Journals online

American Journal of Medicine and Surgery (AJMS) Volume 6, 2021

HBM PsychotherapeuticModel in DepressiveDisorder - Case Study

Flor Gonçalves *- Degree in Clinical Psychology, Master in Psychoanalytic Psychotherapy, Master HBM Research.*

Sylvie Ribeiro *- Degree in Clinical Psychology, HBM Research*

1. Sociodemographic Data

- Name: C.
- Age:53
- Gender: feminine
- Marital status: married
- Children: 2
- Household (ascendants and/or descendants): 0
- Academic qualifications: 4th grade
- Employment status: unemployed
- Psychiatric medication (if yes, which): Triticum (150 mg); Xanax (0,5 mg); Fluoxetine (20 mg); Topiramate (25 mg).
- Relevant physical conditions: diabetes

2. Anamnesis

2.1. Mental state/clinical observation

C. showed at the consultation with an unkempt appearance, slouched and apathetic posturing, slow and self-deprecating speech, although without any apparent cognitive impairment.

2.2. Motive for the Consultation and symptoms shown

Patient C. came to the Assessment and Diagnosis Appointment (CAD) accompanied by her husband, mentioning that he had insisted for her to come to the appointment. She stated she did not want to come to the consultation, because she knew no one could help her and also because she had already been through several types of therapy, to no effect. Despite that, she accepted to carry on with the consultation and stated her main complaints and the existence of persistent feelings of sadness and melancholy, lack of self-esteem, anhedonia, mental confusion and difficulties in concentrating, insomnia and significant loss of weight and not having the ability to control and reorganise her emotional state.

2.3. Biopsychosocial History

C. stated she was born in a normal delivery and showed cognitive and psychomotor development within normal parameters. Her childhood was spent in a small village in the North of the country, where she lived alone with her parents. Her parents were quite strict and conservative, never allowing her to have much interaction with other people, outside the family unit, nor showing displays of affection towards her. Up until her marriage, C. mentioned her life was limited to going to school and helping her mother

out with the domestic chores, recalling she had always been a sad child. In fact, her childhood and adolescence were marked by feelings of loneliness and some disenchantment regarding life in general. She got married when she was 18 years old, not for love, but so she could have some freedom. However, she soon got pregnant and, despite wanting to work, her husband insisted she stayed at home to take care of their son. One year later she had another child. Since then her life, literally, revolved around the growth and development of her children until they left home. The younger daughter left home at 23, having emigrated to Switzerland and the older son left 2 years later, having moved to Lisbon with his wife. About 1 year ago, C's husband developed a cancer and this event brought changes to her daily life, especially regarding the stage of the disease and her husband's convalescence and, later, his frequent presence at home, since he started only working mornings.

2.4. History of the problem

According to C., the clinical state started when her daughter left home, having aggravated 2 years later when her son also left home. Since her children left home, C. feels her life has no meaning. Her younger daughter stopped studying after she finished the 12th grade, having had, after that, some precarious, temporary and mostly part-time jobs. In fact, she spent a lot of time at home, needing her mother's support for everything, as had been the case her whole life. When her daughter decided to emigrate, C. mentioned that her whole world came crashing down. She could not imagine "her little girl" away from her and exposed to all sorts of dangers. The first times were of great anguish and C. stated that she couldn't sleep, both for the fears concerning her daughter and for the "deafening silence" which was felt around the house. Her husband would leave in the morning and only come back at night, they would have dinner and he would then retreat to the office. Her son only came home to sleep, eat and change his clothes. The house's daily chores became an ordeal, she mentioned that what got her out of bed was the fact that she had to prepare her son's meals, take care of his clothes and the other domestic tasks. When her older son left home, C. completely crumbled. She mentioned periods of intense sadness and melancholy, with frequent crying and feelings and thoughts of uselessness ("I'm useless now"; "I'm worth nothing, that's why they all abandoned me"), spending weeks without leaving her bed to do anything. She sought several types of help, namely, psychiatry, traditional psychology and alternative medicine, but according to what was said, she didn't improve much. C. stated that her husband's disease was a demanding period, but one that brought her children back home, mentioning this stage with ambivalent feelings. When her husband recovered, she stated she felt herself sink to the bottom once more. She added that her husband's presence at home is confusing to her, because if before, he was not there, because he was working, now he is still not there and their living together has become in a way, distressing for both.

3. Diagnostic and evaluation instruments

During theCAD (Assessment and Diagnosis Appointment), the assessment of the clinical case was performed, applying psychological evaluation tests: **SCL-90; BDI-II** (*BeckDepression Inventory*):46-severe depression;**BAI** (*Beck Anxiety Inventory)*:35-severe anxietyand**Pittsburgh sleep quality index**:15-sleep disorder; carrying out a clinical interview following the HBM (Human Behaviour Map) Model evaluation

protocol and checking for the presence of symptoms described in the diagnostically and statistical manual of mental disorders(DSM-V).

4. Differential diagnosis

Insofar as patient C.'s complaints follow a series of changes in her life which were experienced by her as highly disturbing, constituting significant causes for stress, we might consider, at first glance, the Adjustment Disorder diagnosis, with depressive mood. In effect, the symptoms shown appeared in the aftermath of both children leaving home and the suffering associated to losing the role of mother and carer felt by C. -Empty Nest Syndrome: middle age parenting role transitional stage, when parents and particularly mothers, due to the intense stress caused by the feeling of loss, respond with sadness, worry, anxiety, affliction, isolation or loneliness (Donida& Steffens, 2018).

However, the hypothesis mentioned above is excluded, since the symptoms shown meet the diagnosis criteria for **Major Depressive Episode**: presence of depressive mood for most of the day; sharp decline of interest or pleasure in all or almost all activities throughout mostof the day; significant weight loss; insomnia; feelings of uselessness or excessive or inappropriate guilt and diminished ability to think, concentrate or indecision; these symptoms cause clinically significant suffering and cannot be attributed to the physiological effects of a substance or any other medical condition, nor are they better explained by another disorder. This disorder followed the experiencing of the Empty Nest Syndrome.

5. Working hypothesis/Clinical case conceptualisation

According to the HBM Model, depression is an introspective emotional state characterized by deep feelings of anguish and sadness.

Over the last 3 years, C. has gone through highly impactful experiences, emotionally. Her children's departure from home constituted a very negative experience for C., since this event shook her belief, values and emotional system. Since she was a child, C. lived experiences which formed mental, emotional and behavioural patterns which worked out as risk/predisposing elements towards the clinical picture presented here. Thus, used to interacting only with her family and having had her life limited first to her parents and later to her husband and her family life, C.'s perception of life was exclusively centred on her role within the family life cycle and her maternal tasks. When her children left home, C. saw her active role as a mother severely diminished and entered a state of emotional imbalance, since all her mental representational system about life was shook. In seeking to instigate the resignification of the experiences which generated pain, her mind entered an introspective state (a state during which one loses all energy, so as not to react to external stimuli, in order to direct all resources towards the task of resignification). However, the experiences were so impactful, that C. was incapable of overcoming them, developing a pathological depressive state.

6. Intervention / Psychotherapeutic evolution

The therapeutic intervention was carried out through 13 sessions, following the HMB Psychotherapeutic Model,divided into two specific stages. During the first stage, called, **treatment intensive stage** C. had weekly psychotherapy sessions and the goal was to remove her from the state of intensive suffering she was in.

Right on the first session we began the emotional dissociation process, using the**Morfese**therapeutic intervention technique and we gradually introduced resignification exercises, using the therapeutic intervention techniques called **Atheneses.**

Through morfese C. started to dissociate from the negative emotions caused by the experiences she lived throughout her live. Thus, over 7 sessions, the patient was intervened, using morfese, a technique through which the patient is inducted into an oneiric process, through gradual and deep relaxation and, after that, using a symbolic/figurativelanguage(vault), we encouraged the patient to place within the vault all the experiences, memories, emotions, thoughts and mental representations which had originated the depression.

During the emotional dissociation process, we also started the therapeutic interventions focused on the resignification of the traumatic experiences, through atheneses, on which we worked with the patient so as to change the negative perception of the experiences she lived. Thus, we explored with the patient the mental representations she had of the problems and helped her change them, by assigning them a new meaning. With C. theathenesesthat were used the most were the "Distortion of Representation" atheneses. Together with the patient, we identified the problem/symptom, exploring the mental representation she had of it and, using language and imagination, we changed the different submodalities (colour, size, texture, form, movement, sound, taste), transforming the internal representations from negative into positive. As an example, we explored with C. the mental representation she had of the depressive state she was in and she described it as a constant feeling of anguish on her chest. Next, we asked that C., while thinking about that feeling, objectified it and characterized it, to which she mentioned that the feeling was like a dark, heavy and very big rock in the middle of her chest, piercing it. Next, guided by the therapist and using her language, imagination and visualisation recourses, C. gradually transformed the big, heavy, dark rock into a small grain of sand, which disappeared into a sandy beach. After reducing the mental representation submodalities C. made of the depression, the feeling of anguish left and stopped affecting her.

At the end of the intensive stage of the treatment, C.repeated the psychological evaluation tests carried out during the CAD and her depressive symptoms had been reduced significantly, showing an absence of clinically significant symptoms: **BDI-II**:9- absence of depression; **BAI**: 9- absence of anxiety and the **Pittsburgh sleep quality index**: 4-good quality sleep. At that moment, C. started to wean off the medication, followed up by her psychiatrist. It should also be mentioned that C. also started recovering her appetite having, gradually, recovered her normal weight.

We then entered the treatment consolidation stage (6 sessions throughout 6 months), aiming at consolidating the therapeutical changes which had been reached, so as to maintain the acquired functionality, prevent relapse processes and stimulate C. to be involved in pleasurable activities and activities which could boost her personal fulfilment and her self-esteem: involvement in volunteering activities at the civil parish's child and

youth home; attendance of zumba classes and planning activities together with her husband, so as to improve the interaction between the two of them. C.'s husband was also actively involved during this process, with some sessions focusing on improving the couple's relationship.

During C.'s last treatment session, she repeated the psychological tests carried out during CAD once more and the positive results shown during the intensive stage remained: **BDI-II**: 7-absenced of depression; **BAI**: 9- absence of anxiety and the**Pittsburgh sleep quality index**: 4-good quality sleep.

7. Conclusion/Process Completion

Despite having come in reticent on CAD's day, at the end of it, C. said she felt a slight hope right on that day, since, for the first time in her life, she had felt someone had truly understood her. On the last session, C. showed a quiet and balanced posture, showing insight about her current and past emotional states and being very satisfied with the results obtained and, in her words, with her "new way of living life".

Through the HBM Therapy, C. managed to free herself from old and dysfunctional emotional patterns, which conditioned her life, on all levels, as well as to develop new thought and reality understanding strategies. In effect, she managed to understand and assimilate, that, regardless of her role in her family life, she had many other roles she wasn't enjoying, namely her role as an individual and as a woman, with her own desires and goals. She started taking better care of herself and becoming involved with extra-family activities such as volunteering and practising physical exercise and, consequently, expanding her social circle and leisure activities (e.g., performing activities with her new circle of friendships), as well as nourishing her marital relationship. C.'s husband played an active and important role in this, since he actively took part in the therapy, following the therapeutic indications worked during the consultations (e.g. supporting and encouraging C. in all these new challenges and invest in the couples' relationship).

Bibliographical References:

- American Psychiatric Association (2014).*DSM-5:Manual de Diagnóstico e Estatística das PerturbaçõesMentais,* 5thedition. Lisbon: ClimepsiEditores.
- Brás, P. (2010). Manual HBM. Unpublished document. London: Master HBM Research.
- Brás, P. (2018). *Feliz para sempre*. Lisbon: PlanetaManuscrito.
- Donida, N. & Steffens, S. (2018). *Síndrome do ninhovazio: sentimentos das mãesemrelação a saída dos filhos de sua casa.*AnuárioPesquisa e Extensão UNOESC São Miguel do Oeste. Available at:

  https://portalperiodicos.unoesc.edu.br/apeusmo/article/view/19674/10443
- Oliveira, J., Certal, C. & Domingues, C. (2016).*OModeloPsicoterapêutico HBM naPerturbaçãoDepressiva.*Article extracted from: Livro de Actas do terceirocongresso da Ordem dos PsicólogosPortugueses.Available at:

  https://spphbm.pt/wp-content/uploads/2019/01/OPP.pdf