

UNIVERSIDAD SAN FRANCISCO DE QUITO

SCHOOL OF BEHAVIOR SCIENCES AND EDUCATION

**CLINICAL STUDY CASE: A COMBINATION OF POST TRAUMATIC STRESS
AND DYSTHYMIA**

By

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DEDICATION

To my parents, Pablo and Maria Luisa who made this possible, and to my grandmother,

Elsa.

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RESUMEN

La Terapia Cognitivo Conductual reduce los síntomas tanto de depresión como ansiedad a un nivel más rápido que cualquier otra terapia (Malkinson, 2010). El sujeto a participar en este estudio de caso es una mujer que cumple con los criterios de Estrés Postraumático y Distimia y fue tratada con Terapia Cognitivo Conductual. Los resultados de este estudio son basados en datos cualitativos y cuantitativos que fueron recopilados por medio de filmaciones y notas clínicas recopiladas en terapia e instrumentos psicométricos como auto-cuestionarios. Cabe recalcar que después de la intervención clínica se pudo observar una reducción de síntomas tanto de ansiedad como de depresión en el sujeto así como distorsiones cognitivas, comportamientos mal adaptados y problemas en relaciones interpersonales y en ocupaciones de manera significativa. De igual manera, se pudo encontrar mejora tanto en establecer vínculos emocionales así como alcanzar objetivos tanto personales como profesionales. También, el sujeto elevó su nivel de autoestima así como su sistema tanto social como ocupacional. Es evidente que el tratamiento permitió que el sujeto aprenda y experimente maneras adaptativas de pensamiento así como de comportamiento y que al final de la intervención no cumple los criterios de Estrés Postraumático ni Distimia.

Palabras Clave: terapia cognitivo conductual, comorbidad, distimia, efectividad, datos epidemiológicos, estrés postraumático, prevalencia, trauma, relajación progresiva muscular, desensibilización sistemática.

ABSTRACT

Symptoms of depression and anxiety are reduced through Cognitive Behavioral Therapy (CBT) at a higher rate than any other therapy (Malkinson, 2010). The subject of this case study is a woman who meets the criteria for Post-Traumatic Stress Disorder and Dysthymia and is being treated with CBT. Results were based on qualitative and quantitative information that had been collected through audio recordings of therapy sessions, clinical notes taken within sessions, and psychometric instruments of self-reporting. After the clinical intervention, the subject experienced a significant reduction in anxiety and depressive symptoms, cognitive distortions and maladaptive behaviors and in relational interpersonal and occupational problems. There were visible improvements in re-establishing intimate relationships, meeting personal goals, self-esteem and social and occupational functioning. The therapeutic treatment permitted the introduction of new healthier mental and behavioral schemas. At the end of treatment, the subject's symptoms no longer met the criteria for PTSD and Dysthymia.

Key Words: cognitive behavioral therapy (CBT), comorbidity, dysthymia, effectiveness, epidemiological data, post-traumatic stress disorder (PTSD), prevalence, trauma, progressive muscle relaxation (PMR), systematic desensitization

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INTRODUCTION

Before PTSD was introduced in the 1980's in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), it was referred to as a gross stress reaction or transient situational disturbance (Meichenbaum, 1993). Previously, it was given names such as 'railway spine disorder,' 'nostalgia,' 'soldier's heart,' 'psychic trauma neurosis' and, 'irritable heart' (Meichenbaum, 1993). Since PTSD involves the presence of intrusive thoughts, hyper vigilance, phobic-like avoidance behaviors, worry over loss of control, fear of the repetition of a traumatic event and exaggerated startle responses, it has been included within the anxiety disorders category. Despite its various anxiety symptoms, PTSD been established as a single disorder (Meichenbaum, 1993).

In recent years, Dysthymia has been re-classified as a chronic affective disorder (DSM-IV-TR, 2000) instead of a personality disorder. Because individuals with Dysthymia are not often asked questions that would lead to its diagnosis, many studies have shown it to be one of the most difficult disorders to diagnose (Breggin, 1991). Studies of people who suffer from Dysthymia indicate that they experience their life as a "flat line"; they do not feel pleasure or disgust in response to any events (Breggin, 1991). It is important to note that mood disorders and anxiety disorders are comorbid in a 70% (Malkinson, 2010). This study discusses a case of PTSD with Dysthymia.

Antecedents and Background

A brief summary of the History of PTSD and Dysthymia

The following information will provide a brief background of the origins of PTSD and Dysthymia.

Origins of PTSD.

There are many theories about the origin of trauma and how it triggers Post Traumatic Stress Disorder. Some theories suggest that trauma emerges due to a genetic predisposition and memory codification; others suggest that trauma originates from environmental experience formed in the memory of the subject (Kempie & Zinziswa, 2012). “The neurobiological approach especially focuses on memory consolidation or over-consolidation, while the psychological traditions often focus on why these strongly formed memories are intrusive while most other memories are only activated by conscious recall” (Kempie & Zinziswa, 2012, p.53).

Many researches support the theory that the memory itself is not the only factor which causes trauma and its development into PTSD. Instead, the trauma and its development into PTSD are caused by the way the event and memory are remembered and coded in the brain (Kempie & Zinziswa, 2012). “The central issue of memory disturbance is important as the event which is etiologically related to the syndrome cannot cause all the symptoms; it is the memory of the event that causes the symptoms (Kempie & Zinziswa, 2012, p.53). Indeed, evidence suggests that the neurobiological responses contribute to the formation of intrusive memory and, therefore, to the origin of the trauma (Kempie&Zinziswa, 2012).

Origins of Dysthymia.

There is sufficient evidence that suggests that Dysthymia originates from a genetic predisposition and heredity factors (Breggin, 1991). Studies reveal that children from families with a history of depression or other mood disorders have a 70% probability of developing a mood disorder at some point in their lives (Cuijpers, Beekman, Smit & Deeg, 2006). Some psycho-social factors that are believed to contribute to the development and existence of a Dysthymic disorder are a lack of motivation from external stimuli in the early years of childhood and emotional detachment of family members (Cuijpers, Beekman, Smit & Deeg, 2006).

The problem

Little is known of how to treat a case of PTSD and Dysthymia in the Ecuadorean context; this thesis attempts to provide further information on how to treat a case with these characteristics on a particular subject.

The subject participating in this case study needs psychological treatment to alleviate her anxiety and depression symptoms, reduce her stress, and improve her quality of life. Her extreme fear and anxiety symptoms are causing concentration problems inhibiting her ability to concentrate on her work and are preventing her from meeting her long-term goals of studying and finding a job abroad. The idea of moving further away from her family and not being present when they need her exacerbates her excessive fear of losing loved ones and her clinical framework of PTSD and Dysthymia.

Roots of the Problem

The subject's loss of family members in a car accident caused her symptoms of anxiety and intensified her symptoms of depression.

Hypothetical solution

Cognitive behavioral therapy will reduce her symptoms of anxiety and depression.

Research Question

How and to what extent will cognitive behavioral therapy reduce the symptoms of anxiety and depression manifested in the subject?

Context and Theoretical Framework

Although there are many therapies that can be effective to treat Post-Traumatic Stress Disorder, anxiety, and other depression-related disorders, Cognitive Behavioral Therapy (CBT) is the preferred method of treatment due to substantial evidence that has shown it to be the most effective treatment method (Hollon & Ponniah, 2009).

Beck's cognitive model, consisting of three fundamental structures--core beliefs, intermediate beliefs, and automatic thoughts (Beck, 1995) was used to interpret the subject's case.

Purpose of the study.

The objective of this case study is to offer high quality information about alternative interventions for PTSD to the Ecuadorean public. Moreover, this case study also attempts to offer detailed treatment information for a comorbid case of PTSD and Dysthymia in Ecuador.

The meaning of the study.

This study is important since it provides detailed information about how to apply Cognitive Behavioral Therapy (CBT) to a case of Post-Traumatic Stress and Dysthymia in Ecuador. It can also serve as a basis for future studies in the field of clinical

psychology and the application of CBT. This study can be a model for future investigations on anxiety and mood disorders.

Definition of keywords

Due to the possibility of misinterpretation of the term “comorbid”, it is important to clarify that in this study, “comorbid” is defined as when there exists a medical condition that occurs simultaneously with another, but both manifest in an independent form (Trull & Phares, 2003).

Author Presumptions

One of the major presumptions is that the subject will be consistently honest with the therapist. It is also expected that the studies of the application of Cognitive Behavioral Therapy performed in the United States, Europe and in other Latin American countries can be applied in the Ecuadorean context. Additionally, it is presumed that the questionnaires applied are valid tools to measure symptoms of anxiety and depression.

Assumptions

It is assumed that symptoms of anxiety and depression can be measured by questionnaires and self-reports. Additionally, it is supposed that it is possible to create a clinical framework based on self-reports and interactions occurring in therapeutic sessions. It is also expected that the therapist has the appropriate training to treat anxiety and depression disorders.

The following literature review is divided into five categories. It is then followed by a description of methodology, an analysis of the results, and conclusions.

LITERATURE REVIEW

Literature included in the review

Sources.

Books in the field of clinical psychology and psychiatry were the primary sources used in this case study. This case study also considered articles from peer-reviewed journals of clinical psychology and psychiatry and application manuals of Cognitive Behavioral Therapy.

Steps in literature review process

The literature review was selected based on a brainstorm of key words that were related to Post-Traumatic Stress Disorder and Dysthymia. Additionally, the most representative authors of Cognitive Behavioral Therapy were taken in account and selected as primary sources. Online journals were also used as references and sources of related investigations and were selected based on the key terms.

Format of the literature review

The literature review is divided and categorized by topics. It is divided in five categories: (a) cognitive behavioral therapy, (b) the Beck cognitive model, (c) a description of post-traumatic stress disorder, (d) a description of dysthymia, and the (e) case conceptualization with cognitive behavioral therapy.

Cognitive behavioral therapy.***Origins of CBT.***

Cognitive Behavioral Therapy (CBT) was developed by Aaron Beck in 1962 primarily for treating depression (Beck, 1995). It started as a short-term process therapy directed towards solving current problems in order to improve the mood and quality of life of individuals (Beck, 1995). Other major theorists, such as Albert Ellis (rational-emotive therapy), Donald Meichenbaum (cognitive-behavioral communication), and Arnold Lazarus (multimodal therapy) contributed to the development of CBT by providing different models and different perspectives (Beck, 1995).

One of the cornerstones of Cognitive Behavioral Therapy, according to Beck, (1995) is that the therapist and client should work together as a team to identify and solve problems. The role of the therapist is to help clients to overcome difficulties by means of changing their thinking, behavior, and emotional responses (Beck, Rush, Shaw & Emery, 1979). According to CBT, any psychological disorder involves maladaptive thinking and behaviors that must be modified in order to achieve more highly adaptive psychological functioning (Beck, 1995).

The patient learns to master problems and situations that he previously considered insuperable by reevaluating and correcting his thinking. The Cognitive therapist helps the patient to think and act more realistically and adaptively about his psychological problems and thus reduces symptoms (Beck, et. al, 1979, p.4).

Construction of the framework of the patient according to CBT.

Beck states that it is important to have a framework of the patient in order to understand the direction that the therapy has to take and the client's way of thinking and

reacting (Beck, 1995). Some questions that can help the therapist build a framework include: What is the patient's diagnosis? What are his/her current problems? How did these problems develop? Why do they persist? What are his/her dysfunctional thoughts and beliefs? (Beck, 1995).

In order to construct the patient's framework, the therapist will find it helpful to hypothesize what early learning, experiences and genetic predispositions are contributing to the patient's current problems (Beck, 1995). In order to understand the patient's current situation and determine the appropriate course of treatment, knowledge of the way a person copes, his affective and behavioral mechanisms, his self-image and world view, and the stressors that contributed to the beginning of the psychological disorder is crucial (Beck, 1995).

Elements used in CBT.

This theoretical orientation involves education, skill building and problem solving. These are the main elements needed in order to reconstruct the patient's distorted beliefs and thinking while ameliorating her symptomatology and negative emotions. CBT also assumes that emotions, behaviors and somatic sensations are moderated by cognitive processes that can be changed or reconstructed (i.e. appraisals of events can be changed as a means to reducing stress) (Malkinson, 2010).

Effectiveness of CBT treating anxiety and depression related disorders.

More than 400 outcome studies show that CBT is highly effective in treating depression and anxiety-related disorders (Malkinson, 2010). CBT is the preferred theoretical orientation based on evidence of its effectiveness in the treatment of individuals with clinical depression and anxiety (Hollon & Ponniah, 2009), Post-Traumatic Stress Disorder (PTSD) and grief (Malkinson, 2010).

The Beck Cognitive Model.

The Beck Cognitive Model affirms that a person's behaviors and emotions are influenced by their perception of their experiences. Their feelings are often closely related to their understanding and interpretation of their experiences and how they interpret the situation (Beck, 1995). The Beck cognitive model consists of three fundamental structures: core beliefs, intermediate beliefs and automatic thoughts (Beck, 1995). Because feelings, emotions and behaviors are central to the therapeutic process, the therapist must also acknowledge and address them in therapy.

Core Beliefs.

Core beliefs are the most central, fundamental and profound thoughts that a person has of himself and his context (Beck, 1995). Core beliefs are experienced by the person as absolute truths; they are rigid and have an over-generalizing quality (Beck, 1995). These beliefs are the origin of intermediate beliefs (rules, attitudes, and assumptions that a person develops as he interacts with his environment) and automatic thoughts (quick, evaluative thoughts that are made quite rapidly and unconsciously) (Beck, 1995).

Core beliefs and intermediate beliefs arise because individuals try to make sense of their environment according to their early stages of development, "They need to organize their experience in a coherent way in order to function adaptively" (Beck, 1995, p. 166). It is important to note that people are not conscious of either their intermediate beliefs or their automatic thoughts. This lack of awareness is what leads them to uncritically accept them (Beck, 1995). Core beliefs, however, are often more explicit. They may even come up in daily conversations like: "I am awful at relating to people!" or "I can't do anything that requires coordination" (Beck, 1995).

Intermediate Beliefs.

As briefly mentioned before, intermediate beliefs are a set of rules that person develops based on their core beliefs. These beliefs are more superficial than core beliefs and influence the direction of automatic thoughts (Beck, 1995). Intermediate beliefs are crucial to the cycle of anxiety and depression; therefore, discovering and being conscious of them can promote positive change (Rhudy, Davis, Williams, McCabe, Bartley & Pruiksma, 2010). Some key aspects of intermediate beliefs are the assumptions, expectations, and relationships a person has about the self and the world (Beck, 1995). These involve the priorities of attention given by the individual and the biases that influence what people notice (or do not notice) and how they think or react in any given situation (Hollon & Ponniah, 2009). Some examples of intermediate beliefs are: "I should avoid meeting new people", "Avoiding serious relationships will keep me from getting hurt" or "I always look for danger and expect it to be there."

Automatic Thoughts.

Automatic thoughts are those immediate, quick and brief thoughts that occur in response to a situation and influence emotions and behaviors (Beck, 1995). Not all such thoughts are problematic. However, negative automatic thoughts are problematic because they have the tendency to appear unnoticed and remained unquestioned (Rhudy, Davis, Williams, McCabe, Bartley & Pruiksma, 2010). Although automatic thoughts are more superficial than the thoughts previously discussed, they are the key to working with the patient in cognitive behavioral therapy (Beck, et.al, 1979).

Learning to monitor and adapt automatic thoughts in a more adaptive, positive, and healthy way is the first step in cognitive behavioral therapy (Geiss, Wagner, Russo, Love & Zatzick, 2011). This activity takes practice, but regularly monitoring automatic

thoughts will help the patient learn the skill and notice them more easily (Geiss, Wagner, Russo, Love & Zatzick, 2011). Some examples of automatic thoughts are: "He thinks I am weirdo", "I won't pass that test", "My heart might stop beating", and "I will get a disease by touching that doorknob."

Studies have shown that identifying and validating automatic thoughts assists in the recognition of erroneous or dysfunctional beliefs (Beck, 1995). Maladaptive thinking patterns manifest themselves in cognitive distortions, in which the individual views a situation subjectively rather than objectively (Beck, 1995). Some of these cognitive distortions include:

- the "all-or-nothing" view, where a situation is viewed in only two categories instead of a whole spectrum of possibilities
- catastrophizing, where the individual predicts the future only in a negative way
- discounting the positive, where positive experiences and attributes are discounted in an unreasonable way
- emotional reasoning, where reasoning is based on feelings instead of evidence
- labeling, where there is the tendency to classify either the individual or others in an overly simplistic way.
- magnification/minimization, where the person tends to exaggerate the negative aspects of the circumstances and minimize the positive.
- selective abstraction, when the person pays attention to parts of the situation, instead of seeing it as a whole.

- mind-reading, where the person thinks he or she knows what others are thinking.
- over-generalizing, where there is a tendency to attribute the same characteristics to every situation, instead of separating them particularly.
- personalizing, where a person attributes all negative experiences and behaviors of others to himself.
- “shoulds” and “musts”, where a person has a fixed idea of how others or her should have. If these expectations are not, the response is disproportionately negative.
- tunnel vision, where the person only sees and focuses on the negative aspects of a situation.

(Beck, 1995).

Substantial evidence has been found that shows that the correction of these cognitive distortions can improve both an individual's mood and quality of life. This is due to the filtration of their automatic thoughts. (Rhydy, Davis, Williams, McCabe, Bartley & Pruiksma, 2010). The individual learns to evaluate automatic thoughts critically, and, consequently, experiences change in his emotions (Beck, 1995).

Emotions.

It is important to distinguish emotions and feelings, since the lack of distinction between the two may cause confusion and contribute to the language misinterpretation (Damasio, 1999). An emotion is a psycho-physiological experience where an individual's state of mind is interacting biochemically (internally) with the context and environment (externally) (Cain & Seeman, 2002). They involve physical arousal, behaviors, reactions

and conscious experiences (Cain & Seeman, 2002). Emotions are commonly associated with mood, personality, motivation and temperament and are a fundamental aspect of most individuals' lives (Cain & Seeman, 2002). According to Damasio, emotions are:

Specific and consistent collections of physiological responses triggered by certain brain systems when the organism represents certain objects or situations (e.g. a change in its own tissues such as that which produces pain, or an external entity such as a person seen or heard; or the representation of a person or object or situation conjured up from memory into the thought process (Damasio, 1999, p.15 in Lane & Nadel, 2000).

In contrast to emotions, feelings are interpretations perceived due to emotions themselves and arousal felt physically (Damasio, 1999). Additionally, feelings are universal since they involve a more individualistic interpretation and cannot be seen through facial expressions or body language (Damasio, 1999).

The term feeling should be reserved for the private, mental experience of an emotion. The term emotion should be used to designate all the responses whose perception we call feeling. In practical terms this means that you cannot observe a feeling in someone else. Like wise, no one can observe your own feelings, but aspects of the emotions that rise to your feelings will be patently observable to others" (Damasio, 1999, p.15 in Lane & Nadel, 2000).

Positive emotions produce a feeling (mental interpretation) of pleasure and are useful as motivation to move towards meeting one's desires and needs. Negative emotions are perceived as unpleasant and motivate the individual to avoid the source of discomfort (Snyder & Lopez, 2007). Emotions such as joy, achievement, motivation,

appreciation, relaxation, confidence, engagement, faith, pride and enthusiasm are considered positive; fear, anxiety, anger, frustration, sadness, detachment, confusion, shame and distraction are generally considered to be negative (Snyder & Lopez, 2007).

Emotions and feelings are central to Cognitive Behavioral Therapy (Beck, 1995). Intense negative emotions may be detrimental to the patient's growth and can have an enormously negative impact upon the individual's ability to think clearly, solve problems, act in an effective way, or enjoy and gain satisfaction (Snyder & Lopez, 2007). For the therapist to make an effective and appropriate intervention, it is essential that the patient is able to make a coherent connection between his thoughts, emotions, feelings and behaviors (Beck, 1995).

Behaviors.

A behavior is known as the action or the reaction that a person performs or manifests based on his emotions and beliefs (Myers, 2000). Behaviors are primarily composed of attitudes, which are evaluative reactions (positive or negative) towards a situation, others, and the context itself (Myers, 2000). A behavior is one of the mediums in which an attitude, emotion or belief can manifest itself (Myers, 2000). All of these factors are interdependent, and can be seen through the ABC dimension (affect, behavior and cognition) in the construction of a person's attitudes (Myers, 2000).

In the Cognitive model, behaviors play a very important role since they are seen as the expressions of the person's beliefs, attitudes and emotions (Malkinson, 2010). Cognitive Therapy is based upon the premise that if an individual's behaviors are modified, his emotions and beliefs will also change. These changes will lead the individual to change his maladaptive behaviors and beliefs, avoid his dysfunctional patterns, and, ultimately, feel better (Beck, 1995).

Description of Post-Traumatic Stress Disorder.

Although PTSD belongs to a broad category of anxiety disorders, its unique characteristics facilitate its diagnosis, and its severity distinguishes it from other anxiety disorders. PTSD involves an exaggerated startle response, hyper-vigilance, avoidance behaviors, intrusive thoughts, worry over loss of control or insanity, and fear of repetition of a traumatic event (Meichenbaum, 1993). People that suffer from this disorder have reported feeling as if they were constantly living in a nightmare (Breggin, 1991).

Demographical data of PTSD.

Prevalence is the proportion of people that manifest a given disorder in a specific time period; prevalence corresponds to the existing number of cases of that disorder in a group or population (Trull & Phares, 2003). This factor can be influenced by a series of characteristics, such as disorder occurrence (if a new disorder appears, the prevalence will increase) and duration (prevalence increases as length of time the individual lives with it the disorder increases) (Trull & Phares, 2003). Because researchers have sampled diverse populations and used distinctly varied methods in assessing PTSD, the overall incidence and prevalence of PTSD is widely disputed. (Meichenbaum, 1993).

A series of studies reveal that the general prevalence of Post-Traumatic Stress Disorder is estimated to be anywhere from 1% to 14%; in high-risk populations, this number/percentage varies anywhere from 3% to 58% (Rhudy, Williams, McCabe, Barlet & Pruiksma, 2010). Community-based studies in the United States suggest a lifetime prevalence for PTSD of approximately 8% of the adult population (DSM-IV-TR, 2000). Studies of at-risk individuals (groups exposed to specific trauma) present the highest rates of PTSD (ranging from one-third to more than half of those exposed) among groups of active members of the military, victims of abduction, former prisoners of war,

rape victims, survivors of genocide, and survivors of ethnically or politically-motivated internment (DSM-IV-TR, 2000).

Epidemiological Data PTSD.

- Three-quarters of the general population in the United States have been exposed to some event in their lives that meet the stressor criterion for PTSD.
- Approximately one quarter of individuals who are exposed to such traumatic events go on to develop PTSD Syndrome. Sexual assault routinely produces the highest rates of PTSD.
- Left untreated, half of those who develop PTSD may continue to have it for decades.
- The rates of PTSD usually decline over time, even without treatment. Rates of PTSD attributed to events caused by humans may never return to normal levels.
- About half of those treated may still meet full criteria for PTSD at the end of treatment.
- Other diagnoses associated with traumatic exposure include major depression, substance abuse, phobia and panic, adverse medical outcomes, and more frequent use of medical services.
- The intensity of exposure is a risk factor for the development of PTSD. Other risk factors include: low education/social class, pre-existing psychiatric symptoms or diagnosis, prior trauma, a family history of psychiatric problems, and exposure to multiple stressful events.

(Meichenbaum, 1993, p. 10)

Description of Dysthymia.

Although one or the other is often the primary diagnosis, approximately seventy percent of anxiety disorders are comorbid with depression disorders. (Breggin, 1991). Individuals that experience dysthymia describe their lives as free from strong emotions, of pain or pleasure (Breggin, 1991). When questioned, people with Dysthymia may describe their limited interest in/or enthusiasm for daily activities. Similarly, they may describe themselves as incapable or uninteresting and report frequent/daily self-criticism (DSM-IV-TR, 2000).

Demographical data of dysthymia.

Research on the prevalence of depression disorders is believed to be approximately 90% accurate because of the general consistency in the investigative methods (Hollon & Ponniah, 2009). “The lifetime prevalence of Dysthymic Disorder (with or without superimposed Major Depressive Disorder) is approximately 6%; the point prevalence is approximately 5%” (DSM-IV-TR, 2000, p.379).

Epidemiological data of dysthymia.

- Dysthymic disorder seems to occur in equal distribution in both sexes.
- Often results in impaired school performance and social interaction.
- In adulthood, women are two or three times more likely to develop dysthymic disorder than men.

(DSM-IV-TR, 2000, p.379)

Case conceptualization with cognitive behavioral therapy.

Origin of trauma according to CBT.

According to CBT, the trauma itself is what causes Post-Traumatic Stress Disorder (PTSD) in a person as well as other anxiety disorders. In order to label any

situation as a trauma or a traumatic event according to the criteria of PTSD in the DSM-IV-TR, the event must be acute or repetitive and play a significant role in the individual's life (Wilson, Friedman & Lindy, 2001).

The creation of trauma according to CBT based on information processing theory.

The Information Processing Theory of CBT suggests that traumas develop when certain emotions (in this case, fear) are encoded in the form of networks in the memory where representations of anxiety-charged events are stored (Sheperd & Bisson, 2004). It is strongly believed that this network of fear contains three types of information: the information about the fear stimuli or situation, the person's response to the fear stimuli or situation, and the meaning of the feared stimuli and the subsequent response (Sheperd & Bisson, 2004).

Fear networks and responses in people with PTSD.

All people have the fear networks listed above. However, individuals with PTSD:

- Have larger fear networks, due to the increased number of erroneous connections between stimulus, response and meaning elements;
- Are more easily activated by stimulus, response and meaning; and
- Experience more intense emotional and physiological responses

(Sheperd & Bisson, 2004).

Furthermore, the fear networks in a person with PTSD are activated when the traumatic memory or experience is remembered or triggered by the environment (bringing up intrusive memories). This recall provokes a high state of sympathetic arousal (i.e. increased blood pressure and heart rate, muscle tension, sweating), intense

feelings of fear and anxiety, and fear responses such as hyper-vigilance, avoidance and escape behaviors (fight or flight response) (Sheperd & Bisson, 2004).

Hyper-vigilance is a natural response following violent trauma. It is way of maintaining the mind and body alert for a real or imagined future threat. Hyper-vigilance can be the outcome of Acute Stress Disorder (Geiss, Wagner, Russo, Love & Zatzick, 2011). There are two ways that a person can react to a threatening event: fight (i.e. confront the threatening stimuli) or flight (i.e. avoid the threatening stimuli) (Ormrod, 2006). Studies of individuals with PTSD have shown that these individuals have a tendency to react with the flight response. This response seems to lead to further anxiety and ultimately results in a series of symptoms, one of which is hyper-vigilance (Breggin, 1991). During a period of heightened hyper-vigilance, individuals with PTSD experience bursts of nervous energy that sustain their flight response act as a drive to keep them performing their flight response (Wilson, Friedman & Lindy, 2001).

PTSD and panic attacks.

PTSD can be diagnosed with and without comorbid panic attacks. Panic attacks and agoraphobia, symptoms of many anxiety disorders, are listed separately in the DSM-IV-TR. If the criteria are met, panic attacks and agoraphobia can be combined with any other disorder (DSM-IV-TR, 2000). A panic attack is a period where the person unexpectedly experiences a sense of terror or fearfulness, at times associated with feelings of an impending death (DSM-IV-TR, 2000). Panic attacks may be diagnosed when an individual experiences four of the following symptoms (palpitations, pounding heart or accelerated heart rate, sweating, trembling or shaking, sensations of shortness of breath or smothering, feeling of choking, chest pain or discomfort, nausea or abdominal distress, dizziness, unsteadiness, lightheadedness or faintness, de-realization or

depersonalization, fear of losing control or going crazy, fear of dying, paresthesia, and chills or hot flushes) for no more than approximately ten minutes (DSM-IV-TR, 2000). Panic attacks can be experienced with or without agoraphobia, in which the individual avoids places without an easy exit or places where help during a panic attack may not be readily available (DSM-IV-TR, 2000).

CBT techniques to treat trauma.

Systematic desensitization.

Systematic desensitization is a type of behavioral therapy invented by Joseph Wolpe that is used to help overcome anxiety disorders as well as specific phobias (Hollon and Ponniah, 2009). This technique should be used only on patients who are prepared for this treatment and have been taught relaxation techniques. Therefore, it is generally inappropriate for patients in the early stages of their treatment (Malkinson, 2010). Systematic desensitization, also called graduated exposure, consists of overcoming an individual's flight response through gradual exposure to the feared stimuli or phobic object (Meichenbaum, 1993). It includes the gradual exposure of the feared stimuli (at first, though narrating, imagining, and remembering) at the patient's individual pace (Ormrod, 2006).

The goal of this process is to interrupt the patient's maladaptive processes and network patterns which encourage the avoidance schema of the feared stimuli or situation (Rhudy, Williams, McCabe, Bartlet & Pruiksma, 2010). The main objective of systematic desensitization is to make the patient confront her own fears at her own rhythm to overcome them (Ormrod, 2005). The patient is gradually exposed to feared objects or experiences, increasing in intensity, until she is able to manage her fears effectively. This

negative reinforcement provides the person with exposure to her most feared thoughts and situations in order to gradually overcome them (Ormrod, 2005).

Systematic desensitization of the feared stimuli or traumatic memory is used by CBT to treat a trauma. The exposure can be done through imagination, by writing of a narrative, or *in vivo* exposure to situations associated with the traumatic event. This exposure needs to be performed in safe conditions, at a pace comfortable for the client (Wilson, Friedman & Lindy, 2001).

Socratic questioning.

Another commonly used technique for treating trauma in CBT is Socratic questioning. In Socratic questioning, the therapist asks the patient open-ended questions that lead to reflection and, ultimately, to behavioral experiments where the patient actually performs the feared action in a controlled scenario developed collaboratively in session. The therapist works with the patient in three areas: the re-experiencing of the trauma through intrusive distressing recollections of the event (flashbacks and nightmares); the avoidance of places, people, and activities that are reminders of the trauma; and the experience of daily increased arousal that can be observed in problems with sleeping and concentration (Rhudy, Williams, McCabe, Barlet & Pruiksma, 2010).

Progressive relaxation.

Progressive Muscle Relaxation (PMR) was identified in 1934 by Jacobson (McCallie, Blum & Hood, 2006). In 1948, Wolpe adapted it for using it in systematic desensitization. Finally, Bernstein and Borkovec adapted it to fit into cognitive behavioral stress management by implementing relaxation through recall, recall and counting, and counting (McCallie, Blum & Hood, 2006).

PMR consists of tensing and releasing the 18 muscle groups which are: 1)right foot; 2)right foot and lower leg; 3)right thigh; 4)lower leg and foot; 5) left foot; 6) left foot and lower leg;7) left thigh;8) lower leg and foot;9) right hand; 10) right hand and forearm; 11) the entire right arm; 12) left hand; 13)left hand and forearm; 14)the entire left arm; 15)stomach; 16)abdomen and lower back; 17)back and upper chest; 18) shoulders and neck and face (McCallie, Blum &Hood, 2006). The technique involves focusing on the tension of each muscle group with a combination of breathing and mindfulness (McCallie, Blum & Hood, 2006). The steps include:

- Relax and use your mind to focus only on the specific muscle area that you are going to tense.
- Breathe in slowly and deeply as you squeeze the muscles of the specific area as hard as you can. The tension should be deliberate but gentle.
- Keep your muscles tense for approximately 8-10 seconds. You must feel the tension in your muscles; they may begin to shake.
- As you exhale slowly, relax your muscles quickly, releasing the tension. Imagine all of the pain and tightness flowing out of your body through the area you just relaxed. For example, if you contracted the muscles in your hand, imagine it being released through the tips of your fingers.
- Focus on the feeling of relaxation compared to tension.
- Remain relaxed for approximately 15 seconds. Then, repeat the process on the next muscle group.

(McCallie, Blum & Hood, 2006, p.55).

Using PMR in CBT permits the physical relaxation of the patient and can teach healthier physical and mental responses to stressors in the context. “Empirical evidence supports the use of PMR in high level tension responses and mind body techniques such as: reducing tension headaches, insomnia, adjunct treatment in cancer, chronic pain management in inflammatory arthritis and irritable bowel syndrome” (McCallie, Blum & Hood, 2006, p.55). Regular use of this technique will result in physical and structural adaptive changes in the brain.

Cognitive behavioral therapy and dysthymia.

Origin of dysthymia according to Beck’s cognitive model.

Beck’s cognitive model of depression emerged through systematic clinical observations and experiments and led to the development of the model used in CBT (Beck, Rush, Shaw and Emery, 1979). This model postulates three specific factors leading to depression: 1) the cognitive triad, 2) schemas, and 3) cognitive errors (Beck, Rush, Shaw & Emery, 1979).

The cognitive triad.

The cognitive triad postulates three major cognitive patterns that lead the patient to think and act depressively. These patterns are: 1) the patient’s negative self-image; 2) the patient’s tendency to interpret his daily and future experiences in a negative way; and 3) the patient’s negative view of the future in general (Beck, Rush, Shaw and Emery, 1979). The first component includes how defective, inadequate, diseased, or isolated the patient sees himself (Beck, Rush, Shaw & Emery, 1979). The patient’s tendency is to blame himself (and his lack of desirability or worth) for his unpleasant experiences (Beck, Rush, Shaw & Emery, 1979). The idea that he is not worthy of happiness is also established in this first component (Beck, Rush, Shaw & Emery, 1979). The second

component consists of how the person sees the world as a threat, and does not think it is possible to accomplish his goals (Beck, Rush, Shaw & Emery, 1979). This component also involves misinterpretations of the interactions between the person, others, and his environment (Beck, Rush, Shaw & Emery, 1979). Finally, the third component is characterized by the person's negative expectations for his future. He perceives the future as an endless cycle of suffering with no chance for improvement (Beck, Rush, Shaw & Emery, 1979). He expects the future to involve constant failure and is continually frustrated by this prospect (Beck, Rush, Shaw & Emery, 1979).

The Beck model views other signs and symptoms of a depressive disorder as consequences of the activation of the negative cognitive patterns (Beck, Rush, Shaw & Emery, 1979). In other words, the subject will act and feel according to what he thinks. Therefore, if he continually misinterprets his interactions, he will continually act according to that negative interpretation. The motivational symptoms (paralysis of will, desire to escape and avoid) can be seen as consequences of the patient's distorted thinking (Beck, Rush, Shaw & Emery, 1979). The person's paralysis of will, can be observed in his pessimism and hopelessness; suicidal wishes can be understood as an extreme expression of a desire to escape (Beck, Rush, Shaw & Emery, 1979). Since the depressed individual sees himself as inept and worthless, he is dependent on others that he considers to be more competent for reassurance and help (Beck, Rush, Shaw & Emery, 1979). Lastly, the low energy and apathy associated with depression may be attributed to the patient's belief that he will fail no matter what he does (Beck, Rush, Shaw & Emery, 1979).

Mental schemas.

The second major element in the Cognitive model, schemas, offers an explanation of why the depressed person maintains his self-destructive thinking and ignores his positive experiences (Beck, Rush, Shaw & Emery, 1979). Any situation is composed of a series of stimuli to which an individual gives selective attention. The stimuli are combined into a pattern in order to construct the situation's meaning (Beck, Rush, Shaw & Emery, 1979). Individuals differ in the way they internalize situations, but have certain tendencies in how they organize and react to events (Breggin, 1991). A schema is this organizational tendency; in other words, even in different situations, stable cognitive patterns (schemas) are activated (Beck, Rush, Shaw & Emery, 1979).

The mental schemas direct how the person differentiates, screens out, and codes stimuli. Stimuli are subject to a process of evaluation or categorization based on past schemes that will determine how the person interprets his experiences. These stimuli go through an evaluative or categorizing process based on past schemas that will determine how the person differentiates his experiences (Beck, Rush, Shaw & Emery, 1979). Schemas are not active all the time, and can be inactive for long periods; they tend to be activated during stressful situations and determine the person's response and emotional reactions (Beck, Rush, Shaw & Emery, 1979). In a person with depression and other disorders, the conceptualizations of specific situations are distorted to fit the dysfunctional schemas that will later be connected with other idiosyncratic or distorted schemas (Breggin, 1991).

Because a depressed person is used to reacting based upon distorted schemas, he loses much of his voluntary control over his thinking. He automatically utilizes the dysfunctional (rather than adaptive) schemas when reacting to others and his environment

(Beck, Rush, Shaw & Emery, 1979). Moreover, his awareness of his distorted reality, tendency to misinterpret situations and even environmental changes, is dependent on the severity of his depression (Breggins, 1991).

Cognitive errors.

The third and final component of the model is cognitive error, or faulty information processing (Beck, Rush, Shaw & Emery, 1979). Cognitive distortions are those errors that are reinforced by the depressed individual's dysfunctional schemas. As a result, the individual tends to ignore that which would contradict these distortions.

Thinking or organizing reality may be categorized as mature or primitive (Beck, Rush, Shaw & Emery, 1979). In primitive thinking, judgments are global, absolute, negative, and irreversible. Mature thinking integrates life situations into relative standards, many dimensions, and uses quantitative rather than qualitative evidence (Beck, Rush, Shaw & Emery, 1979). In primitive thinking, the individual attributes his failures to himself; in mature thinking, the person sees failures as a part of the context (Breggin, 1991). In a depressed person, primitive, and, therefore, emotional thinking, is dominant. His response tends to be negative, extreme, and marked by a sense of failure (Beck, Rush, Shaw & Emery, 1979).

METHODOLOGY

Justification of the selected methodology

The design category used in this case study is a quantitative analysis based on the collected data in the pre-treatment and post-treatment application of the SCL-90. This self-inventory provides a numerical value representing the overall severity of discomfort experienced by the individual.

The subject began individual Cognitive Behavioral Therapy on the October 28, 2010 and met with me for weekly, one-hour sessions for eight months. The SCL-90 self-questionnaire was applied before and after the treatment to measure the results of the intervention and determine if there was a change in the subject's reported symptoms.

Investigation tool applied in the study

The Symptom Checklist 90 (SCL-90) was applied at the beginning and end of the treatment. The SCL-90 is a psychiatric self-report inventory applicable to individuals between 13 and 65 years old. It consists of 90 symptoms scored on a five-point Likert scale (where 0 corresponds to "None" and 4 corresponds to "Extreme") (Holi, 2003). The questionnaire asks the individual to rate symptoms experienced during the week prior to the evaluation (Derogatis, 1983). It detects the presence of an individual's psychopathology and psychological distress (Derogatis, 1983). Studies have revealed that the SCL-90 is a useful tool to evaluate progress and measure results in any therapeutic treatment (Holi, 2003).

According to Derogatis, the SCL-90 is intended to measure the intensity of each symptom on nine different sub-scales: somatization, obsessive-compulsive, interpersonal

sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism (Derogatis, 1983). It also includes three global indices of distress: the Global Severity Index (GSI) which is said to be the best single indicator of the current level of the disorder, the Positive Symptom Distress Index (PSDI), which is believed to be a measure of intensity that assesses the response style of the patient (i.e. whether the patient is “exaggerating” or “underreporting” his/her symptoms), and the Positive Symptom Total (PST) which is the total score of the index previously mentioned (Derogatis, 1983).

The reliability of this test consists of two types of measurements, internal consistency and test-retest (Derogatis, 2000). The literature and studies consulted have shown that the internal reliability of the SCL-90 ranges from 0.77 to 0.90. The test-retest reliability demonstrates a range of 0.78–0.90 of accuracy (Derogatis, 2000).

The SCL-90 has been translated into several languages and standardized for different populations (Holi, 2003). It is well suited for measuring general mental health and changes in symptomology, and has been used to determine the outcome in various psychopharmacologic and psychotherapeutic clinical trials (Holi, 2003). Although the researcher has to trust patients to consistently report their symptoms, research has demonstrated that the SCL-90 can be used as the primary or sole outcome measurement in treatment trials. Also, as mentioned in Holi’s study: “The GSI and sometimes the DEP and ANX subscales have been used as psychiatric outcome measures” (Holi, 2003). The SCL-90 has not been adapted for Ecuador, so this study used the adaptation for Buenos Aires developed by Maria Martina Casullo and Marcelo Perez (Casullo & Perez, 2008).

Description of the participants

Number.

There was one participant in this study who took the SCL-90 prior to and after the clinical intervention

Gender.

The subject was a thirty-year old female.

Socio-economic status.

The subject was a member of a middle socio-economic class.

Specific characteristics related with the study.

The subject had no known intellectual disabilities, learning disabilities, or special needs.

Sources and data collection

Mental status examination.

My observation of the subject revealed her to be alert and aware of her surroundings. The subject was neatly dressed and well groomed. Her speech patterns were fast, loud, and apparently pressured. She demonstrated a coherent association between ideas and thought processes. The subject's emotional memories were sometimes biased and distorted. This is the area to which her treatment will be directed.

Despite a generally flat affect and depressed and anxious mood, the subject was quite cooperative. The subject presented difficulty when asked to define her own needs and wants. She seemed unusually dependent on others to provide meaning in her life. The subject appeared to have above average IQ, with apparently strong analytical skills.

The subject was currently employed as an instructor at a university in Quito. She expressed a desire to study abroad in the future.

Identifying data.

The subject was a thirty-year old unmarried Ecuadorian woman, currently employed full-time as an instructor in a university in Quito. She was bilingual (English and Spanish) and usually came to therapy wearing clean, semiformal clothing. The entirety of her childhood and adolescence was spent in Cuenca, Ecuador. She moved to the capital, Quito, Ecuador, to attend college when she was nineteen years old. In Quito, she lived by herself; at the time of her treatment, she was living with her youngest brother, a twenty-two year old college student.

The subject came voluntarily to the services offered by the psychology department in a private university of Quito. She sought help for her symptoms of depression and anxiety. The subject identified her symptoms of depression as including low energy, fatigue, sadness, feelings of hopelessness and loneliness, a lack of a sense of purpose in life, poor concentration, difficulty making decisions, low self-esteem, intrusive thoughts of the death of a loved one, difficulty falling sleep, and recurrent distressing dreams. The aforementioned symptoms were evident in self-reported questionnaires as well as in vivid therapeutic sessions. Additionally, she reported symptoms of anxiety including accelerated heart rate, sweaty hands, chest pain, breathlessness, muscular tension, fear of losing control or going crazy, hot flashes, excessive worrying and fear of death (mostly the death of others), dizziness, irritability, hyper vigilance, exaggerated startle response, and difficulty in staying asleep.

The subject exhibited a tendency towards obsessive negative thoughts and intense anxiety about the safety of others. The subject reported that there was no time of day when she felt relaxed or without heaviness in her body. She reported overloading herself with tasks to avoid unwanted thoughts. She denied experiencing suicidal ideation, homicidal ideation, paranoid ideation, or auditory/ visual hallucinations. She denied a history of suicide attempts or delusions.

Personal history.

The subject reported a childhood, adolescence, and early adulthood with no significant trauma. She lived with both of her parents and siblings until her move to Quito at nineteen. She described herself as an introverted, smart girl who loved to read and spend time with her family. As the eldest of four children, she reported that she acted like a mother figure for her siblings, protecting them and feeling guilty when something happened to them.

The subject sought psychological treatment due to her inability to cope independently with the death of her cousin in a car accident. She did not report any history of mental health or psychiatric issues and had never been medicated for such issues. This was the first time that she had consulted a therapist.

The subject reported that she started to experience anxiety symptoms approximately two months after the death of her cousin. These symptoms persisted for nine consecutive months. When they became unmanageable, she looked for help.

The subject also mentioned the presence of symptoms of depression during her adolescence, at age fifteen. These symptoms intensified somewhat when she was

separated from her nuclear family at nineteen. She denied any legal problems or criminal records.

Family History.

The subject was born and raised in a city of Ecuador by her biological parents. Her parents are still married, and she describes her relationship with them as emotionally close. She is the oldest daughter of four siblings: two males who are twenty-six and twenty, and one female who is twenty-two years of age. She and her siblings lived in the same household until the subject moved to Quito to attend college. As an Ecuadorean, the subject belongs to a collectivist culture. Consequently, her attachment to her family members may be stronger than that of individuals from more individualistic cultures (Myers, 2000).

The client reported that her nuclear family (i.e. her parents and siblings) has no history of mental illness. She mentioned that one cousin was diagnosed with bipolar disorder and is receiving psychiatric treatment. She described her family of origin and extended family as very close and interdependent. She also emphasized how these family connections have contributed to her role of caretaker within her family. She observed that she frequently resolved conflicts within her extended and nuclear families.

During the therapy, she made several references to herself as the “mother” of her siblings. She also mentioned that she is frequently consulted (often by her parents) about her family’s decisions. The subject attributed her ability to resolve problems to these interactions and dialogues. She also observed that she enjoyed the feeling of being needed by her family members. She reported that she had always received (and always expected to receive) her family’s unconditional support.

Diagnosis and functional assessment.**AXIS I:** 309.81 Post-Traumatic Stress Disorder (chronic)**AXIS I:** 300.4 Dysthymic Disorder (late onset)**AXIS II:** V71.09**AXIS III:** Allergies: sinusitis and rhinitis.**AXIS IV:** A, B Problems with the primary support. Problems related to the social environment.**AXIS V:***Initial GAF:* 50

(Serious symptoms and serious impairment in social and occupational functioning)

Current GAF: 55

(Moderate symptoms and moderate difficulty in social and occupational functioning)

Diagnostic criteria for 309.81 post-traumatic stress disorder.

A. The person has to be exposed to the traumatic event in which both of the following were present:

1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others

2) The person's response involved intense fear, helplessness or horror.

Note: In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is re-experienced in one (or more) of the following ways:

- 1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. *Note: In young children, themes or aspects of the trauma may be represented through repetitive play.*
 - 2) Recurrent distressing dreams of the event. *Note: Children may experience frightening dreams without recognizable content.*
 - 3) Acting or feeling as if the traumatic event were recurring (including a sense of re-living the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur when intoxicated or upon awakening). *Note: In young children, trauma-specific reenactment may occur.*
 - 4) Intense psychological distress in response to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - 5) Physiological reactivity to exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of the stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- 1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma
 - 2) Efforts to avoid activities, places, or people that arouse recollections of the trauma
 - 3) Inability to recall an important aspect of the trauma
 - 4) Markedly diminished interest or participation in significant activities

- 5) Feeling of detachment or estrangement from others
 - 6) Restricted range of affect (e.g., does not expect have a career, marriage, children, or a normal life span).
- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
- 1) Difficulty falling or staying asleep
 - 2) Irritability or outbursts of anger
 - 3) Difficulty concentrating
 - 4) Hyper vigilance
 - 5) Exaggerated startle response
- E. Duration of the disturbance (symptoms in criteria B, C and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than three months

Chronic: if duration of symptoms is three months or more

Specify if:

With delayed onset: if onset of symptoms is at least six months after the stressor.

(DSM-IV-TR, 2000)

Diagnostic criteria for 300.4 dysthymic disorder.

- A. Depressed mood for most of the day, as indicated either by subjective account or observation by others, for at least two years. *Note:* In children and adolescents, mood can be irritable and duration must be at least 1 year.
- B. Presence, while depressed, of two (or more) of the following:
- C. During the two-year period (one year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than two months at a time.
- D. No Major Depressive Episode has been present during the first two years of the disturbance (one year for children or adolescents) i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission. *Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for two months) before development of the Dysthymic Disorder. In addition, after the initial two years (one year in children and adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.*
- E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode and criteria have never been met for Cyclothymic Disorder.
- F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

- G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- H. The symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.

Specify if:

Early Onset: if onset is before age 21 years

Late Onset: if onset is age 21 years or older

Specify if (for most recent two years of Dysthymic Disorder):

With Atypical Features (see p. 420)

(DSM-IV-TR, 2000)

Clinical scales and dimensions SCL-90.

Pre-test.

The following clinical scales were found to be in the normal ranges when taken in October 2010: the clinical scale of Somatizations (Som; T= 45), which evaluates the presence of symptoms that the person perceives in relation to corporal misbalances (i.e. cardiovascular, respiratory and gastrointestinal); the scale of Obsessions and Compulsions (O-C; T=55), which includes impulses, thoughts and behaviors that are experienced by the subject as impossible to avoid or un-wanted; the scale of Interpersonal Sensitivity (Ins; T=61), which detects the presence of inadequacy and feelings of inferiority by the person when comparing himself to others; the scale of Hostility (Hos; 50) which detects the thoughts, feelings and behaviors that indicate the presence of anger; the scale of Phobic Anxiety (Pho; T=55) which reflects a persistent fear of specific situations, people, places and objects that is irrational in relation the stimulus that triggers

it; and finally, the scale of Psychoticism (Psy; T=55), which represents any symptoms of hallucinations, thought control and schizotypal traits in human experience(T=<63).

In contrast, the clinical scales of Depression (Dep; T=65), Anxiety (Anx; T=63) and Paranoid Ideation (Par; T=65) reflected a significant clinical elevation. The scale of Depression (Dep; T=65) showed an elevation from the higher end of the normal clinical range (T=63), demonstrating that the subject could be experiencing a dysphoric mood, a lack of motivation, a low level of energy, a feeling of hopelessness, and suicidal ideation. Additionally, there was a significant elevation in the Anxiety scale (Anx; T=63), which reflected the possible presence of the general symptoms of anxiety such as nervousness, tension, fear, and panic attacks. Finally, there was a clinically significant elevation in the Paranoid Ideation (Par; T=65) scale, demonstrating the presence of paranoid behaviors and thought disorders such as projective thinking, fear of the loss of autonomy, and high levels of suspicion.

Post-test.

In contrast to the Pre-test, all of the scores of the aforementioned clinical scales of the test administered in July of 2011 were found to be within the respective normal clinical ranges (T < 63). The specific values of the clinical scales were: Somatization (Som; T=35), Obsessions and compulsions (O-C; T=50), Interpersonal Sensitivity (Ins; T=60), Depression (Dep; T= 55), Anxiety (Anx; T= 55), Hostility (Hos; T=35), Phobic Anxiety (Pho; T=50), Paranoid Ideation (Par; T=55) and Psychoticism (Psy; T= 55).

Overall indexes of distress.

Pre-test.

The scores of the test administered in October 2010 demonstrated that the Global Severity Index, (GSI; T=60), the Positive Symptom Distress Index (PSDI; T= 55) and the

Positive Symptom Total (PST; T= 61) all valued were within the normal clinical range (T=<63).

Post-test.

In the post-test administered in July of 2011, the Indexes of Distress, the Global Severity Index (GSI; T=40), the Positive Symptom Distress Index (PSDI; T= 45), and the Positive Symptom Total (PST; T= 55) were valued within the normal clinical range (T=< 63). These values represent the measurements of the outcome of the therapeutic intervention.

ANALYSIS OF RESULTS

Details of analysis

Clinical Scales and Dimensions.

Between the administration of the pre- and post-tests, all clinical scales (except for the scale of Psychoticism; Psy, that remained the same) decreased. The most significant clinical difference observed were in the Hostility scales. The difference between the pre-test (Hos; T=50) and the post-test scores (Hos; T=35) was 15 T-points. The three scales that follow in order of greatest difference between tests are: the scale of Somatization (Som; pre; T= 45, post; T= 35), Depression (Dep; pre; T= 65, post; T= 55) and Paranoid Ideation (Par; pre; T= 65, post; T= 55) – all with 10 T-point differences. Another clinically significant, difference in T-point value (of eight points) was observed on the clinical scale of Anxiety (Anx; pre; T= 63, post; T= 55).

All of the scales mentioned before (Hostility, Somatization, Depression, Paranoid Ideation, and Anxiety) that showed the most clinically significant differences between tests, conform to the patient's clinical picture. The subject had significant unexpressed anger at her family and herself. Her suppressed emotions resulted in symptoms of depression, anxiety, somatization and paranoid ideation. Due to the interdependence and positive correlation between these symptoms, it is reasonable to expect the value of these scales to lower together.

One possible explanation for significant reduction of the Hostility scale score is the amount of anger on that was processed and expressed during the therapeutic intervention. The intervention helped the subject to understand this anger and transform it

into a more positive emotion. Due to the correlation between the hostility and somatization scales, a reduction in the hostility scale would be expected to lead to a reduction in the somatization scales, a symptom of this repressed anger. This accounts for the somatization scales having a significantly lowered post-treatment score.

Although the elevations in the Depression, Paranoid Ideation, and Anxiety scales were the most clinically significant, the Hostility and Somatization scales are still relevant to subject's clinical picture. They represent one of the major positive changes in her behavior, emotions, and the reconstruction of her mental schemas. It is reasonable to expect the reduction in anger and anxiety would lead to a reduction in the symptoms of depression, anxiety, and paranoid ideation.

The clinical scales that were elevated significantly outside of normal ranges in the pre-test (Depression, Dep; T=65; Anxiety, Anx; T=63 and Paranoid Ideation, Par; T=65), resulting in a diagnosis of PTSD, dropped down to the normal clinical range $T < 63$ (Depression, Dep; T=55; Anxiety, Anx; T= 55 and Paranoid Ideation, Par; T=55) in the post-test. After treatment, the subject no longer met the criteria for a diagnosis of PTSD.

The primary goal of treatment was to reduce the patient's anxiety and increase her motivation/improve her outlook on life. Therefore, one would expect a successful intervention to show a decrease in these scales. Additionally, the clinical intervention was directed toward reducing the patient's symptoms of anxiety, depression, paranoia and altering the mental schemas that were contributing to these issues. The significant lowering of the T-scores between the two tests suggests that the clinical intervention reduced the patient's symptoms and was helpful in improving the patient's quality of life.

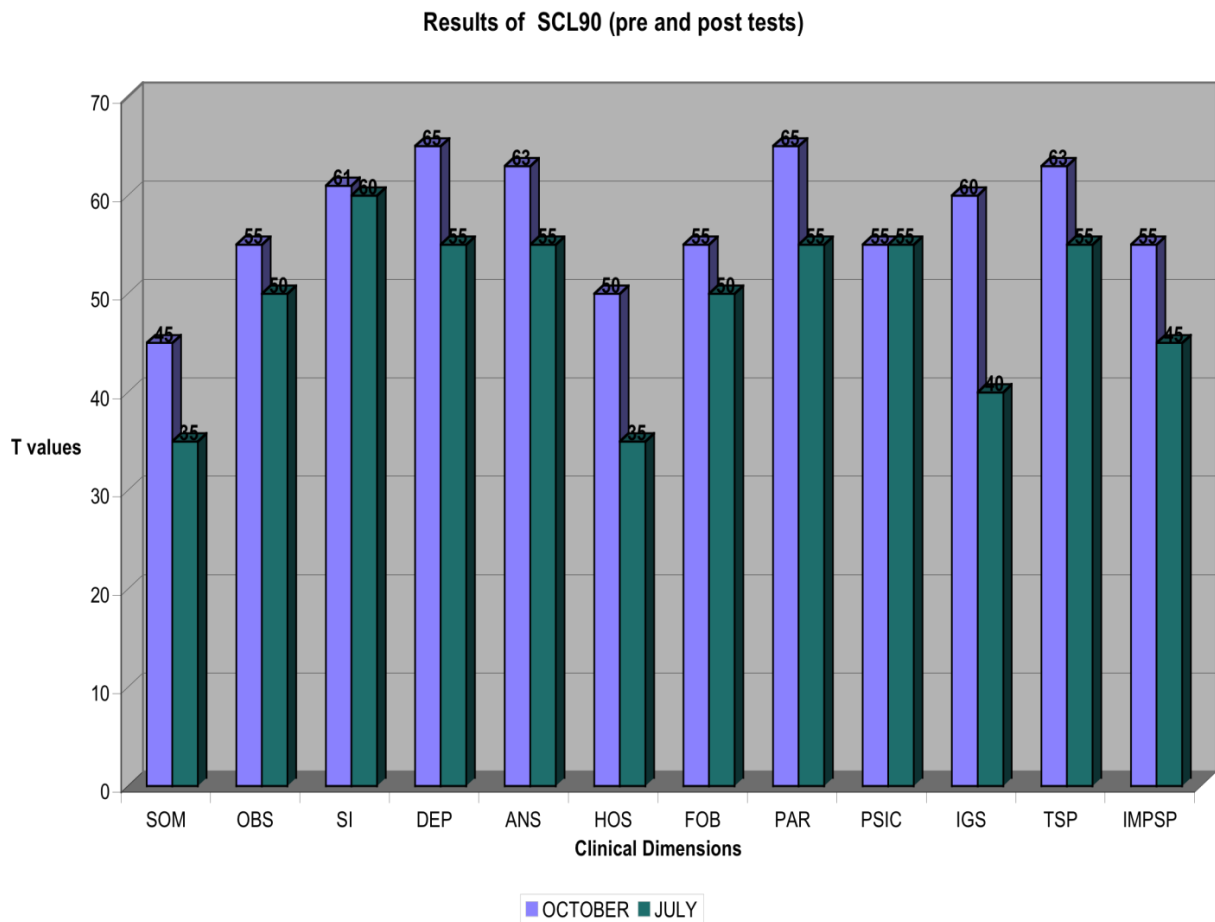
Finally, the clinical scales of Obsessions and Compulsions (O-C; pre; T= 55, post; T= 50) and Phobic Anxiety (Pho; pre; T= 55, post; T= 50) reflect a difference between tests of 5 T-points. The clinical scales of Interpersonal Sensitivity (Ins; pre; T= 61, post; T= 60) shows a difference of 1 T-point and the scale of Psychoticism (Psy; pre; T= 55, post; T= 55) remained the same. Because the patient did not manifest clinically significant elevations of these symptoms at the beginning of treatment, the treatment would not be expected to affect the scores on these scales.

Overall indexes of distress.

In general, the three Overall Indexes of Distress reflect a decrease between the pre- and the post- tests. The most clinically significant difference is found in the Global Severity Index (GSI; pre; T= 60, post; T= 40) of a 20 T-point decrease, showing that the severity of the patient's symptoms had decreased notably.

The greatest difference was found in the Positive Symptom Distress Index (PSDI; pre; T= 55, post; T= 45) with a 10 T-points decrease in current symptomatology between the tests. The Positive Symptom Total (PST; pre; T= 61, post; T= 54) reflected a difference of 7 T-points indicating a decrease in the patient's conscious intention to project herself as if she were happier/more secure/more confident than she actually is (i.e. with an overly-positive image).

The changes in the Overall Indices of Distress reflect an improvement in the patient's quality of life at the end of treatment (Global Severity Index: GSI; pre; T= 60, post; T= 40 and the Positive Symptom Distress Index: PSDI; pre; T= 55, post; T= 45).



Case conceptualization.

Beck's Cognitive model applied to the subject.

The subject expressed a series of distorted beliefs and maladaptive behaviors. She has the tendency to think in extremes, (i.e. in “black and white”). A statement from her September 15, 2010 session demonstrated this type of extreme thinking, “The result of my work is either absolute perfection, or a total failure; there are no middle points.” Additionally, she tended to over-generalize, failing to recognize distinctions between events. In the session of November 21, 2010, she mentioned how “a simple negative interaction with my students can ruin my entire day and mood.”

During her therapy, the subject mentioned core beliefs such as: “My life has no meaning”; “I am not worthy of love”; “I am like a mushroom, alone in the shadow. Everyone else is in the sun”; and “Nobody likes me for who I am, but for what I do for them.” On the other hand, some intermediate beliefs or attitudes she had were: “For people to like and need me, I must help them at all times”; “If I am the best and most efficient worker, people will always respect and think I can do everything”; “It is awful not to be able to solve problems by myself” ; and “I must have a partner to fit into society and be like everyone else.” Some of her automatic thoughts were: “At this age, I will never find someone to marry if I haven’t already found him”; “Everything that I do at work needs to be perfect; otherwise, I feel really angry with myself”; “Meeting someone can only be negative for me in the long-term”; and “People only talk to me or pay attention to me when they need something.”

All of these distorted beliefs led to maladaptive behaviors that could be clearly seen in the subject’s actions. Some of them included: avoiding meeting new people, making her work the biggest priority of her life (as well as giving herself extra work), assuming the responsibility for her loved ones’ problems, and overprotecting her younger brother who lived with her.

DSM-IV applied to the subject.

The subject of this case study clearly portrayed the symptoms, behaviors and emotions presented in PTSD and Dysthymic Disorder. According to these theories, the subject’s trauma originated in the death of her cousin. Everything that reminded her of his death contributed to a fear network related to the death of her loved ones and triggered her symptoms and discomfort. This fear grew over time.

The traumatic death of her cousin in a car accident meets criterion A of PTSD according to DSM-IV- TR. Her response involved extreme fear, helplessness, and horror. Since she experienced constant and recurring thoughts, images, and dreams related to the day of her loss, Criterion B is also met. In our sessions, she mentioned several times that she kept re-living and feeling (physically and psychologically) the way she felt on the day she answered the phone and was told that her relative had died. Afterwards, she would become over protective with her living relatives.

The subject reported that she would avoid any thoughts, feelings, places, people, conversations, or activities that reminded her of the trauma (Criterion C). She mentioned that she didn't go to Cuenca for five months because she wasn't ready to face the event. She didn't want to be reminded of her cousin. She exhibited escape and avoidance behaviors by immersing herself in her work and avoiding free time. On most days, she was completely overloaded with work: She sometimes even assumed responsibilities that were not hers. In one of the sessions, she said: "I love to keep myself busy all the time. That way, I can escape. I don't have time to worry or think about things that bother me." Rather than deal with her own issues, she helped to solve her loved ones' problems, "Other's problems are much easier to solve than my own. I get really scared when I think of my own problems. I'd rather take care of others' problems, and avoiding thinking about my own."

She reported experiencing alienation from others, including her family, and not feeling a part of anything. The subject experienced a sense of a foreshortened future. She often mentioned how ridiculous it was for her to meet and interact with people if she was destined to lose them one way or the other. She exhibited symptoms of anhedonia; she

lost interest in participating in activities that given her pleasure in the past, like family reunions, professional workshops, photography, going to the movies, spending time with friends, and going out to eat.

The subject exhibited symptoms mentioned in Criterion D including: difficulty falling sleep, irritability, hyper-vigilance and an exaggerated startle response. She attributed her difficulty falling asleep to her constant worries and rapid thoughts. In one session, she observed: “I don’t understand why it is so difficult now to fall asleep. That used to be the activity I enjoyed the most.” She also mentioned experiencing high levels of irritability when asked for help from others.

The subject’s excessive devotion to her work and desire to keep busy were examples of hyper-vigilant behaviors. The subject stated: “Sometimes I don’t know where I get this energy from. Many people think that I am a wonder woman at work or something, but it is not that. I just like to do as much as I can to keep myself busy. That way, I don’t have time to think and have horrible thoughts.”

The subject exhibited startle-response behavior, frequently checking her cell phone (i.e. every three to five minutes) for messages informing her of bad news. She also called her younger brother many times (at least five to fifteen) to ensure that he was all right and to ask if he needed something from her.

When the subject called a family member but did not receive an immediate answer, she had panic attacks. She reported experiencing shortness of breath, pressure in her chest, hot flashes, sweating, and palpitations. She mentioned being extremely worried about these sensations and feelings because she didn’t understand their origin.

These symptoms persisted for more than one month, thus fulfilling the requirements of Criterion E for PTSD of the DSM IV. In addition, the disturbances caused significant social and occupational distress or impairment (Criterion F). The subject began to isolate herself from her friends, peers, and relatives. She was no longer as effective and rapid at performing her job functions.

As Ehlers and Clark stated in their cognitive model of the persistence of PTSD, PTSD becomes chronic when traumatized individuals interpret everything as a threat (i.e., “Nowhere is safe”) (Shepherd and Bisson, 2004). Because the subject experienced symptoms for more than three months, her PTSD would be classified as a chronic. The subject demonstrated a chronic level of stress, observing, “It is like there is danger everywhere I go. I can never relax. I need to be ready in case something happens.” These beliefs constantly fed her fear network, and contributed to a heightened arousal in her sympathetic nervous system. She experienced intense feelings of anxiety (among other symptoms) and exhibited pronounced hyper-vigilant and avoidance/escape behaviors.

The subject met all of the DSM-IV-TR criteria for Dysthymic Disorder. The patient reported feeling depressed for more days than not during a seven-year period (Criterion A). She also said that since the age of twenty-three (she was thirty), she had gotten used to low energy, low self-esteem, difficulty making decisions, and intense feelings of hopelessness (Criterion B). In several sessions, the subject described how exhausted she felt after work and how she always felt “low”. Also, she exhibited low self-esteem, saying things like, “I don’t deserve love”; “I think any man would prefer any other woman over me” and “I am not at all surprised that I don’t have a partner.” Although her work schedule was the same on Wednesday and Friday, she had great

difficulty deciding which day she preferred for her therapy sessions. Her poor decision-making skills were also evident in her anxiety about deciding her weekly activities.

Rather than make a choice, she often decided to just stay home. Her intense feelings of hopelessness were demonstrated through her comments, “What difference does it make if I act in a more positive way if things are never going to change?” and “I know that I will carry this cross for the rest of my life. Things will never be better for me.”

During a two-year period, she had never been asymptomatic for more than two months at a time (Criterion C). Because she had never had a major depressive episode (Criterion D) or a manic, mixed, or hypomanic episode, she did not meet the criteria for Cyclothymic Disorder (Criterion E). Further, her disturbance was neither due to a psychotic disorder (Criterion F), nor a direct physiological effect of a foreign substance or general medical condition (Criterion G). Her symptoms caused significant distress or impairment in social, occupational or other areas (Criterion H). This impairment could be seen in the subject’s isolation and decreased professional productivity. She found that it took her three times as long as it had previously to finish many tasks. Finally, because the subject was twenty-three when she developed these symptoms, her dysthymic disorder, would be classified as late-onset.

Preliminary steps and treatment goals.

The first step to the treatment was to establish a solid therapeutic relationship with the client, including a good level of rapport and trust. The treatment was focused upon the client’s stated desires, “I want to stop worrying so much and always feeling like something awful is going to happen. I want to devote more time to myself. I want to be at peace.”

Short-term goals.

The initial short-term goals were to familiarize the patient with the cognitive model and to psycho-educate her about the basis of Cognitive Behavioral Therapy (i.e. the cognitive model and her diagnosis) (Beck, 1995). The subject needed to understand the therapeutic process, her treatment, and the purpose of any assignment or behavioral experiment set in sessions (Beck, 1995).

In early sessions, the patient learned how to monitor her mood and how to identify dysfunctional thoughts (Beck, 1995). She developed an understanding of the relationship between thoughts, emotions, mood changes, and behaviors (Beck, 1995). She also learned how to change maladaptive thoughts into adaptive ones and develop healthy action/reaction behavior (Beck, 1995).

The short term goals of the intervention were: 1) To reduce anxiety and depression symptoms; 2) To evaluate the patient's way of thinking and the creation of thought distortions; 3) To improve the patient's daily life style by reducing the frequency, intensity, and duration of her negative symptoms; 4) To improve her daily functioning by substituting bad habits for good ones; 5) To stop her pattern of blaming herself 6) To heighten her awareness of her own (present and future) needs and desires; and 7) To teach relaxation techniques that would help the subject to be more relaxed and calm in her daily life.

At the beginning of the therapeutic process, the subject was asked to explain her self-image and symptomology in as much detail as possible. It became clear that her anxiety and depression would need to be addressed together. She had depressive thoughts like, "I feel so lonely. I know this will never stop." or "I know that I am destined for tragic life. That's why I prefer to not become intimate with people." In several sessions

she mentioned that, “It makes no sense to become attached to other people. Sooner or later, they are going to leave.”

The subject described her anxiety in detail: “I feel so afraid when I am alone”; “I can’t stop thinking that something bad is going to happen to my family”; “My heart starts beating so hard that I think it is going to come out of my chest.” She also expressed thoughts that would perpetuate her anxiety, “When you least expect it, something awful can happen. That’s why you have to always be ready for anything.”

The subject reported experiencing such thoughts, likely a major contributing factor to her depressed and anxious mood, frequently. She received psycho-education about her condition and began to monitor her thoughts through written logs. As the therapist, I highlighted and discussed any thinking distortions from these logs with the patient.

An early step in the therapeutic process also involved identifying the origins of her feelings. The first sessions included completing thought record and mood monitoring worksheets. The subject also completed written reflections about her most unpleasant experiences and sad memories. These activities were completed in order to identify any distorted thinking in her world view.

Initially, these worksheets were completed in-session. However, when it became clear that the subject understood how to complete them independently, the written reflections were assigned as homework. They were then read and discussed during the next session. In order to change the subject’s mood and perspective, these written tasks were analyzed, emphasizing more alternatives and positive outcomes than those found in the reflection. Each session concluded with the patient explaining the most important

lessons of each session and their applicability to her daily life. The conclusion of each session was also used to emphasize key points and clarify any misunderstandings.

The subject created a list of activities that she had enjoyed in the past. Next, a schedule of activities was developed to promote a more healthy and pleasurable lifestyle. Because the subject had mentioned a tendency to isolate herself in her apartment because she did not have a partner, a list of activities for her to engage in independently was also developed. These activities were initially rather simple (i.e., going to the park), but gradually increased in time and intensity (i.e., going to her favorite restaurant or to the movies). These activities were developed to disrupt the subject's mental schema that certain activities could not be enjoyed independently.

In part due to lack of self-confidence and low self-esteem, the subject reported that she didn't have a solid social network in Quito. Therefore, another treatment goal was to improve the subject's self-concept. This would help her to be more comfortable with meeting new people and, ultimately, forming close relationships with some of them. The subject also made deliberate changes in her lifestyle. She engaged in more activities, established good habits (i.e., exercise, engaging in pleasurable activities, a consistent sleep schedule), and attempted daily challenges (like engaging in more independent activities).

Once the subject's self-esteem improved, she was introduced to the phase of systematic desensitization. This technique helped the subject to make noticeable progress in overcoming her fears. She was gradually exposed to the trauma through *in vivo* imagery, narration, and writing techniques. In several sessions, the subject mentioned being proud of how she finally stopped avoiding her fears. In one session, the patient

reported, “Now I understand...Confronting my fears gradually has made me less afraid. That would not have been possible without this therapy”.

An important part of the therapeutic process involved the subject reaching a more balanced view of the trauma and realizing that she could no longer blame herself for it. In session, she practiced depersonalization skills, including role-plays between therapist and patient. The subject was also asked to reflect through questions like: ‘If I were the one telling you about this issue, what advice would you give me? What have you learned from this experience? Could you name at least three positive things that have come of it? What are the things that you can’t take responsibility for or control? What is something new that you realize about your experience?’

A major goal of early therapy sessions was to relax the client as much as possible. The use of thought-stopping techniques and dialogue during negative self-talk helped her to take advantage of the therapeutic intervention. In early sessions, she mentioned: “Now that I feel much more relaxed and calm, I can start being objective. My mind is more peaceful without all of those intrusive thoughts.” She learned to cope with disturbing thoughts that might contribute to her anxiety cycle by imagining an enormous stop sign. She would then give herself a positive pep-talk like, “I have to stop thinking the worst. I have to be more relaxed to have a clear mind and soul.”

During therapy, the subject was taught skills (such as list-making) to reduce anxiety and help her make decisions. She also learned to use Progressive Muscle Relaxation and confront her fears through Graduated Exposure Therapy. Graduated Exposure Therapy was used to help the subject overcome the fear of travelling that she said prevented her from discovering new worlds. The subject began by discussing

travelling and progressed to visualizing taking a trip. These techniques were used to help her achieve her long-term goal of travelling abroad.

Long-Term Goals.

The long-term goals of the therapeutic intervention were: 1) To create a solid and healthy patient-therapist relationship that would serve as a model for future relationships; 2) To provide information (psycho-education) to the patient about PTSD and Dysthymic Disorder, its components, processes, results, and related emotions and behaviors; 3) To use systematic desensitization to her feared emotions and overwhelming memories in order for her to process and change her mental schema of reaction; 4) To enable the patient to make decisions based on her desires rather than the needs or desires of others her own fears; 5) To teach and practice adaptive thinking and functional behavioral and emotional techniques; 6) To identify exaggerated triggers, reactions, and maladaptive ways of relating to others and the world 7) To assist the client in a re-organization of her life and emotional schemas, not based on the past and her previous losses; 8) To understand the role of death and perceive as a part of life rather than a source of fear; and 9) To enable the patient to develop new intimate relationships.

Themes and Interventions.

The subject displayed an unhealthy attachment mechanism in her daily interactions and role in her nuclear family. She felt that to be loved and accepted, she had to be needed. She had also spent much of her life solving other people's problems and acting as a mediator. As a therapist, my role was to make the subject aware of these behaviors and attempt to teach her better and healthier ways for her to relate to others. In many sessions, we role played alternative ways of reacting to and interacting with others.

As a therapist, I had to soothe and psycho-educate the subject about her tendency to blame herself for these tendencies. I told her things like, “Don’t take full responsibility for your desire to help others and be needed. That was created within a context. It was the best you could do with the options that you had at the time.”

A major issue that emerged in session was the subject’s anger towards her parents. She mentioned experiencing anger towards them (especially her mother) since she felt that she had been forced as a child to assume responsibilities that were not hers, “I get so angry when I think about all the times they made me take care of my younger siblings instead of letting me play with them.” She stated on various occasions that she felt angry and frustrated when she remembered how overprotective and demanding her parents had been during her childhood: “Until I started therapy, I didn’t understand why I behave the way I do, and why I sometimes got so angry with my parents that I couldn’t even talk to them.” Although this was a difficult realization for the subject, I tried to focus her on how her understanding of her past could benefit her relationships, including the one with her parents, in the future. This belief is supported by Roizblatt’s assertion that it is therapeutic for the individual to understand the reasons for his particular development in a nuclear context (Roizblatt, 2009). In addition, I supported the subject as she processed and expressed her emotional responses to these realizations. This assisted her in the creation of new emotional schemas.

At a certain point in subject’s treatment, she stopped reacting with her fear network and put her plans into action. She wanted to go abroad and experience new things as she had when she lived in Europe at age twenty. In therapy, we discussed how she could do those things, without expecting the worst and being afraid. Near the end of

her treatment (in July of 2009), she summoned the courage to enroll in an academic course (in Europe) that she had wanted to take. She mentioned in one of the sessions: “I am so happy that I am actually doing what I want, and that my decisions are based on that instead of fear.” Since she made new friends and interacted socially (rather than just professionally) with people of her own age, this was the major turning point in her treatment.

Another turning point in therapy was when the subject returned to Cuenca to face her memories and her unresolved issues with her parents. She told her parents that she no longer wanted to act as a mother to her siblings or be the official family helper and problem-solver. In the session after the trip to Cuenca, she said: “I feel so great now; it’s like magic! Thank you so much for encouraging me to do things. That’s just what I needed. And do you know something? My parents took it really well. They understood me, and they told me that from now on they always want to know what I really want and think.”

At the conclusion of her intensive therapy, the subject was still working on her long-term goals. Now that her levels of anxiety and depression have markedly decreased, her treatment will be focused upon her secondary goals and long-term needs. She will have follow-up sessions every two weeks. In response to her progress, the time between her sessions may increase. I will continue to monitor her progress until she decides that she has made a full recovery.

Importance of the study

This study can serve as a precedent for future studies in the field of clinical psychology and medical research since it is conducted to support and contribute the

knowledge and investigation in the field of medicine. Also, it provides an evaluation of treatments for efficacy and safety (clinical trials) in health of individuals and promotes the development of new and better treatments.

Additionally, it can provide a model and a resource for other students in the University San Francisco de Quito, the Ecuadorean community, or investigators in the field of clinical psychology.

Summary of the author's bias

Ethical/legal issues.

The American Association of Psychology's ethical code was adhered to during all stages of the subject's treatment (Fisher, 2003). These principles include:

- Benefit and not harm
- Loyalty and responsibility
- Integrity
- Justice
- Respect of the rights and dignity of others

(Fisher, 2003)

In addition, the ethical principles of Standard # 2, "Competence", of Standard # 3, "Human Relations" and of Standard #4, "Privacy and confidentiality" pertinent to the patient's protection and best interests were respected (Fisher, 2003).

As followed in principle 3.10 of "Informed Consent" of Standard # 3 of "Human relations", the patient was informed about her treatment and her rights as a patient. She accepted the treatment's policies and procedures verbally and in writing. The first session included a detailed discussion of Principles:4.01 of "Maintaining Confidentiality", 4.02

of “Discussing the Limits of Confidentiality”, 4.03 of “Recording”, 4.06 of “Consultations” and 4.07 “Use of Confidential Information for Didactic or Other Purposes” to allay the client’s fears about the misuse of the information gathered in sessions (Fisher, 2003).

To help the patient feel more comfortable and eliminate her concerns about participating in the treatment, all of the patient’s requests during treatment were respected. In accordance with Principle 3.04 of “Avoiding Harm” located in Standard # 3 of “Human Relations”, the client was never greeted in the workplace (Fisher, 2003). In addition, the risk of running into colleagues or students before or after therapy, was reduced by meeting with her only in the third floor offices. In early sessions, the client explicitly mentioned the importance of these policies to help her avoid any negative repercussions of her treatment in the workplace.

Treatment relationship issues.

Emotions are a part of every human interaction (Menninger & Holzman, 1973). Due to the intimate interactions between patients and therapists, studies have shown that therapy is one of most emotionally evocative of human interactions. Studies have revealed that therapy is one of the media where most of these thoughts, emotions and sensations (i.e. reactions) are created, due to the complexity of the interaction between the patient and the therapist (Menninger & Holzman, 1973). When the person experiences thoughts, emotions and sensations in response to the therapist, it is known as transference. Transference is the sum of the primary impulses that the patient feels in his relationship with the therapist. However, transference is not the product of a new

situation. Instead, it is a re-creation of the subject's significant relationships from his childhood with the therapist (Menninger & Holzman, 1973).

The therapist's attitudes, thoughts, and emotional reactions towards the client are known as counter-transference. All of these reactions and emotions are not necessarily experienced on a conscious level. Nonetheless, they may be manifested in a positive or negative way. As a result, it is critical for the therapist to monitor these phenomena in order to avoid interference in the therapeutic process.

Several studies have revealed that when a therapist deals with counter-transference in a therapeutic session with another therapist, the patient's therapy will be four times more successful (Florenzano, 1984). Additionally, if the therapist keeps written records to monitor the automatic thoughts of the patient, the therapy will be twice as successful. (Florenzano, 1984).

An awareness of the emotional atmosphere of the therapeutic intervention is crucial to an understanding of the issues associated with transference and countertransference (Florenzano, 1984). Also, knowledge of the patient's personality traits and reaction tendencies is helpful to resolve relationship issues that emerge in therapy.

Defense mechanisms in the subject.

At the beginning of treatment, the subject tended to react defensively when she failed to meet her own expectations. She seemed irritated when she was told that she was not supposed to do something or that she was doing something unconsciously. During the course of therapy, she developed certain cognitive and social skills that helped her cope with this defensive attitude.

On several occasions, the subject arrived ten to fifteen minutes late to the session. She immediately stated something like, “I have the right to be late since I everybody asks for my help, and I am so busy. Sorry.” or “I don’t want to give an explanation of why I am late. I am always punctual. I’m sorry though.” She would then repeat that she was “sorry” at least three times. In these situations, I would tell her to not be upset because I understood that no one could be perfect and punctual all the time. Through this technique, I attempted to subtly draw her attention to her defensive reactions.. I would also remind her that people need to be less self-critical and forgive themselves for not being perfect.

Counter-transference.

I believe that the subject felt generally safe and comfortable with me. She mentioned numerous times how important the therapy was to her and that she trusted me more than anyone. At the beginning of the treatment, however, I worried that she would perceive me as too young and inexperienced to help her with her problems. To cope with my concerns, I reminded myself that it was normal for a patient to test a therapist at the beginning of therapy. In fact, the subject did state during our fifth session that she didn’t know if I was capable of helping her because I was younger and less experienced than she. Nonetheless, the subject eventually trusted my abilities and expressed her appreciation for my honesty.

Another example of counter-transference that arose during therapy was my frustration with the subject when she complained and admitted that she liked to be seen as a victim. I was annoyed that she didn’t realize how fortunate she was to be healthy, have a job, a family, and a comfortable economic position. When I became aware of my reactions, I talked with my psychologist. I discovered that my reaction to the subject was

due to the similarities between her behavior and that of someone close to me. Once I understood the reasons for my reactions to the subject's behavior, it stopped bothering me so much. After that, every time that the subject behaved in that way, I would remind myself of my personal association with the behavior. As a result, I was able to feel tenderness instead of anger and frustration towards my patient. Similarly, I occasionally had to remind myself that it was the subject's therapy, not mine. Therefore, I had to give her the most that I could without engaging my own emotions and desires.

Transference.

The subject's transference consisted primarily of her perceiving and comparing me to her best friend. She mentioned several times she mentioned how my speech patterns were similar to those of her friend. In one session, she expressed her transference clearly, "I am sorry if I raised my voice when you suggested that I change the way I think. It reminded me of a similar discussion that I had with my best friend." Throughout the therapeutic process, I sensed that she related me with her best friend. Since she told me so directly, I took the opportunity to let her know the importance of this realization and its potential for enriching her therapy.

Other key elements to be considered in an analysis of the relationship issues associated with treatment are gender and culture. Because the subject mentioned feeling understood, I think that it was positive for her that I am a Hispanic female. Studies have found that female therapists, with generally stronger empathetic skills than their male counterparts, have a higher success rate for treatment of loneliness and hopelessness in women (Snyder & Lopez, 2007). In the therapeutic context, it is helpful if the patient and the therapist are from the same culture and are accustomed to similar social, familial, identification roles notions of identity and customs (Snyder & Lopez, 2007). Further,

when the therapist and the patient grew up in the same context, they have higher levels of verbal and nonverbal communication (Snyder & Lopez, 2007).

CONCLUSIONS

Response to research question

Cognitive behavioral therapy helped the subject with the modification of dysfunctional thinking and behaviors and the introduction of new healthier mental and behavioral schemas. After the therapeutic intervention, the subject no longer met the criteria for Post-Traumatic Stress Disorder and Dysthymia.

Limitations of the study

A major limitation of any case study is that its results, based on a single individual, cannot be generalized to a wider population (Trull & Phares, 2003). Additionally, the results of an investigation and their interpretation may be influenced by the researcher bias phenomenon (Trull & Phares, 2003). In order to obtain meaningful results, case-studies must be longitudinal. However, both the subject and the environment of the study are subject to change from external factors.

A secondary limitation of this study was the fact that it was the researcher's first experience treating PTSD. A more experienced investigator might have applied therapeutic techniques in a more deliberate fashion. The therapeutic process may also have been slowed by the patient's initial trepidation about working with a student.

Another limitation of the study was that the SCL-90, used to measure the effectiveness of the treatment, is not standardized for Ecuador. Although the test has been adapted for Hispanic populations, further investigations would be required to ensure that the test had been appropriately adjusted to the Ecuadorean populations. To the best of my knowledge, there have been no tests developed in Ecuador (or elsewhere) to

specifically measure the effectiveness of a therapeutic intervention in Post-Traumatic Stress Disorder and Dysthymia.

The therapeutic process may have been slowed by the subject's initially informal approach to her treatment sessions. At the beginning of treatment, the subject changed/cancelled her appointments, arrived late, or stayed longer than the allotted time. Although these issues were solved throughout the course of the therapy, these factors may have somewhat/likely hindered the therapeutic process.

On the other hand, case studies that include the extensive study and description of an individual have proven useful in the study of abnormal behaviors and the investigation of treatment methods (Trull & Phares, 2003). They assist researchers both in the generation of hypotheses for future studies and as a means to challenge theories that are universally accepted.

This study attempted to provide detailed information from an individual case study of use for the generation of future hypotheses and further investigations in clinical psychology. Finally, this case study is grounded in Allport's observation (1961) that individuals should be studied individually (Trull & Phares, 2003).

Recommendations for future studies

This case study provides information about an option for a therapeutic intervention for PTSD and Dysthymia in the Ecuador. A collectivistic culture (i.e. any Latin American culture) has more influence and impact on the severity of these two disorders due to the level of dependency that exists in this culture among individuals (Kempie & Zinziswa, 2012), therefore it would be useful to provide knowledge in this area and see the existent relationship between culture and mental disorders.

Additionally, this case study may be used as background for investigations in clinical psychology and research-based therapeutic treatments. It may assist in the generation of hypotheses regarding the correlation between anxiety and depression disorders. This case study also serves as a detailed source of information to support or refute any previous or future hypotheses on related clinical topics and can aid as a prelude for further studies on the impact of culture in PTSD and Dysthymia.

General Summary

One strength of this study case is that it provides detailed and qualitative information about PTSD and Dysthymia. Moreover, like all case studies, this study facilitated a genuine relationship between the subject and the researcher, something rarely achieved in other investigational contexts.

This case study can provide the researcher with a flexible framework for therapeutic intervention in such cases. The therapeutic process was assisted by the patient's cooperative attitude and willingness to participate in this study. The results of the invention seem to indicate that Cognitive Behavioral Therapy contributed to a reduction in the subject's symptoms of anxiety and depression.

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