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Efficacy of Cognitive Behavioral Therapy for Major Depressive Disorder: Case Study

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Abstract

Cognitive-behavioral therapy CBT for major depressive disorder MDD is one of the most impactful treatments in the world. The aim of this case study was to find out the impact of CBT for MDD. This study included a case suffering from major depressive disorder. The participant was a member of a household community in Iraq's Kurdistan Region. According to the aim of the study, the psychotherapist worked with one case of depressive disorder, according to the study's aim. There were a total of 27 therapy sessions for the cases. It appeared that cognitive-behavioral therapy is a beneficial therapy that leads to remission of depression symptoms in patients. This study delves into various treatment methods for depressed patients and provides a detailed analysis of CBT, connecting epidemiology to the psychotherapist's case.

I. INTRODUCTION

Depression can be defined as a form of psychological distress, and a severe form of depression is widely considered to be the most distressing condition in the entire world. Ian H (1996) claims that when it comes to psychiatric disorders, depression is by far the most prevalent. Depressive episodes affect twenty percent of the human population at some point in their lives. Each year, more than one hundred million people around the world experience depression.

Helgeson and Zajdel (2017) state that chronic medical diseases are more frequent than they were in the previous century, despite the fact that people are living longer than they did in the previous century. Chronic medical illnesses are diseases that continue to exist for an extended period of time and can also be marked by remissions, fluctuations, or worse. Conditions such as cardiovascular disease, diabetes, cancer, and arthritis are examples of common chronic diseases. Patients frequently participate in a variety of health-related behaviors in order to manage a chronic disease. These behaviors include taking medication, following a diet, engaging in physical activity, and visiting their physicians to check on their condition.

Major depressive Disorders (MDD) is among the most common in the world and includes different symptoms, but it has two main symptoms of depressed mood and loss of interest in life. People with this disorder see the world with a negative view and increased suicidal thoughts, and suffer from other symptoms (American Psychiatric Association, 2013). In addition, the prevalence of these symptoms in people's life is extremely high, resulting in a large amount of clinically meaningful pain and harm (Marcus & Olfson, 2010). As a result of these qualities, there has been a significant growth in the search for alternatives to the treatment of depression over the course of the past decade, with the primary focus being placed on psychotherapy interventions within this quest. There have been published research that demonstrate the effectiveness of psychological

treatment in reducing the symptoms of depression. These studies are both controlled and comparative (Cuijpers et al., 2011).

In ancient psychiatry, the diagnosis was different, and specialists believed that extreme sadness was a reaction to an emotional reaction to living conditions. During the past years, tools and research were developed to diagnose patients more accurately. Depression has descriptions that specialists can easily identify. For example, this disorder in history is one of the easiest disorders to diagnose over 2500 years. In DSM a reference to the historian Stanley Jackson that in Greek texts a reference to symptoms of depression, in Hippocrates' literature, they write about depression, but Hippocrates linked depression to fear and delusions (Horwitz et al., 2016).

Furthermore, an effective treatment for depression is cognitive behavioral therapy (CBT), which is the style of psychotherapy that has received the most research and is based on Beck's cognitive theory (Beck, 1976). In the previous studies, meta-analysis has demonstrated that cognitive behavioral treatment (CBT) and medication have equivalent effects on major depressive disorder (Cuijpers et al., 2013). Beck et al. (1979) suggest that CBT is a family of techniques that are among the most established empirically supported depression treatments. Cognitive therapy (CT) is the most extensively performed intervention, yet all of them are similar. CBT assumes that incorrect beliefs and inappropriate information processing cause and maintain depression. This 'cognitive model' states that correcting maladaptive thinking reduces acute distress and symptom recurrence.

Every person in the world feels sad and they say we have been exposed to depression in our life at a time, but most of these times there is not enough intensity and time that the individual must appear to be able to say that this person has been exposed to depression. Symptoms of depression vary, for example, people with depression complain about focus on their flaws, it is difficult for them to pay attention and to absorb what they read and hear, and lose hope in life, they complain about their social aspect. They suffer from social withdrawal. Many suffer from depression and want to sit alone and away from people. Suicide is common among people with depression, and most of them complain of physical symptoms including fatigue and low energy. Most people with MDD believe that their physical symptoms are serious medical conditions (Kring et al., 2016).

Major depressive disorder based on DSM-5 requires the presence of 5 of more of symptoms and the duration of these symptoms is at least two weeks, and with a depressed mood or loss of interest in pleasure, it must include symptoms, for example, change in appetite, sleep, decision-making, or concentration, and many of them complain of worthlessness, suicide, psychomotor agitation, or retardation. MDD is an episodic disorder because symptoms sometimes exist for some time and then decrease. Nevertheless, major depressive episodes tend to dissipate over time and the untreated episode sometimes lasts for 5 months or sometimes longer. In major depressive episodes, there is recurrence: meaning when a certain episode disappears in most cases the person is exposed to another episode. For people who experience a major depressive episode, about a third of them will have another episode of depression in their lifetime. An individual's increased experience of episodes of depression increases the individual's experience of another depressive episode by 16% (Kring et al., 2016).

I. Diagnostic criteria according to (ICD-10) (World Health Organization, 2016)

In typical mild, moderate, or severe depressive episodes, the patient suffers from lowering of mood, reduction of energy, and decrease inactivity. Capacity for enjoyment, interest, concentration is reduced, and marked tiredness after even minimum effort is common. Sleep is usually disturbed and appetite diminished. Self-esteem some ideas of guilt or worthlessness are often present. The lowered mood varies little from day to day, it is unresponsive to circumstances, and may be accompanied by so-called 'somatic' symptoms, such as loss of interest and pleasurable feelings, waking in the morning several hours before the usual time, depression gets worse in the morning, marked psychomotor retardation, agitation, loss of appetite, weight loss, and loss of libido. Depending upon the number and severity of the symptoms, a depressive episode may be specified as mild, moderate, or severe.

II. Differential Diagnosis of Major Depressive Disorder

Nearly half of the patients with category I BD and nearly three-quarters of those with category II BD may

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experience the first episode of depression (Patella et al., 2019). Bipolar disorder (BD) diagnosis guidelines are based on the occurrence of a manic or hypomanic episode to differentiate between unipolar depressions (Perlis et al., 2006). A delay in the diagnosis of BD, or even errors in diagnosis can cause a delay in treatment, and therefore, prolong suffering (Patella et al., 2019). A major depressive episode is an appropriate diagnosis if the mood disorder is not judged to be the immediate pathophysiological consequence of a serious medical disease (e.g. multiple sclerosis, stroke, and hypothyroidism) based on human experience, physical assessment, and experimental results (American Psychiatric Association, 2013).

Depressive episodes differ from the bouts of sadness that every person goes through during his life, sadness occurs because of an event in life, and it is appropriate with the event (Wakefield & Demazeux, 2016) to the diagnosis of major depression requires five symptoms for at least two weeks (Wakefield et al., 2010). In each of these ADHD and MDD, distractibility and poor anger resistance will occur; if the criteria is met in each of the addition to mood disturbance, attention deficit/hyperactivity disorder will be diagnosed. Although with children with attention-deficit/hyperactivity disorder whose mood disorder is characterized by irritability rather than depression or loss of interest, the clinician must be cautious not to over-diagnose major depressive events (American Psychiatric Association, 2013), The difference between symptoms of ADHD and MDD are important because, they have a direct effect on therapeutic considerations (Knouse et al., 2013). Substance/medication-induced depressive or bipolar disorder. This syndrome is distinguished from MDD by the fact that a substance (e.g., drug abuse medication, a medication, a toxin) appears to be etiologically linked to mood depression. A depressed mood that happens only in the sense of cessation of cocaine, for example, is diagnosed as a depressed disorder induced by cocaine (American Psychiatric Association, 2013).

III. Case Documentation 1

1. General Details of the Therapy

Patient code:	LJM004
Diagnosis classification (as per ICD-10 and DSM 5):	Major Depressive Disorder- ICD-10 code F32.1/ DSM-5 code 296.22
Treatment type	(Hospital) individual therapy, long-term treatment
Duration of treatment:	27 sessions from 10 June 2019 to 12 February 2020
Socio-demographic data:	23 years, female, married, 1 child, house wife.
Referral modus and reason for treatment:	The patient came out of her own volition for treatment. The psychiatrist referred the patient for therapy. The reasons for coming were complaints of depression symptoms such as a depressed mood, loss of interest, insomnia, loss of energy, and feeling guilty.

II. ANALYSIS OF THE PROBLEM

2.1. Description of current symptoms:

After 5 to 6 months of pregnancy and exposure to poverty, the patient LJ came to me with a complaint, stating, "My mood has changed significantly." I have been experiencing a depressed mood, which has persisted to this day, leaving me feeling perpetually sad and hopeless about life. I cannot do my house duties." Her husband and sister have noticed her low mood due to her inability to perform household duties, her reluctance to visit relatives such as her father and sisters, her pessimistic outlook on life, and her self-critical attitude. She also expressed her lack of confidence that her situation will improve. The patient said, "My husband and two of my sisters noticed this thing in me and told me to go to a psychiatrist because every day my mood is depressed, I cannot do anything, and I have a headache." The patient was complaining that she

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suffers from insomnia and that her sleep is not enough to gain energy. She also said, "I cannot sleep as much as I used to before. I am unable to sleep for more than 4 hours in a 24-hour period; if I do fall asleep, it disrupts my sleep, leading to nightmares. She also expressed her reluctance to leave her apartment and her isolation from people. Initially, she had a social personality, but now, she prefers to spend time with her daughter in the garden before returning home. She expresses no interest in going anywhere with her friends or anyone else.

These symptoms led to marital disputes between her and her husband. "I do not love my husband; I want to divorce him, but my father does not allow it," the patient said. I feel that my husband does not care about me much and does not love me; he always works, and even when he comes home, he uses his mobile phone." The patient's indication was that she suffers from a lack of appetite and has lost 3.5 kilograms in one month. The patient said, "I feel constant fatigue and loss of energy, and thus I cannot clean my house, meeting my child's needs." The patient complained about her concentration and forgetting things easily. She said, "If I put something somewhere, then I forget where the thing is in a short time." Fortunately, the patient had no suicidal thoughts, and she had no plan or attempted suicide due to her depression. She also mentioned that she gets angry a lot and without any reason with her husband, which led to a decrease in the love between her and her husband and a decrease in the sexual relationship; sometimes in a month they had only one sexual relationship. She did not take the same care of herself as she had in the past, including her clothes and personal hygiene. She said, "I don't know where I'll start my life again. My thoughts are mixed; I feel a loss of hope in life. I always tell myself at this time that I became a mother; now I cannot work outside the home, and I want to change this routine in my life. I want to work again."

2.2. Psychological / psychopathological examination:

The patient is twenty-three years old, has a good appearance proportional to age and gender, and has a normal weight. It does not display any abnormalities in the body or face. Her facial expressions showed fatigue, uneasiness, and a depressed mood. She maintained a closed and non-talkative connection. In the first session, she was helpful, open-minded, called for help, and spoke slowly in a low-pitched tone. There are no indications of disturbance of memory, attention, or focus. She has no thoughts or attempted suicide, and no drug or alcohol abuse.

2.3. Test Findings:

- According to MINI, the patient fulfilled the criteria of Major depression disorder (MDD). MINI International Neuropsychiatric Interview. English Version 5.0.0.DSM-IV.
- According to the scale (BDI - Beck's Depression Inventory), the patient met the rate (22). (see appendix 1)

2.4. Consumption of Medication, Psychotropic, Addictive Substances: she gets consumption of medication one types: Citalopram 20mg, one pill in 24 hours

2.5. Social History:

The patient is 23 years old and has 5 sisters and 7 brothers. Her family lineage is 12; she is older than one family member. She and her husband have a small makeup store. The family earns financial income from this store, and their financial condition is not good (poor) because they do not have many customers in the store until they pay the rent of the apartment and the store. The money is not enough for them to buy things necessary for their daily lives. She continued her studies until she finished high school. She did not go to college because her average was too low to continue studying there. At the moment, she and her husband live in Dohuk governorate; they live in a small rented apartment. The patient thinks that she should go and help her husband with work so that their financial situation develops for the better. The patient grew up in a family that had many problems, and so far, they have problems among family members. She also has problems with her brothers and father, and her relationship with her husband's family is not good. The patient's husband, a graduate of the College of Science, is currently not pursuing his degree; he works in a make-up store. She lacks friends, with the exception of her younger sister. The patient now believes that she has no chance of success in life.

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2.6. First Impressions:

The client was appearing tired and sleepy, the patient was feeling shy, there were signs of sadness and anxiety on her face, her speech was slow, and her way of sitting appeared uncomfortable.

2.7. Development of Life History:

The patient had no idea about her birth, so it was natural. She was born in Dohuk in 1993. Since her childhood, she has remembered that when she was 6 years old, her older brother molested her. She said, "Me and my brother were in a room alone. My brother said to me, take off your clothes until I see you without clothes, but I did not accept that." When the patient remembers this situation, she hates her brother and feels sad, and sometimes she says to herself, He was young when he asked to take off my clothes. During her childhood, her father and brothers beat her, sometimes locking her inside the house when she yearned to play with the neighbor's children, but they denied her this opportunity. The patient remarked, "I never forget this thing in my life, because I hated my childhood so much, and I even burned all my childhood memories, such as pictures, clothes, etc." The patient experienced severe grief when she was unable to attend college due to not having the necessary grades and not having enough money to attend a private college. She expressed, "Many of my friends were able to continue their studies in college, but I was unable to do so." I was very sad about not going to college until now."

At the age of 16, she had a romantic relationship. She first met this boy through a friend at school, and their relationship lasted for six months. However, a major incident occurred in her life during this time. Fearing that he would end their relationship, the patient consented to a sexual relationship with the boy. This led to two sexual encounters, but the boy abruptly left the girl without any explanation. Despite her love for him, the patient indicated that he had already married another girl. The turning point that resulted in a strained relationship between the patient and her father occurred when a young man proposed marriage to her, a request she refused to accept. The patient explained, "My father wanted me to marry this young man, but I did not accept. After that, disputes started between me and my father." My father always told me that you didn't respect my words and accused me of having secret romantic relationships. Until now, when I see my father, this talk is repeated and leads to disputes between me and my father." The patient was always crying and swearing to her father that she had no secret relationships. The person who asked to marry her was always writing to the patient and threatening the patient and saying to the patient, "You must marry me because I love you." The patient said, "He used to speak to me respectfully and say to me I love you, and after I rejected the guy, he started threatening me, and he used to tell me if you do not marry me, I will tell your father. Your daughter has relationships with young people, and I was very afraid about this matter." This anxiety and psychological pressure with the boy lasted for about a year and a half. The patient said, "I will never forgive my father because he was the main reason I reached this stage of depression." Family and social pressures led them to marry a young man who worked with her at work. to order to get rid of the problems, she met her husband for the first time at a job, working together in the same store. When she married, she was 20 years old. The patient said, "I agreed to marry him, because he was a good character at work and was active, When I had a problem in the house, I used to talk to him about my problems, and he calmed my nerves." She said to herself, "This is a good opportunity. I will marry a good person, and if he loves me, my life will be better and without problems." After marrying the young man, the patient soon realized that her husband had not shown her the same love as before. As a result, they incurred debts due to the high cost of her wedding, leading her to remark, "I wish I had never married." Then they moved to a rental apartment, and their financial situation was poor, the patient indicated that she could not bear the responsibilities of marriage and their financial situation. She went to work one day, and she and the store owner were alone at work. The store owner offered her a sexual relationship in exchange for an increase in her monthly salary, but she declined. Subsequently, the store owner accused her of stealing, which left her depressed. Following her termination, her husband also left the job. She and her husband then opened a small store to sell makeup. She said, "After my pregnancy, I stopped working, and then day after day, my mood decreased and the symptoms of

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depression increased." After all these difficult events that the patient experienced, now the patient feels symptoms of depression and does not know how she will deal with these symptoms, and again, it regains strength, The patient said, "From my childhood until now, I have been exposed to problem after problem."

2.8. Present Medical History:

The patient does not have any history of any physical or psychological disorders, but in her life, she was exposed to situations that led to the emergence of symptoms of depression, but she was able to control them.

III. CENTRAL TOPICS

3.1. Central Topics and Weighting of the individual Symptoms:

The most disturbing symptoms for the patient are when she goes to her father's house and starts conflicts between her and her father and becomes nervous with her father, her lack of participation in social activities, and her lack of energy and strength to perform home duty and take care of her child in a necessary manner. This greatly upsets her, and this leads the patient to feel guilty in front of her child.

3.2. Resources

After the couple's therapy, her husband was a great help to her because he knew that his wife needed much support and assistance. For example, he used to give his wife the opportunity to go and work on shopping days, and her husband takes care of their child, and her sister was always supportive of coming to therapy. Mention her internal resources, that is to say, her strengths: for example, a sociable person, intelligence, and sports.

3.3. Solution Attempts

The sources of her happiness were her younger sister and the patient's indication that when she feels upset and pressured, she talks to her sister on the phone. She was motivated to come out of the house and go together to restaurants or tourist places, or when she felt upset, she watched the series on TV. The patient was enthusiastic about the therapy, and she used to take medications as prescribed by the psychiatrist.

3.4. Explanation – Macroanalysis, biographical background to the disorder

- As a child, the patient was exposed to a state of molestation from her brother, and these memories disturb the patient greatly until now.
- Since her childhood, the patient has been subjected to continuous beating by her father and older brother, for not going outside the house.
- Not going to college led to severe grief for the patient and so far, she is affected by it.
- The sexual relations that the patient had with the young man who she loved, was greatly affected, and so far, the patient did not want to remember these memories, because she is very upset.
- A year and a half of anxiety and stress from a father and a young man.
- The pressure, to which the patient was subjected during and after marriage, unemployment, and a bad economic situation, was one of the main reasons that led to the patient's exposure to depression and the development of her symptoms.
- The harassment of her by her store owner and accusing her of a thief led to her deep sadness.
- Since her childhood, the patient was subjected to psychological pressures, and these pressures continued with her. Every time of her life, she was exposed to certain stress, but when she had to stay at home with her new child and couldn't use her usual coping skills of going out with her sister and going to work, the patient developed symptoms of depression and feels her symptoms every day. Also, the continuing repetition of blame from her father deeply affects her; she is unable to express her anger to him, which adds to her depression.

3.5. Explanation – Perpetuation of the Disorder

Behavior Analysis:

Situation: When she goes to her father's house. My father will talk about the fiancé, who I did not marry; disputes will start between me and my father.

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Cognitive Reaction: My father does not love me.

Emotional Reaction: Anxious, anger, sad and uncomfortable

Physical Reaction: sweating, Heartbeat, shortness of breath, shaking hands, and muscle spasm.

Behavioral Reaction: start talking nervously, crying and leaving the room

Consequence – short-term: reduction of tension, decreased physical symptoms, a decrease of the anxiety, and comfortable, relaxed.

Consequence – short-term: Situation remains unchanged; her father still repeats the story.

Consequence – long-term: patient cannot cope; she didn't have enough control over her symptoms.

Consequence – long-term: Persistent symptoms of depression.

Diagnosis classification

MDD/ DSM-IV code,296.22

MDD/ ICD-10 code, F32,1

IV. PLANNING THE TREATMENT

4.1. Targets

Patient wanted to control her anger when her father talked about her fiancé and what she wanted; her father would stop repeating the fiancé's story. The patient needed adequate sleep so that she could do her daily activities during the day. Going to work again was one of her important goals. She wanted to break her daily routine and solve her problems with her husband. (see figure 1).

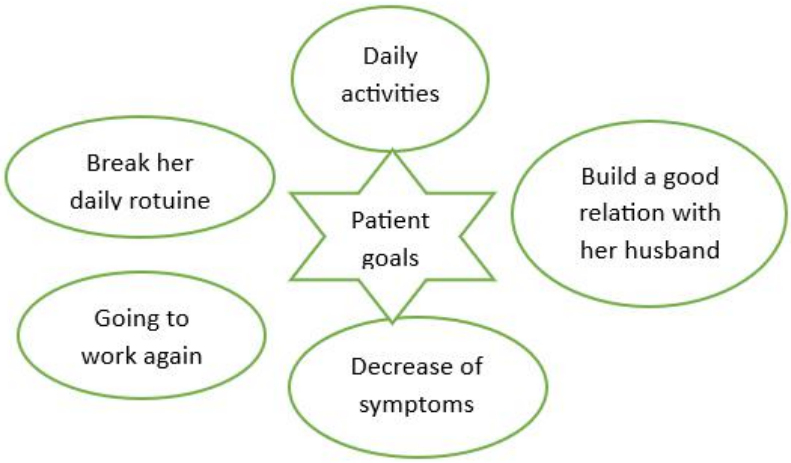

Fig.1: Patient goals

4.2. Therapist: Collection of information from the patient was one of the main goals of the therapist, build a good relationship with the patient and treat the symptoms of depression and choose the appropriate techniques, to help the patient, treat the symptoms she is suffering from (see figure 2).

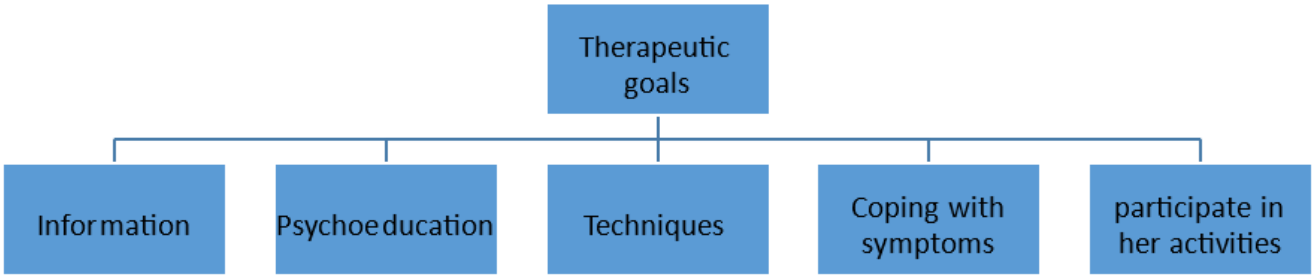

Fig.2: Therapist goals

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4.3. Therapy Planning

Choice of strategic Procedures;

- Fill out the consent form and building a good relationship with the patient and this relationship were based on respect and trust.
- Explain to the patient the importance of confidentiality in psychotherapy, so that the patient can talk about the details of his problem and its causes.
- Diagnosing the patient's disorder, and relying on scientific sources to diagnose the disorder and the severity of symptoms of the disorder.
- Psychoeducation of the patient about the disorder that she suffers.
- Establishing a rule for therapeutic sessions.
- Discuss and explain with the patient ABC model how thoughts affect behavior and emotion and vice versa.
- Cognitive Restructure and Thought Control Technique: We used these techniques to enable the patient to control his negative thoughts and change them into positive ones.
- Behavioral activation: This technique aims to control and break the daily routine.
- Couple therapy: it was important to the patient, to know how to deal with each other.
- Problem-solving technique: To knows how to choose the appropriate solutions for her problem.
- Role plays: This technique was used to prepare the patient for the situation with her father and to resolve disputes between them and her father.
- Explanation to the patient about relapse prevention.
- Farewell session and follow-up.

4.4. Considerations on forming the relationship:

When she first came to the therapy session, I welcomed her well. At first, I introduced myself to the patient. What is my name? What did I do here? Then she introduced herself to me. Fortunately, I was able to establish a trusting atmosphere with the patient, leading to her education. I tried to ensure that the patient did not feel upset, and during the psychoeducation session, she increased her confidence in me because she said, "I feel you understand me well."

V. COURSE OF THE TREATMENT

5.1. Psychoeducation

At this stage, I tried to educate the patient about depressive disorder, its symptoms, and how these symptoms developed. In this session, I focused on explaining to the patient how thoughts affect emotions, bodies, and behaviors (see Appendix 2). I explained this idea with an example of her situation with her father and how she thinks that her father does not love her. This idea makes her feel sad and anxious, makes her feel short of breath, and makes her nervous around her father. I explained to the patient what psychotherapy is, as well as the difference between psychotherapy and psychopharmacology. During the psychoeducation session, I focused on explaining to the patient depressed thinking, which is negative thinking with no flexibility, and non-depressed thinking, which is positive thinking with flexible and changeable thoughts for the better. I explained to the patient the importance of carrying out the homework that I gave to the patient and the worksheet. For example, at the end of each session, I give the patient the worksheet (a mood thermometer worksheet) (see Appendix 3). The goal is so that the patient knows the severity of her symptoms and so that I know whether it changes the patient's mood or not.

5.2. Cognitive restructuring

In this step, I applied this technique, (see Appendix 4) and this technique helped the patient identify her negative thoughts that control the patient's life and affect her feelings and behaviors negatively, change them into positive thoughts: For example, my husband does not like me and does not speak with me much. With the help of this technique, I developed another alternative and positive idea for the patient (see Appendix 5) which is "My husband loves me, but he is tired at work, so the reason is that he is not able to speak and discuss a lot." In this technique, we used Socratic questions (see Appendix 6), and at the end of

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the session, we wrote the alternative idea on a piece of paper, and I asked the patient to keep this paper. I provided her with stickers, instructing her to place them on various surfaces such as doors, TVs, and Teflon (refer to Appendix 7). If she had a negative thought, she should display the paper containing the alternative idea and read it. This technique, known as the Thought Control Technique, should not be overlooked. After being taught, the patient was able to identify her negative thoughts and change them into positive ones day after day.

5.3. Behavioral activation

I explained to the patient how the behavior directly affects a person's mood, both negatively and positively. In this step, we verified the activities that she was enjoying before she was depressed, (see appendix 8) and found that she had some enjoyable activities for herself; for example, when she used to go to work, she used to enjoy it a lot, visiting relatives, playing sports, and going to the wedding. In the first step, we identified the work activity, and I asked the patient, "How did you feel when you went to work?" She responded, "It was a good feeling." We made a weekly schedule for this activity step by step (see Appendix 9) and agreed that the patient must go an hour to work every day instead of her husband and then reward herself, for example, by eating something she loves and watching how her mood affects her, then she must increase her work hours in the weeks after that, the patient managed to improve her daily routine. In the other example of activities, we agreed that every day for 15 minutes, they would do some exercises at home; after that, the time of exercise would increase.

5.4. Couple therapy

The patient's husband actively participates in the psychotherapy process, gaining knowledge about the disorder and symptoms his wife experiences. This allows him to assist his wife in reducing her symptoms and serve as her primary supporter. Fortunately, the patient's husband was open-minded and educated. We discussed some basic and important points related to his wife, such as the importance of having calm discussions with her and providing support. His behavior changed in front of his wife. One of the important things is to solve the lack of sexual relations between them. The husband said, "I do not engage in sexual relations because I am tired at work." I discussed with them that when any problem occurs, they should focus on solutions without interrupting each other, understand all the problem points well, and be good listeners, so that they can solve problems without negative effects.

5.5. Problem-solving technique

First, I educated the patient about the (problem-solving technique). The main goal of this technique was to help her solve her problems so that she could go to work again. First, I encouraged the patient to set an agenda for the problems that appeared to her during the past week, which is still disturbing the patient, and the problems are expected to happen in the coming days, The problem was to solve the problem with her father. (See Appendix 10). After identifying the problem, we moved to the stage of brainstorming, which is the stage of creating good solutions, and she had a negative problem orientation; for example, she said, "It never solves my problem with my dad." For this idea, we did cognitive restructuring again, After that, I encouraged the patient to innovate appropriate solutions to the problems and to set realistic goals that were possible to accomplish. For example, I'll try to not answer my father; I'll try to talk to one of my father's friends; even his friend will tell my father not to repeat my story; etc. After that, the patient evaluates the consequences of the solution she chooses—did they play a significant role in solving her problem or not? And then I gave her homework. After that, we achieved the goal that we set for ourselves to solve the problem.

5.6. Role-plays

This technique aimed to teach the patient how to deal with her father in a specific situation and to learn various methods of handling it. During this exercise, the patient also learned relaxation and breathing exercises to help her overcome her anger. In the first step, we identified the problem and encouraged the patient to share all the information and words used during the discussion with her father. The patient was able to think clearly about the problem and provide all the necessary information before we began the role-play. Then we wrote the scenario in detail so that the patient felt that it was real, and I read the scenario to the patient until the patient felt that she was in the situation and her symptoms increased, such as

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heartbeat and body temperature, patient said I feel now in the situation, and then we discussed what she had learned so that she could learn from the experience. The patient's experience and self-confidence increased as she handled the situation with her father, and she quickly developed positive reactions to the situation.

5.7. Relapse prevention

I explained to the patient "Sometimes returns some symptoms, and sometimes all of them. If again, you suffer from your symptoms, refer to the papers we used during the treatment. The patient was very aware of the steps they took together (see appendix 11).

5.8. Evaluation and Targeting achievement

The client was able to achieve goals, for example, she was able to go to work, her symptoms decreased and increased her mood (see figure 3), solve her problem with her father, and do home duty. Now the patient is satisfied with her life and has solved problems with her husband. The patient said, "Now I feel a great improvement in my life, and now I know how I will face all his problems well." For the symptom measurement section, the (BDI - Beck's Depression Inventory) scale was used, and this scale was used three times, before therapy (22), after therapy (10), and during follow-up sessions (3), (see figure 4).

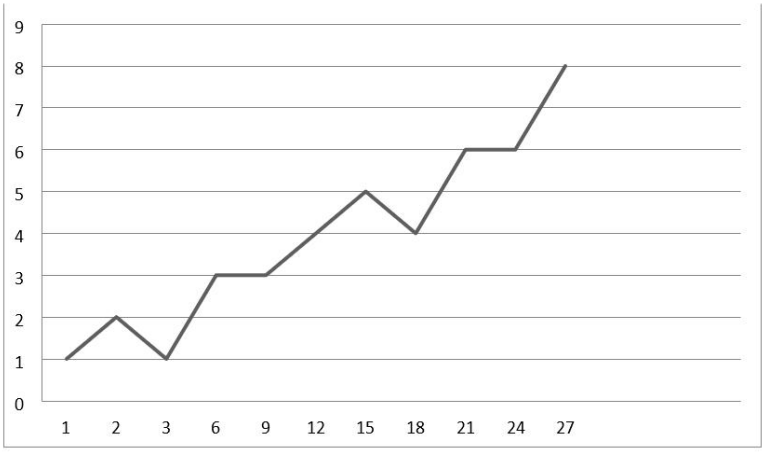

Fig.3: The Patient's Mood From the First Session to the Last Session

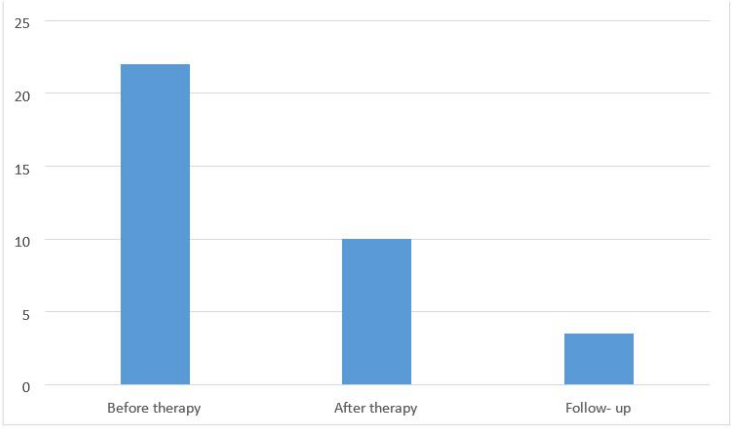

Fig.4: The Patient's Depression Rate According to BDI Scale.

5.9. Critical Statement/Hypotheses

From the point of view of the psychotherapist, many factors contributed to the success of the psychotherapy process from the perspective of the psychotherapist. For example, one of the main points was planning treatment and choosing the appropriate techniques according to the patient's consent and the achievement of her goals. The patient's husband was

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an assistant to his wife until he managed to break the routine and reduce her symptoms. Among other factors, the patient's sister was a constant supporter of her sister, for example; she always encouraged her to come to the therapy sessions, and the patient was following the rules of the psychological sessions that we had put together. One of the difficulties I faced in the therapy process was that, first, her husband did not have the right time to come to the session because he was busy in the store. Secondly, the patient managed to adapt to her father.

5.10. Therapist's Learning:

I learned that when the family is supportive of the patient, it leads to a rapid improvement in the patient, and neglect of the spouses leads to a decline in the love relationship between them and sometimes leads to divorce. Through the application of these techniques, especially role play, I benefited greatly from them, and I had an experience that I repeat with other cases, and it became clear to me that the cognitive behavioral therapy approach was a great treatment for depressive disorder.

VI. GENERAL DISCUSSION

We often describe ourselves as being depressed when we suffer from unhappiness. Every person suffers from symptoms of depression from time to time at different times of life, but some people suffer from depressive disorder, depressive disorder leads to severe and long-term psychological pain, and after time this pain increases, for example, they are unable to perform the simplest activities of daily life, and even some of them lose the will to live and they attempt to suicide (Comer, 2015). The major depressive episode depending on the (DSM-5) is two weeks or more and the patient must have at least five symptoms of depression, including loss of pleasure in life and - or a depressed mood. In severe cases, the patient may suffer from psychotic symptoms, for example, delusions and hallucinations. Some patients suffer from suicidal thoughts. The symptoms of depression differ from one person to another in terms of their severity and variety. Depression has many symptoms and includes five functional areas: Emotional, motivational, behavioral, cognitive, and physical (Comer, 2015). I will discuss each section and relate it to the cases mentioned above.

- Cognitive symptoms: an obvious feature of people with depression blaming themselves and having negative opinions about themselves (Lopez Molina et al., 2014), and pessimists, and it leads to their sense of hopelessness and leads them to contemplate suicide (Shiratori et al., 2014), often people with depression complain about their inability to solve problems (Chen et al., 2013).
- Emotional symptoms: Many depressed patients feel sad and depressed, they feel dejected and many of them describe themselves as "empty, insulted and miserable," Without a sense of humor, they do not feel pleasure in things like others people, and some patients suffer from anxiety, anger, irritations, and crying spells (Comer, 2015).
- Behavioral symptoms: One of the clear symptoms of depression is a depressed person who has a lack of activity, productivity, and want to be alone at home and speak slowly, compared to people who do not suffer from depression (Tibubos et al., 2019).
- Motivational Symptoms: People who are depressed also lose interest in their daily activities. Almost everybody complains about a lack of motivation, initiative, and spontaneity. They may have to coerce themselves into going to work, conversing with friends, eating meals, or having sex. This condition has been called a ‘ paralysis of will’ (Comer, 2015).
- Physical symptoms: Often cases are misdiagnosed as psychological conditions, but they are diagnosed with medical conditions (Bai et al., 2014).

According to (DSM-5), there are many differential diagnoses close to the MDD such as manic episodes with irritable mood or mixed episodes, mood disorder due to another medical condition, substance/medication-induced depressive or bipolar disorder, attention-deficit/hyperactivity disorder, adjustment disorder with depressed mood and sadness. Also, there are some other disorders that comorbid with MDD such as substance-related disorders, panic disorder, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, and

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borderline personality disorder. The data indicate that there is a strong correlation between suicidal thoughts and the severity of depression, meaning that patients with depression are more likely to think about suicide (O'Donovan et al., 2013). According to (Al-Qadhi et al., 2014), depression has multiple underlying risk factors such as chronic medical illness, stress, chronic pain, family history, low income, job loss, substance abuse, low self-esteem, lack of social support, history, being single, divorced, or widowed and traumatic brain injury. According to studies, the risk factors that lead to depression and suicidal behavior emerged as a childhood abuse (Tunnard et al., 2014). There is a strong correlation between marital quality and the appearance of depressive symptoms in adults, decreased marital quality leads to major depression symptoms, and both influence each other in a periodic way (Goldfarb & Trudel, 2019).

Many patients do not like medicines because of the side effects they suffer from, even if patients are educated about medicines they were upset with, and especially when medicines make them sleep longer or feel dizzy because of the side effects. In Iraqi - Kurdistan, therapists can apply CBT to patients, through my work at Azadi Hospital and camp in Duhok. CBT was applied to depression disorders patient and the results were highly effective because the therapist method was not complicated, but the psychotherapist who works in the Kurdish culture should be aware that not all techniques can be applied due to customs and traditions. But this will not be an obstacle to the CBT therapy. The patient in Iraqi-Kurdistan wants the first session to be therapeutic, this sometimes leads the patient to terminate the psychological sessions and the reason is the lack of education among the general public. There is a difference between psychotherapy for people who suffer from depression and those who live in camps and house communities, according to my experience; therapist worked with patients in camps and Azadi Hospital in Dohuk. Psychological therapy with the camps was more difficult, because their lives are more difficult and they suffer from various financial, psychological, and social problems, but the house community patients had a more stable life, for example, they had the most opportunity for entertainment, for example, going to a park. Among other difficulties, the patients did not know any information about psychotherapy, and many patients did not accept psychotherapy first, but after explaining the psychological therapy process to them and applying the techniques with the patients, and a great improvement appeared to them, they accepted a lot and then the patient was more enthusiastic and committed to the therapy.

One of the most difficulties therapist faced was at the time of the spread of Covid-19, a decision was issued by the government to impose curfews and therapists were relying on remotely therapy. Many patients were not educated and their understanding of psychotherapy was difficult, and therapists found it difficult until the idea reached them. Many customs and traditions affect the process of therapy in Kurdish society, for example, many patients avoid coming to psychotherapy because of social relationships, for example, if one of the patient's relatives, neighbors or a friend sees the patient receiving psychotherapy, our fear that they will say that the patient is crazy or anything else that leads to embarrassment to the patient, and sometimes if the patient is a female, the family of the patient often does not agree to come to psychotherapy alone. These reasons sometimes led to the failure to continue the psychotherapy process, the patients who used to live in the camps were ashamed more than the house community to come to therapy, because their homes were close to each other, and their social relations were stronger. With all the difficulties, CBT with patients was effective for many mental disorders, and special therapy of depression.

VII. CONCLUSION

A major depressive disorder is one of the most common disorders in the world. MDD has two main symptoms which are depressed mood and loss of pleasure in life. The patient has 5 or more symptoms out of a group of 9 symptoms, MDD affects many areas of a person's life, for example, social and occupational, and many depressed patients suffer from other disorders with depression, for example, general anxiety, social anxiety, and dysthymia. Suicide is one of the important point most focused on depression patients because they are suffering from thoughts and behavior related to suicide. Depression is more prevalent among females than males. There are various risk factors for MDD, and each of them has

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its studies, for example, there are genetic, neurotransmitters, brain imaging studies and HPA axis (hypothalamic–pituitary–adrenocortical axis) is overactive, and there are other causes related to the social and psychological field. According to the large number of studies that have been conducted on depression, but so far there are many questions about depression that need studies and accurate scientific answers because depression is a complex disorder. However, we have successful treatments, like psychotherapies, for example, interpersonal psychotherapy, psychodynamic therapy, in particular, CBT according to many researches it is the best treatment for patients who suffer from depression.

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