

Solution-Focused Brief Therapy for Major Depressive Disorder: A Single Case Study

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Abstract

Marital problems are one of the leading causes of depression in low income countries. In collectivistic cultures, inability to bear child makes individual more vulnerable towards depression. An increasing body of literature suggests the efficacy of solution-focused brief therapy for depressive disorders. People with eagerness to see change and not showing response for cognitive behaviour therapy respond to solution-focused brief therapy. This case study describes the course of major depressive disorder in a 39-year-old female and treatment strategy of solution-focused brief therapy. The client in this case responded to the therapy and also showed optimistic change in her attitude. Treatment implications of solution-focused brief therapy with its effectiveness on females with major depressive disorder have been discussed in the article.

Keywords: Major Depressive Disorder, Solution Focused Brief Therapy, Marital Problems, Female

1. INTRODUCTION

The prevalence of mental health disorders, e.g. anxiety and depression, have become a challenge for low income countries where malnutrition and infectious diseases are still to be dealt with and no budget is allocated to mental health services. Another reason of the significance of these disorders is the resultant functional impairment, thus causing financial crisis as well (Mirza and Jenkins, 2004). Depression manifests itself in the form of mood dysregulation, despair, hopelessness, and vulnerability in adolescence, yet, at times it goes unnoticed. Research studies from the Western context estimate that as high as 18% of adolescents suffer from depression. In the absence of adequate research

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Authors' Note: *An earlier version of the article was presented at the first national conference on Qualitative Psychology held on 5th March 2020 at NUST. We wish to acknowledge the useful comments received from the participants of the conference as well as the three Anonymous referees of the NJSSH.*

studies in the Pakistani context, the prevalence of depression is difficult to estimate; however, one systematic review cautiously cites prevalence of depression and anxiety at 34% in the overall population of Pakistan (Lowe *et al.*, 2005).

Depressive disorders are treated with psychopharmacological medication and psychotherapeutic treatment. Both types of treatment are well established through research trials involving thousands of patients (Nemeroff and Schatzberg, 2002). Depression focused psychotherapy involves behaviour therapy, cognitive behaviour therapy, psychoanalysis; whereas, a new way of treatment known to be effective for depression is Solution-Focused Brief Therapy (Grant and Thase, 2001).

Solution-Focused Brief Therapy (SFBT) was proposed by Insoo Kim Berg and colleagues in 1982 (O' Hanlon and Weiner-Davis, 2003). The idea of the therapy is to consider client as an expert of his/her life and the ones who know best about the possible solutions needed for their problems. This idea is coming from a strength-based perspective giving autonomy to the client. It focuses on identifying and amplifying strengths of the client in place of focusing on causes and correction of deficits (Rapp *et al.* 2006). The therapy is goal-oriented with a focus on present and future rather than past experiences and places focus on how to resolve the problem rather than causal factors (Spilsbury, 2012). SFBT also advocates the use of individuals' social context, personal resources, and social resources to find out the solution for their problem.

Solution-focused brief therapy has been adapted and found effective in Chinese culture for the treatment of mood disorders as the focus is on finding solutions and seeing improvement in near future as compared to deep-rooted analysis of the problem and its emergence (Chan and Chung, 2016). In Pakistani culture, psychological problems, being considered taboo, take a toll on individual and hence in order to come for therapy they want to see swift improvement (Rossler, 2016).

The process of the therapy starts with a miracle question designed with the aim to minimize the discussion of the problem. It rejects the concept of the solution being connected with elimination of problem (Shakarami, 2014). Miracle question helps the client imagine the change they want in their life and what they want out of the therapy.

Miracle questions helps the therapist to elicit details from the client about the solution and determine what part of it is already happening. It is followed by the scaling question that defines the next step for the client (Javanmiri, *et al.* 2013). The scaling is from 0 to 10 where the client is asked to rate their condition, 0 being least desirable and 10 being most desirable.

Another significance of using the scaling question is the focus on how client reached the particular number by encouraging them to know their strengths rather than why the number is not higher. Hence, it helps the client to take short steps to reach their desired solution with a step-by-step increase in their satisfaction with the self (Cepukiene and Pekrunosis, 2011).

Solution-Focused Brief Therapy is a way of exploring exceptions in life of the client. It instils hope and helps the client to see a better future for himself (Franklin *et al.* 2011). Theoretically, the efficacy of SFBT is supported by humanistic approach and behavioural approach, as well as SFBT works on changing the relation with environment by focusing on the strengths of the client. Studies show that solution-focused brief therapy is more efficacious in quicker reduction of symptoms and show better results for clients with comorbid disorders (Knekt *et al.* 2008). Several meta-analysis and systematic reviews reveal that solution-focused brief therapy is effective in case of depression and other psychological disorders (Concoran and Pillai, 2007). Hence, this therapy provides quick efficacy and better results as discussed in the case in this article.

2. METHOD

We used a single-case study research design to investigate the solution focused brief therapy for major depressive disorder. Methodologically, the case study is an interpretivist and idiographic tool in qualitative research. In clinical context, a single case can provide preliminary but in-depth understanding of the under study behavioural problems. Hence, to investigate the efficacy of the therapy, a single-outcome was necessary to provide a guideline for future researches and interventions.

2.1. Case Introduction

The current case describes the treatment of a 39-year-old client. The client is a Pakistani woman who came to a Mental Health Centre in Pakistan on account of irritability, disturbed sleep, and lack of interest in daily activities.

The client was educated up to class 8 and is a housewife. She is a resident of Rawalpindi and lives in a nuclear family. She is married for the past 16 years and has no children. The client is a Muslim Pathan. She is second-born of six siblings and belongs to lower middle socioeconomic status. The clinical psychologist had seven meetings with the client that lasted for 45 minutes on average. Sessions were conducted in Urdu keeping in view the client's convenience.

2.2. Presenting Complaints

The client reported that she had been experiencing “low mood, crying spells and sleep disturbance”. She experienced “irritability” and difficulty “initiating” sleep. She had “lost interest” in the routine activities including “house chores and hobbies”. The client reported “helplessness and hopelessness”. She had “apprehensions regarding future” and “increased heart beat”.

2.3. History

The client was unable to recall the exact onset of her symptoms however; it started in the first four years of her marriage when the client had six miscarriages. It triggered conflicts between the client and her in-laws. The client reported that she started experiencing “sadness, crying spells, and helplessness” in that duration. When the client was pregnant for the sixth time, she was hospitalized because she was “internally very weak” and needed “complete monitoring and medical care”. According to the doctor, everything was normal and the client remained hospitalized for six months when she again miscarried due to some “undefined and unexpected” reason. According to the client, this incident worsened the client’s symptoms and she became “hopeless and fatigued” all the time. Few days after the miscarriage, her in-laws forced her husband to divorce the client. Client’s husband used to “support” the client but never “argued” with her parents due to which he used to remain “silent” in front of his parents. The client attempted suicide at that time. She doused herself with kerosene oil and was about to set herself ablaze when her husband came to the room and stopped her. At that time, the door of the room was “closed but not locked” and she had “no idea” how her husband came at that very moment. Upon probing, the client reported that her intention was to “end her life” as she could not “think to live without her husband”.

The client’s in-laws used to “taunt” and “blame” her all the time. They asked her husband over and over to remarry. The client reported that she remained “irritable” and continued to experience “low mood and crying spells”. The home environment was very “strained” and seven years prior to the intake interview, the client’s husband shifted the client to another house on rent. He used to stay with the client for five days a week and for two days he used to live with her his parents.

The client reported that shifting to other house changed the “stressful” environment led to a decrease in the stress “created by her in-laws” however; the client’s symptoms continued. Six years prior to the intake interview, the

client's husband remarried. The client reported that her husband told the client about his second marriage one week prior to the ceremony. The client's symptoms exacerbated and she started experiencing "anger outburst". She became destructive in the state of anger, triggered by "minor" things. She used to break household items in the state of anger. Her sleep got disturbed and she had difficulty sleeping. The intensity and frequency of crying spells increased. One week following the second marriage of her husband, the client attempted suicide. She took six sleeping pills and her intent was to end her life. There was no one in the house at the time of the incident. When the house owner did not see her for the whole day she called her husband who came and the client recovered in a few hours and did not "require" any medical help.

2.4. Assessment

The client's symptoms are suggestive of 296.22 (F32.1) Major Depressive Disorder, moderate i.e. depressed mood, loss of interest, disturbed sleep, crying spells, irritability, helplessness, and hopelessness. These symptoms have caused significant impairment in the client's daily functioning.

The client was experiencing sadness, crying spells, lack of interest, and helplessness for the past 14 to 15 years. She had never been without these symptoms for a significant amount of time i.e. two months while her functioning was not impaired in this duration. Hence, it suggests that the client had Persistent Depressive Disorder for the past 14 years and currently she meets the full criteria of Major Depressive Disorder.

The client was assessed on Bipolar Affective Disorder. However, the client denied any history of elevated mood, inflated self-esteem, decreased need for sleep, more talkative than usual or any of the related symptoms. Therefore, Bipolar Affective disorder was ruled out.

The client experienced increased heart rate due to which she was assessed for anxiety disorders. However, the client denied any of the symptoms of anxiety except increased heart rate. Specifier i.e. with anxious distress was not given as the client denied symptoms such as, restlessness, worry, tension, fear of something awful happening or of losing control.

Self-report questionnaire was administered to assess the degree of depressive symptoms, at the start and in the second last session of the therapy.

Beck Depression Inventory–II (BDI-II). Beck Depression Inventory is a self-report questionnaire with 21 items used to identify the depressive symptoms and to assess the degree of severity (Beck, Steer, and Brown, 1996). Test takes are required to respond to each item on a scale of 1 to 3. Total scores of all

items, obtained by summing up the responses, The greater the score, the higher the level of severity of depression. The cut-off scores show the level of depression as, 0 to 13 indicating minimal level or no depression, 14 to 19 as mild depression, 20 to 28 as moderate depression and 29 to 63 as severe depression. The client's initial score was 29 indicating the initial severe level, whereas the score in subsequent sessions decrease to 24 and 18, and at the end was 12 indicating no depression.

3. CASE CONCEPTUALIZATION

The client was a 39 year-old, middle school qualified housewife, married for 16 years with no children. She sought help voluntarily for her symptoms that included depressed mood, disturbed sleep, crying spells, loss of interest, irritability, and hopelessness for the past six years.

The client experienced emotional distress at a very young age due to chronic illness i.e. diabetes, and break up of a five-years long engagement. Shortly after recovering from this distress she entered the marital bond that initially made her happy as she had an affectionate bond with her husband. Then, repeated miscarriages brought distress for the client in multiple ways; the grief and bereavement, changing attitude of the in-laws as well as the fear of getting divorced and husband getting remarried.

Miscarriages, that demand high emotional support and medical care for the mother, were instead dealt with blame and feelings of guilt for the client over her inability to become a mother. The time required to process the grief used to be laden with numerous emotional stressors made the client consider ending her life. The husband, who was supportive and affectionate towards the wife and obedient towards the parents, made the client's position in the family and in the life of the husband frequently challenged and she lived numerous years with this insecurity.

The discomfort and distress, caused by the attitude of the in-laws, ended for the client when she was moved into a separate house. However, the client still carried her hopelessness and the associated desire to become a mother; hence, the change did not prove to be significant in terms of her psychological health.

The second marriage of the husband triggered the client's current major depressive episode. What the client had feared for years eventually materialized and it was hard for her to accept the reality, hence, the development again made her contemplate suicide. The client belonged to a male-dominant Pathan culture that follows female submissiveness as compared to the mainstream culture. The client has seen submission of women to men in her family, throughout her life

which she considered a norm. While divorce and second marriage are a norm in the culture if the female is unable to become a mother, second marriages without any obvious reason are not uncommon in Pathan culture.

The client was in the state of ambivalence regarding living together with the second wife of her husband in the coming months. On the one hand, she was happy as she would be with the children all day long; on the other, she was apprehensive regarding her bonding and understanding with the second wife. In Pathan culture, if a man has two wives, it is expected from both of them to live together happily and perform all the house hold chores together. The client considered it her responsibility and that of the second wife to maintain a peaceful home environment for their husband when they live together, depicting her cultural belief.

The client is someone who faced multiple hardships in her life and never sought any psychiatric/psychological help due to which her symptoms became chronic. However, the client is motivated to change and she had shown adherence to treatment and responded well to medication and psychological intervention that seemed to make her prognosis better.

3.1. Course of Treatment and Assessment of Progress

The client received seven individual therapy sessions over the course of two months, with each session lasting for 45 minutes on average.

3.2. Course of Treatment

Session 1. The initial goal of treatment was to build rapport and understand the context in which the client was living. Initial sessions were further utilized to Psycho-educate the client regarding the problem and importance of adherence to treatment. As the client was seeking psychological help for the first time, the course of treatment was discussed with the client that included minimum time duration required before the effect of medication can be observed and the collaborative mode and process of psycho-intervention.

Adherence to medication and working in alliance with the psychiatrist was discussed with the client so that the medical treatment can continue with the therapeutic treatment. Deep breathing exercise was used to control the heart rate of the client, which she rated initially as 8 out of 10, whereas the tolerable level for her was 3 out of 10 on a rating scale of 0 to 10.

Session 2 to 4. Solution-focused brief therapy was introduced in the second session starting from the “miracle question”. Miracle question is primarily based on the concept of how client would spend a day without illness, if it happens because of some miracle. Their answer entails what is missing

from their life, and the same is then worked upon. The client was distressed regarding her inability to perform household chores as she used to do before. Solution-Focused Brief Therapy was used to help the client visualize the change in terms of specific, doable behavioural tasks. The exhaustive list of behavioural task was generated with the client.

According to the client, on the rating scale, the client considered herself at level 8 when she first appeared in the session. She wants to reach level 2 (10 indicating highest level of stress, 0 indicating no stress).

The client's task for the sessions was specified which she was able to perform and felt better by fourth session. She reported that she was able to,

- Talk to her co-wife
- Talk to her step-daughters
- Control her habit of breaking things in anger
- Make her bed and arrange her clothes
- Spend time with guests

The performance of the mentioned tasks also improved her mood and made her better motivated for future sessions. Since research has shown positive outcome of abdominal breathing for the symptoms of anxiety, the same method was also continued with the client in this phase (Chang et al., 2009).

Risk assessment was also done in each session to ensure the client's safety. At the start of treatment, client reported no suicidal ideation.

Session 5 to 7. In the progressive sessions, solution-focused brief therapy was continued as the final goals of the client were,

- Ability to control anger
- Ability to take more interest in house errands
- Cook food of husband's choice
- Acceptance for the co-wife as she had to live under the same roof with her
- Interest in going for picnic and shopping

By the sixth session, the client was able to sleep without the use of medication. In order to counter the anxiety accompanied by living with co-wife, guided discovery was also used to identify the most worrisome thoughts of the client. She anticipated arguments with the co-wife, upon which she was helped to come up with more constructive and possible ways to deal with her anticipated stressors that she might encounter. She came with the solution of using deep breathing, keeping herself busy, and accepting the situation at hand in order to resolve the problem.

During termination phase, relapse prevention was discussed with the client, upon which she reported that she will use the techniques learnt in the

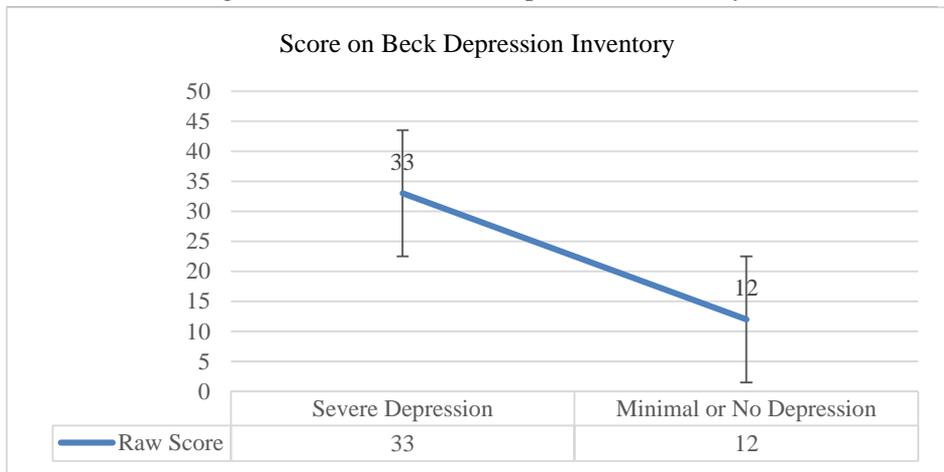
session herself in order to be able to resolve her problems. The client was also given contact details of the administration for follow-up. The client felt relieved and happy after the treatment employed.

3.3. Assessment Progress

The client’s depressive symptoms decreased with the treatment progression. Her score of 33 decreased to 12 by the end on Beck Depression inventory II, as shown in Figure 1. The client also showed decrease in the level of symptoms on the scale of miracle question Solution-Focused Brief Therapy. Her symptoms decreased as initially she was on level 8 and by the end she was on level 2.

The client showed increased acceptance and motivation for change during the treatment. She was able to perform the chores for which she initially lacked energy and by the end she was ready to live with her co-wife; the significant cause of her depressive symptoms.

Figure 1. Score on Beck Depression Inventory



3.4. Complicating Factors (including medical management)

In this client’s case, the only complicating factor was related to ethics. After the first session with the client, her husband suddenly asked the therapist outside the consultation room regarding the client’s problem in front of the client. As consent was not taken to talk about her condition to any of her family members except in emergency situations, the husband was told that the client was distressed and it was difficult to say anything with surety after the first

meeting and without discussing it with the client. However, it was made clear to him that she needed medication and therapy.

In the second session, her feelings of her husband inquiring about her case were addressed. In addition, the confidentiality and limits of confidentiality were also reassured.

3.5. Access and Barriers to Care

There was no significant barrier to care and access, however, at times, the client was not regular in attending her sessions due to her domestic commitments. This difficulty was overcome by rescheduling the session in the subsequent weeks.

3.6. Treatment Implications of the Case

This case study shows that for the treatment of women with depression from developing countries, the use of solution-focused brief therapy along with relaxation techniques is effective. It has shown a positive outcome in lesser time frame as compared to conventional psychotherapies like Cognitive Behavior Therapy etc. The client's cognitions and behaviour showed significant change following the course of therapy.

4. RECOMMENDATIONS TO CLINICIANS AND STUDENTS

The most important recommendation for clinicians and students is to remember the fact that solution-focused brief therapy does not focus on eliminating the causal factors causing suffering but on the impairment it leads to. It focuses on how an individual's daily routine has changed due to the painful experience and how by changing the factors in routine, their suffering lessens. Hence, the therapy emphasizes on finding solutions (O'Hanlon and Weiner-Davis, 2003).

Another important recommendation is that solution-focused brief therapy is effective in cases where clients are unable to show efficacy in cognitive therapies due to limited education and psychological mindedness (Delgadillo et al., 2014). In a country like Pakistan, where mental health awareness is insubstantial, clients' turn out rate for therapy is low (Naeem *et al.* 2010). However, with use of a therapy focusing on direct solutions, clients' satisfaction level and motivation for therapy increase.

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