CASE REPORT

UTILIZING COLLABORATIVE EMPIRICISM IN THERAPY WITH COMBINED DEGENERATIVE SPINAL CORD DISEASE: A CASE STUDY

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ABSTRACT

The present case study aims to highlight effective role of Collaborative Empiricism from Cognitive Behavioral Therapy in psychological adjustment of patients with chronic medical condition. It gathered evidence from ten longitudinal therapeutic sessions carried by the author, a postgraduate clinical psychologist in placement at the time, with a 35 year old female client medically diagnosed with Combined Degenerative Spinal Cord disease for the past eight years referred first times for Psychological services. She received diagnosis with Major Depressive Disorder. The overall approach of therapy in this case, set in collaboration with the client, was to bring insight and acceptance of her medical and psychological diagnosis and finally to facilitate her in regaining psychological independence by restoring her existing potentials. Therapeutic sessions, conducted once a week, were structured around achieving specific goals set with her and gaind focus in resolving client's concern of limited independent functioning, eventually re-defining independence in her present life. All therapy sessions were supervised and carried out at the inpatient facility of a government institute of rehabilitation and medicine, over approximately two months. The study gives insight into significance of placing psychological therapeutic services in a multidisciplinary rehabilitation process. The client was treated as an expert bringing evidence from her life and making personal decisions. This empowering approach met with considerable improvement in multiple domains of the client's life over the longitudinal course of therapy.

Keywords: Cognitive-behavioral therapy, Collaborative empiricism, Combined degenerative spinal cord disease, Psychological adjustment.

CASE REPORT

Present case is of a 35 year old married female client, admitted in a multidisciplinary rehabilitation facility, undergoing rehabilitation treatment for combined degenerative spinal cord disease. The disease lead to sensory-motor deficits, nearly permanent loss of physical function, increased susceptibility to infections, and pressure sores[1]. Her medical condition, in addition to low financial and social support, posed an increase risk for her developing psychological disorders[2]. During her eight years long medical treatment, physical symptoms worsened and she developed distrust and a confrontational attitude towards her doctors. This strengthened her schema that the world is a dangerous place, and no one is trustworthy. She ruminated over her inability to meet high standards of personal independence in face of a physical ailment; client perceived herself as defective and adopted an all-or-none thought pattern. The resulting psychological distress manifested in frequent crying spells, guilt, insomnia, irritability and suicidal ideation without active planning. Such symptoms pushed her towards feeling low. She was formally assessed and diagnosed with Major Depressive Disorder - Moderate type by Clinical Psychologists at the inpatient facility (Author 1, 2 & 3)[3].

The present case studies the effectiveness of utilizing collaborative empiricism for psychological adjustment of client with chronic medical condition. Collaborative Empiricism in the present case is defined as the shared effort of the therapist and the client in determining an intervention plan for the client that warrants cooperation between the two members in order to explore aspects of dysfunction to be addressed

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in therapy[4]. All therapeutic sessions, were based on the Cognitive Behavioral Therapy principle of Collaborative Empiricism known to help regain psychological adjustment among clients with post-spinal cord injury psychosocial issues[5-9]. This also enhanced relational competency and gave the client a sense of empowerment over her life[10].

In the present case, Collaborative Empiricism operated as the Clinical Psychologist and the client conceptualized her concerns from her narrative based on evidence of her stated thoughts, feelings and behaviors. Triggers were identified and target thoughts and behaviors were stated as goals of therapy to be challenged or altered to achieve favorable outcomes. Psychological adjustment in this study is defined as a dynamic construct; its degree indicated by the absence of or reduction in the presence of an existing psychological disorder, as well as adaptation of healthy coping mechanisms when one has a chronic illness[5]. The present study measured psychological adjustment by the scores on Beck Depression Inventory-II (BDI-II); A quantitative measure of the diagnosed clinical depression in client. Additionally, author's clinical judgment and client's feedback at the end of each session was analyzed to understand the dimensions of psychological adjustment in client. Reduction in BDI-II scores would indicate positive psychological adjustment[11].

The nature and purpose of the present therapeutic approach was discussed with the client, and she consented to opt for an intervention based on collaborative empiricism. Limits of confidentiality were discussed at the beginning of first therapeutic session. Author (1) conducting the therapeutic sessions was a post graduate clinical psychology trainee in placement and under supervision of an on-site (Author 2) and an off-site supervisor (Author 3). A psychiatric consultation was recommended for the present client owing to the severity of clinical diagnosis however the in-patient facility did not provide psychiatric services and the client did not pursue psychiatric consultation at another location due to her medical and physical limitation; thus the client did not receive any psychiatric treatment during the course of her therapy session with Author 1. Ten therapeutic sessions were carried out, scheduled once a week, utilizing collaborative empiricism, with each session of forty-five to fifty minutes duration. All therapy sessions were supervised (Author 2 & 3) and carried out at the inpatient facility of a government institute of rehabilitation and medicine, over approximately two months. The client was educated on interconnectedness of thoughts, feelings and actions, thereby enabling her to formulate an active understanding of her present cognitive, emotional and behavioral functioning. She was also psycho-educated on the role of long standing idiographic patterns of thinking by examining personal life events[10]. Active role of both therapist and client was ensured, and discreet, measurable short-term and long-term goals of therapy were constructed and agreed upon in collaboration. It provided aim for each session and opportunity to the client for assessing her progress and actively participating in the process. On the first session she scored on the lower end of Severe Depressive on BDI-II (29).

Short-term goals, designed to provide immediate symptomatic relief by aiming to resolve currently present conflicts in thoughts, were identified as relating to client's decisions about medical treatment. The primary concern was client's failure to visit gym for her regular physiotherapy, out of fear of falling and being unable to break the fall owing to lack of motor control. This fear heightened after witnessing the same incident with another patient.

By using cognitive and behavioral intervention of thought challenging using thought records, downward arrow technique and guided discovery, the client was helped to ascertain the benefit of going for physiotherapy and address the associated fears which were functioning as a barrier. The behavioral technique of constructing hierarchy for the feared situation helped motivate her to go to the gym. Behavioral experiment was constructed where she agreed to gradually

increase her visits to gym, and the length of her stay there, with or without engaging in exercise. Client had achieved the preparation stage of change[11]. In the follow-up session, client reported of having visited the gym and engaging in thirty minutes of physiotherapy, despite remaining fearful. She reported relief and sense of empowerment afterwards.

Second concern was to consult recommended doctor due to his expertise in neurological diseases. This was especially problematic due to client's long standing schema of distrust towards varying doctors. The goal was to visit the recommended doctor for expert consultation by booking an appointment and arriving at the clinic on time; measured by the doctor's prescription received on client's file. Cognitive exercise solicited alternate thoughts by looking at both the pros and cons for "going" and "not going" for consultation. Client agreed on a rational level that the recommended doctor was an expert professional through evidence of his efficiency in the field however, she was reluctant to take the step towards this goal. The behavioral experiment was helpful though a hierarchical plan arriving at the most desirable action, resulting in client's readiness to make the appointment with the doctor herself. Client had achieved the contemplation stage of change[12]. In the next session, client revealed that she visited the doctor as scheduled however, she did not enter in his office for the meeting. Her reluctance was discussed leading to client arranging for another appointment and this time she went in for the consultation and accomplished her set goal.

Long-term goals of therapy focused on the overall context of her life problems, were worked on throughout the course of subsequent sessions and were somewhat achieved during the small course of therapy by using behavioral activation and cognitive restructuring exercises. Client's feedback and author's clinical judgment coincided that by the end of last session, she had achieved better problem solving skills by generating at least three alternate ways of thinking about a situation; and to gain independence by regulating personal negative thoughts, distressing emotions and unhelpful behaviors; as was also measured on her reduced scores of Beck Depression Inventory-II now on the upper end of Mild Depressive category (19)[11].

CONCLUSION

During the ten therapeutic sessions, client's progress was monitored through her active input and feedback, in-session and between-session observation of her behavior and increased ability to think in a diverse fashion, verbal self-reports by consulting health professionals on team, and her significant therapeutic gains towards the end of the therapy. Quantitative measure of Beck Depression Inventory-II was also used. Client developed a greater insight to her patterns of highlighting negatives and disqualifying positives, and increasingly high standards of performance for self. In each progressive session she required reduced facilitation to generate alternate views to a problem. It was the client's observation and therapist's judgment that her depressive symptoms had significantly reduced in severity, if not in type. Her somatic complaints reduced; was careful regarding the pressure sores and eventually was relieved of them. Her scores on BDI-II dropped ten points on the scale. This report illustrates the utility of collaborative empiricism in contributing to significant reduction in the post-spinal cord psychological distress. It adds to the literature supporting use of CBT with clients receiving rehabilitation services to help regain functionality in physical as well as psychological domains[10].

CONFLICT OF INTEREST

This case study report has no conflict of interest to declare by any author.

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