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Letter to the Editor

Self-explored cognitive behavior therapy: A patient's experience

Sir,

Cognitive Behaviour therapy (CBT) has been recommended as the first line of non-pharmacological therapy for most of the anxiety disorders (Obsessive compulsive disorder, specific phobias, social phobia etc.) (Kaczkurkin and Foa, 2015). It has also been utilized with proven efficacy in trauma related disorders like post-traumatic stress disorder (PTSD) too (Ehlers et al., 2010, 2003). Such type of specialized therapy is often provided/educated by trained psychotherapists/psychiatrists or psychologists. However, there is evidence of self-help CBT in PTSD with some efficacy (Ehlers et al., 2003). Self-help CBT is found to be quite helpful in those patients who have high degree of motivation, strong willpower and low sense of hopelessness so as to overcome/conquer acute distressing anxiety (MacLeod et al., 2009). In this regard, we report a patient's experience of self-discovered self-help type of CBT in a senior army officer who had possibly developed PTSD.

Mr. X, a 45 years senior army officer came for a routine psychiatric follow up visit so as to enquire if his symptoms of past psychiatric history would ever reoccur again. Upon exploration, he revealed that 7 years back, he happened to visualize the mutilated dead body of his colleague's wife who was ran over accidentally by a train. He recollects that during that time, he did not have any dreadful experience and tried to comfort his colleague and participated in the funeral rituals. Later, in the evening, he resumed his routine activities till late night, but due to heavy work schedule he was unable to get sleep that night. Next day, as he was posted in a war prone zone, he had no rest and worked till late evening. By evening, he started to feel tired and when he tried to sleep, he recollects that he was unable to fall asleep and he started to get the image of the mutilated dead body again and again whenever he tried to close his eyes. He began to feel restless and started having palpitations. He shared his problems with his wife, who comforted him and reassured him. But, he was not able to get sleep for consecutive three nights and would get the above mentioned images whenever he would try to rest along with heightened anxiety. Further, he started to get afraid of darkness and would feel as if he would get attacked by some unknown men if he switched off the lights. He also started to get flashbacks of past traumatic memories (of 10 years back) when he had to encounter terrorists during a terrorist attack in the border area. Additionally, he started to get various dreadful images of dead terrorists too if he tried to get asleep. He would be extremely frightened and would grab hands of his wife whenever he would go to any dark place; would not allow to switch off lights of his room/washroom. His condition worsened in next 3–4 days and he was unable to do his work efficiently like before. He started to voice ideas of hopelessness and death wishes. Throughout this period of 6–7 days, he was well-oriented to time, place and person and there is no reported history of any substance use. He visited a general physician and was prescribed benzodiazepines with no help. Later, he was taken to a psychiatrist, who advised him Tab. Paroxetine 25 mg and benzodiazepines with which in next 10 days, his sleep and anxiety symptoms improved. However, he continued to have the flashbacks and nightmares along with fear of dark places for almost 4 weeks, with no improvement with medications. He did not follow up with the psychiatrist because of social stigma and due to substantial improvement in anxiety and sleep.

He then started to self-motivate himself to face the situations. He engaged himself in physical activities and physical exercises, would self-talk to himself that he can overcome these situations as he had faced many worse situations in the past. He would be motivated by his wife too. After few weeks, he decided to face his fear. He would ask his wife to lock him up in his room for few minutes and not to open the door till he said. He recollects that he would get extreme anxiety but would face the anxiety and it would subside in next 20–30 min. Further sessions, he tried with room locked with lights closed gradually with increased duration of time. He recollects that in about 8 weeks times, he had substantial improvement in his anxiety and did not have any fear when faced with darkness. He stopped getting recurrent images in dreams and nightmares too. He continued to take Paroxetine 25 mg for about a year after which he stopped by self by gradual tapering of doses. He neither had any comorbid physical illness or substance abuse nor had any family history of mental illness. Retrospectively, a probable diagnosis of PTSD Vs acute stress disorder was made. Since he had no symptoms, he was not prescribed any medications and was advised to maintain positive mental health by practicing both physical activities and yoga. He was asked to follow up immediately if ever he faced with any similar stressful life events for early intervention and was educated about the nature of illness.

1. Discussion

The aim of this patient report of his traumatic experience and methods employed so as to overcome the symptoms of acute stress was to focus upon the fact that in some patients, self-discovered/self-explored techniques to face anxiety may work significantly. As in the case described, after his anxiety symptoms subsided with medications, he started to develop self-help techniques in the form of positive self-talk and self-explored exposure based behavior therapy which immensely helped him. Studies have reported that self-help works in patients who have high levels of motivation, credibility, adherence, self-efficacy and a lower degree of hopelessness (MacLeod et al., 2009). Our patient possibly had all these factors which helped him.

Guided self-help CBT therapies (using self-help materials/booklets/Bibliotherapy) have been found to have benefits for treatment of depression and anxiety in primary care in Western countries (Ridgway and Williams, 2011; Warrilow and Beech, 2009). Self-help cognitive therapy for trauma related disorders like PTSD have also been developed which includes self-study modules and self-exposure therapies with good results (Ehlers et al., 2003; Wild and Ehlers, 2010). In our patient, although he had no idea what he was trying to do but in some

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or other way he developed his own way of self-help motivation/cognitive strategies and self-explored exposure strategy to overcome his fearful situations.

This case illustrates that self-help cognitive and behavioral strategies can help patients who have good degree of motivation and such strategies complied with psychoeducation can be employed in low resource settings like India for the benefit of patients with mild to moderate anxiety and depressive disorders.

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