic attacks. Further on the current session, I set up with my patient what he had to do when he thought a panic attack would trigger:

Breathe abdominally - while I am telling this in my mind I breath abdominally, this will help to establish a state of physical relaxation and psychological association;

Not to resist the panic attack, to let the body get out of it, nothing will happen - I wrote on a file that I gave him at the end of the session the following suggestions to use: "I don't resist my states, I let them down, it will not take more than 10 minutes. The condition will be released and I will feel much better. If I resist, I will only emphasize the negative state and make it last longer. I'm letting myself go with the flow, everything will go much faster if I do not resist. I let time pass - If I'm still, the discharged adrenaline will be metabolized within 5 minutes and I will feel much better".

To live the present -I focus on an object around - If it happens in the house I try to do something simple (I read a newspaper, I watch TV, etc.) or number from 1000 to 1 out of 7 in 7; if it happens to me outside the house, I try to talk to someone, but not on my own.

Manage positive suggestions - nothing will happen, the state will be consumed without anything happening; I told my patient that every time he experiences panic, he will follow these steps and notice that the panic attack will diminish in intensity. That is why he must not avoid them, but on the contrary overcome them all, doing so will speed up his recovery. Avoiding panic-stricken situations will strengthen the vicious circle in which it revolves (I explained this idea to his case - his isolation in the house led to the installation and reinforcement of panic attacks). I continued then to do the Schultz relaxation exercise. The patient feels good after these exercises.

In this **session**, thinking that my patient better understands what anxiety and panic attacks are, and that he will better understand the consequences of his condition, I tried to re-explain anxiety and panic attacks. Asking him how he felt in the previous week, he answered, “I felt much better. It’s like I’m not really so scared. I’m trying to think about how you told me and I’m going over them!”

I started this session by evaluating the tasks my patient had to accomplish in the previous week. He told me that this time he made the walks in the park (but not all, on some days he seemed “not in the mood”, I told him that the lack of mood is part of the same vicious circle we try to break), being able to pass much better over the fear of “not feeling anything at heart”. I’ve been trying to reinforce the idea, “You’ll never do anything, nothing will happen to your heart,” “It’s natural for heart rhythm to become stronger when we do more exercise or feel a strong emotion.” The patient went out to the market, each time unaccompanied, and each time the panic states tried to settle, but he did the steps we set up and managed to cope with. It is important that he realizes that nothing is happening by himself, that the heartbeat is calming for itself.

I tried to play a supportive rather than interpretive role. The improvement achieved gave hope to my patient and increased the therapeutic alliance. I have tried to emphasize these states through formulas such as “you are on the right track, from now on, it is only a matter of time, everything will be fine!” Prior to the Schultz relaxation exercise, I set out the tasks to be done daily in the next week:

- Daily walks (on foot and accompanied - minimum 30 minutes);
- Abdominal breathing exercises (with time limit- minimum of 10 minutes, minimum 3 times a day before the Jacobson exercise);
- Jacobson Progressive Muscle Relaxation Exercises (3 times a day);
- Contacting former colleagues to establish a meeting.
- I ended up with a relaxing exercise Schultz.

Session no. 5

I started this session re-expressing my mechanisms involved in the panic attacks setting in, underlining that, although I do not resist my states, I can replace catastrophic interpretations by positive self-suggestions (“nothing will happen, everything will be fine”); Instead of focusing attention on the inside of the body, it can focus attention on anything else (around). To avoid suppressing anxiety as a condition by my patient, I tried to redefine the state of anxiety by saying that anxiety is an essential energy state for survival, that it exists in all people, except that when it exceeds a certain limit it becomes harmful (“everything that is too much, ruined).

I partially took over a formula from the Higgins hypnotic intervention: “Like any other form of energy, anxiety can damage too much, so it can be used optimally, you cannot be anxious without being a person with a lot of imagination, people with no imagination rarely experience anxiety; therefore, anxiety is not a totally negative state, it must only be controlled, which you have begun to do!”.

I considered very important for him to understand that these states can be controlled, that they do not simply discharge, and that he does not passively participate in these states.

The effects of this control can be seen by themselves - attacks have decreased in intensity and frequency since he has a strategy of fighting against them (I have tried to use this improvement as a positive anchor in therapy and make my patient get he feels responsible for the progress he has made).

Tasks to be performed daily the following week remained the same:

- Daily walks (on foot and accompanied - minimum 30 minutes);
- Abdominal breathing exercises (with time limit- minimum of 10 minutes, minimum 3 times a day before the Jacobson exercise);
- Jacobson Progressive Muscle Relaxation Exercises (3 times a day);
- Contacting former colleagues from work, high school/faculty to establish a meeting;

From the evolution of my patient up to this session, it can be said that lack of hope, the uncontrollability of body feelings (accompanied by feelings of renunciation) and negative expectations as depressive (associated with panic attacks) have diminished. I concluded this session with a relaxing Schultz exercise.

Sessions no. 6, 7, 8

I considered my patient's evolution was good, and he was on the right track, so I opted for a supportive approach, running the next two sessions only with accompanying exercises without trying a significant recall of my patient's thoughts and states. In these **sessions**, I focused on supportive formulas ("you are on the right track, your condition will be greatly improved, etc.") and on relaxation exercises. I communicated the decision to terminate therapy (as a result of the very good improvement of his general condition) at the end of the eighth session.

Session no. 9

This is the last session (patient's condition is greatly improved, panic attacks are reduced as much frequency and intensity), for which I have proposed to be more supportive, and try to induce my patient a state of optimism.

I considered that the general therapeutic objectives were achieved; the most important is that the premises were created for their better realization. I have noticed in my patient's evolution that depressive symptomatology has been reduced by reducing the anxiety symptoms. I considered that although my patient's condition was not completely improved, he was on the right track, and he can now manage his own states (he also became aware of most aspects that influence the emergence and evolution of panic). I thought that in this session I would prepare him for the eventual relapse. I tried to resign the possible panic attacks that may occur. I told him that there might be panic attacks, but this is irrelevant to the idea of reshaping the anxiety disorder. It is good to interpret the possible panic attack as an event from which to learn something - to analyze it, to think what exactly has caused it.

I resumed the formulas to strengthen control and to emphasize the absence of danger – "For your healing, it is important to be aware of the absence of danger. Now you know that this is not about a weakening of your heart, but just about a misinterpretation of a physiological reaction that has no relevance in terms of affecting your longevity or your health." I tried to emphasize these states through formulas such as "You are on the right track, from now on, it is only a matter of time until panic attacks are gone, everything will be fine. From now on, you know what to do."

I told him that the tasks he had to accomplish daily during psychotherapy are good for him to continue to use, because they have certain advantages, regardless of whether the anxiety states have disappeared (the advantages are psycho-physical relaxation, preservation of a good psychic tonus, much healthier breathing, better oxygenation of the body, etc.). I used the following tools:

Cognitive level:

1. Dysfunctional Attitude Scale (DAS);

2. Attitude and Belief Scale, (ABS -II);
3. Automatic thoughts questionnaire (ATQ).

Personality structure:

1. Eysenck Personality Inventory (EPI);
2. Defensive- coping mechanisms (B-Cope).

Subjective affective level:

1. The profile of the emotional distress (PDE);
2. Beck Depression Inventory.

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