Using Cognitive Behavioral Therapy to Support a Caregiver of a Severe Traumatic Brain Injury Survivor: A Case Study from India

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Abstract
Background: Caregivers of individuals with moderate to severe traumatic brain injury (TBI) face significant psychological burden due to prolonged caregiving responsibilities. Research indicates high levels of stress, anxiety, and burnout among caregivers, often compounded by limited awareness and support. This issue is particularly relevant in developing countries like India, where family members assume caregiving roles with minimal psychological assistance. There is a growing need for accessible, evidence-based interventions such as Cognitive Behavioral Therapy (CBT) to support caregiver wellbeing.

Case Description: The case involves a 63-year-old mother caring for her son with TBI for seven years. She reported persistent stress, emotional exhaustion, and overwhelming concerns related to caregiving demands and financial strain, despite engaging in self-care practices such as yoga, meditation, and social support.

Intervention & Progress : A culturally integrated CBT intervention was delivered across six weekly sessions, focusing on cognitive restructuring, identification of unhelpful thought patterns, and grounding techniques. The caregiver showed reduced emotional distress, improved emotional regulation, and enhanced coping confidence.

Conclusion: This case underscores the importance of structured psychological support for TBI caregivers in India and highlights CBT as a practical and effective intervention for improving emotional wellbeing.

Keywords: Traumatic Brain Injury, Caregiver Burden, Cognitive Behavioral Therapy, Case Study, Psychological Wellbeing.

Theoretical Background and Basis for Treatment
Traumatic brain injury (TBI) is a prevalent and unforeseen serious issue that can result in long-term or even permanent disabilities (Peeters et al., 2015). It significantly impacts public health, annually around 10 million individuals are affected, highlighting its critical implications for health (Hyder et al., 2007). Globally, people spend more than 8.1 million years living with illness or disability due to TBI, and this number is expected to increase because of population growth, urbanization, and rising motor vehicle use (James et al., 2019; Taylor et al., 2017).

Survivors of brain injury face considerable amount of physical, psychological, social, and financial challenges that not only affects the individual but also their caregivers (Dillahunt-Aspillaga et al., 2013; Scott et al., 2019). Many survivors depend on the family members for ongoing support, including care, rehabilitation efforts, help with daily activities, social engagement, and financial assistance (Ruet et al., 2019).

Due to the sudden onset of traumatic brain injury (TBI), caregivers quickly adapt to new roles and responsibilities as the individual with TBI moves through various stages of care and into the post-acute phase of rehabilitation and community-based services and support (Abrahamson et al., 2017). Research indicates that as many as 44% of caregivers for individuals with TBI experience depression, and up to 67% report feelings of anxiety, which are significantly higher than those found in the general population (Marsh et al., 2002; Ponsford & Schönberger, 2010).

Studies have determined that caregivers require long-term emotional support, even up to 15 years post-injury (Verhaeghe et al., 2005). Although it's been noted that interventions aimed at caregivers tend to be more beneficial than other interventions targeted towards the survivors and caregivers combined (Kreitzer et al., 2018). It is crucial to note that many caregivers do not receive any form of intervention due to various reasons; some may prioritize the needs of the survivor over their own, while others may be either unaware of such interventions or skeptical about their effectiveness (Dillahunt-Aspillaga et al., 2013).

Cognitive Behavioral Therapy (CBT) is well recognized for its effectiveness in the treatment of various psychological disorders (Beck, 2011). Numerous studies have implemented CBT to offer psychological support to individuals with Traumatic Brain Injury (TBI) and their caregivers (Kreutzer et al., 2002; Ponsford et al.,

2016). Previous studies indicate that CBT significantly enhances the psychological well-being of caregivers for those with TBI while providing tools for caregivers to address mental health challenges such as depression and anxiety (Backhaus et al., 2016; Kreutzer et al., 2009).

While Cognitive Behavior Therapy (CBT) is widely recognised as an evidence-based intervention for emotional difficulties, its effectiveness can be enhanced when culturally meaningful frameworks are integrated into the therapeutic process (Satapathy et al., 2022). Culture shapes individuals' belief systems, emotional expression, coping styles, and interpretations of illness (Sinha et al., 2021). In collectivistic societies like India, individuals often conceptualize distress through culturally embedded narratives related to fate, duty, spirituality, and role functioning, which may not be adequately addressed through standard Western CBT protocols alone (Satapathy et al., 2022). Integrating culturally relevant concepts within a CBT framework allows therapy to remain structured and empirically grounded while increasing personal relevance, emotional engagement, and therapeutic alliance (Naeem et al., 2019).

In the present intervention, Cognitive Behavior Therapy (CBT) was integrated with culturally aligned therapeutic elements (reflective teachings from the *Bhagavad Gita)* (Prabhupada, 1986) to enhance cultural congruence, client receptivity, and internalization while incorporating therapeutic metaphors and cognitive anchors. This culturally sensitive integration aimed to align therapeutic processes with the client's belief system, thereby strengthening therapeutic alliance and facilitating deeper cognitive and emotional processing.

Case Introduction

A caregiver aged 63 years pseudonym is Rita, which was chosen to maintain anonymity, was seen at a speciality centre where she came for follow up for her younger son who sustained severe traumatic brain injury involving frontal cortex and left hemisphere damage following a road accident in 2018. She was subsequently approached to ascertain her willingness to participate in a Cognitive Behavioural Therapy based intervention as part of the study.

Presenting Complaints

Rita reports persistent emotional exhaustion, recurrent episodes of emotional breakdown, frequent feelings of stress, sadness, frustration, and helplessness. She also reports distressing thoughts, intense emotional and physiological reactions during her son's aggressive episodes, and heightened anxiety related to financial pressures. Her symptoms include increased heart rate, freezing responses, and a pervasive sense of bodily distress.

History

The caregiving responsibilities were initially shared, though Rita assumed full responsibility within six months, managing the medical needs, behavioral difficulties, and rehabilitation with limited professional guidance. The prolonged stress of night-time monitoring, multiple surgeries, and minimal support contributed to significant emotional and physical exhaustion. Her burden intensified after separating from her husband in 2020 and further escalated following his death in 2023, which left her with financial liabilities. She has also faced marital abuse, which contributed to long-standing emotional vulnerability. Rita reported that she often compared her son's anger outbursts to her husband's behavior, which intensified her emotional distress and fostered concerns that her son might develop personality traits like those of her husband. She reports no history of any psychiatric disorder. Despite these challenges, she continues to manage caregiving role, household responsibilities, and a small business.

Assessment

Assessment was conducted through detailed clinical interviews, Mental Status Examination (MSE), and formulation guided by Beck's Cognitive Case Formulation model. In line with the cognitive model proposed by Aaron T. Beck, the client's presenting concerns were conceptualized by identifying core beliefs, intermediate beliefs (rules and assumptions), automatic thoughts, emotional responses, and behavioral patterns.

Case Conceptualization

The client's current difficulties can be understood within a cognitive behavioral framework. Several predisposing and precipitating factors appear to have contributed to the development and maintenance of her distress. Her son sustained a severe traumatic brain injury (TBI) in 2018. Additionally, she reported a history of marital conflict and emotional abuse, followed by separation in 2020 and her husband's subsequent death in 2023, which resulted in significant financial burden. These cumulative stressors likely increased her psychological vulnerability and reinforced a heightened sense of responsibility.

Based on these experiences, the client appears to hold several maladaptive core beliefs, including: "I am alone and responsible for everything," "I am incompetent if I cannot manage," and "My needs do not matter." These core beliefs gave rise to conditional assumptions such as: "If I feel tired or overwhelmed, I am a bad mother," and "If others do not listen to me, I am not valued."

In triggering situations particularly when her son becomes aggressive or verbally abusive these underlying beliefs are activated. She experiences automatic thoughts such as, "I can't handle this anymore." The meaning she attributes to this thought reflects deeper schema-level interpretations, namely, "I am helpless and trapped."

These cognitions result in intense emotional responses, including fear, anxiety, and helplessness. Physiologically and behaviorally, she responds with emotional shutdown, withdrawal, and heightened arousal (e.g., increased heart rate). Although withdrawal and emotional suppression may provide temporary relief from distress, they function as maladaptive coping strategies that maintain her sense of helplessness and reinforce her negative core beliefs.

At the same time, she engages in some adaptive coping strategies, including yoga, walking, reading, and listening to podcasts. However, under high emotional stress, maladaptive coping responses are more readily activated, perpetuating the cognitive emotional cycle.

Overall, her difficulties appear to be maintained by the interaction between longstanding core beliefs of responsibility and inadequacy, situation-specific automatic thoughts of being unable to cope, and avoidance-based coping strategies that prevent corrective emotional processing.

Course of Treatment and Assessment of Progress

In accordance with the Rita's goal to reduce distress a culturally integrated CBT intervention was delivered across six weekly sessions following informed consent. Due to the ongoing nature of caregiving demands, a stronger focus was placed on altering unhelpful thoughts through cognitive restructuring, psycho education, and strategies that emphasize self-compassion. Techniques such as thought records, Socratic questioning, and the downward arrow method were utilized to identify cognitive distortions and unproductive beliefs regarding control, responsibility, and self-efficacy. Fundamental beliefs about helplessness and inadequacy were tackled using evidence-based methods for changing beliefs and compassionate reframing, with the goal of fostering balanced thought patterns, effective coping strategies, and enhanced emotional regulation within the caregiving environment.

Session 1

The first session focused mainly on rapport building and exploring the client's emotional experiences related to her caregiving role. The client was encouraged to talk about recent events that made her feel overwhelmed and distressed. She reported frequent episodes of crying, emotional shutdown, and physiological symptoms such as increased heart rate, freezing, and feeling "overstimulated" during her son's aggressive episodes and financial stressors.

Emphasis was placed on normalizing caregiver burnout and building therapeutic trust. She was encouraged to speak freely without feeling pressured to "stay strong." The client was also psycho-educated about caregiver burnout and the basic principles of CBT and was guided to understand the relationship between thoughts, emotions, and behaviors using examples from her daily caregiving experiences.

Session 2

During the second session, thought record alongside socratic questioning was used to explore the automatic thoughts that emerged, such as "*He doesn't care about me"* and "*I'm not valued,"* in reaction to the incident where her son raised his voice at her. The interpretation associated with these thoughts was, "*He doesn't care about me,"* which led to feelings of sadness and a sense of being unloved. The thought record helped her analyze the evidence supporting and contradicting these beliefs, as well as to identify cognitive distortions which ultimately contributed to a decrease in emotional intensity and enhanced emotional regulation.

Homework assignment: As homework, the client was asked to maintain a thought record to monitor her thoughts, emotions, and behaviors in emotionally triggering caregiving situations.

Session 3

The third session focused on psycho educating the caregiver using the Stoic concept of Control. As noted by Epictetus: "Some things are in our control, while others are not…" (Enchiridion, 1,1-2). The caregiver was guided to differentiate between: Factors within her control, factors that can be influenced or changed, and factors that must be accepted with adaptive coping.

To enhance client receptivity and anchor her thoughts further a Shloka from the Bhagavad Gita was used *"One can only choose to perform his designated duties, but the results of an individual's action are not in our control. The power of results of each action is purely vested in Krishna's control".* (Bhagavad Gita, 2.47). In the above verse, Lord Krishna advised Arjuna to fight the battle as a matter of duty without the result's attachment. If one gets attached to the results of his work, he is the cause of the action and later enjoys or suffers depending upon the

result of the action. Whether attachment is negative or positive it causes bondage. Nevertheless, fighting as a matter of one's duty is what Lord Krishna advised Arjuna to do. This cultural congruence allowed her to perceive that she was taking emotional responsibility for many factors that were not fully within her control, such as her son's emotional reactions and financial outcomes. This helped reduce her self-blame.

Using the automatic thought worksheet, the core beliefs were identified. She was then introduced to the distinction between facts and thoughts. Using structured discussion, she realized that she often believed her thoughts without critically evaluating whether they were facts or interpretations. This session focused on building cognitive awareness rather than changing beliefs.

Homework assignment: The caregiver was asked to do control circle exercise where she had to write 3 things that are not in her control, 3 things she can influence and 3 choices she can make daily

Session 4

The fourth session focused on introducing the concept of core beliefs. The core beliefs were explained as deep, long-standing assumptions about the self, others, and the world that shape emotional responses and behavior. The core belief identified were "*I am incompetent",*" *I am a failure".*

Using Socratic questioning, the client was guided to differentiate between emotional withdrawal due to burnout versus actual personal inadequacy, steering towards understanding difference between aggressive behavior from others versus personal responsibility or failure. Through this process, she began to recede that her emotional shutdown was more reflective of psychological exhaustion and stress response rather than evidence of incompetence. She also acknowledged self-respect and pride in the person she is becoming, despite ongoing external challenges.

Additionally, she was asked evidence supporting and contradicting the belief using the core belief worksheet. She initially struggled to find contradictory evidence, but with support she identified several caregiving behaviors that reflected commitment and effort. By the end of the session an alternative adaptive belief was developed.

The session ended with a saying from Epictetus "It is quite impossible to unite happiness with a yearning for what we don't have. Happiness has all that it wants, and resembling the well-fed, there shouldn't be hunger or thirst." (Discourses, 3.24.17). It asserts that it is "quite impossible to unite happiness with yearning for what we don't have" and forms parallels with CBT on the role of maladaptive cognitions in emotional distress. This stoic framing anticipates this model by positioning that distress is maintained by evaluative judgement rather than objective outlook. The metaphor of happiness as a "well-fed" state suggests cognitive sufficiency as an internal orientation characterized by acceptance, gratitude, and flexible preference rather than rigid demand. This aligns with third-wave CBT approaches (e.g., Acceptance and Commitment Therapy, mindfulness-based interventions), which emphasize reducing attachment to outcomes and increasing psychological flexibility.

Homework assignment: The client was asked to maintain a daily Core Belief Evidence Log for one week. She was instructed to identify situations where the beliefs "*I am incompetent"* or "*I am a failure"* were activated.

Session 5

A distressing thought related to motherhood was identified in previous sessions "*I don't love my child."* The session started with a verse from Bhagavad Gita "*O son of Kuntī, the nonpermanent appearance of happiness and distress, and their disappearance in due course, are like the appearance and disappearance of winter and summer seasons. They arise from sense perception, O scion of Bharata, and one must learn to tolerate them without being disturbed"* Bhagavad Gita (2.14). In the above verse: There's a beautiful idea that says emotions are like seasons winter and summer. They come and go. Just like winter doesn't mean the world is permanently cold, a difficult emotional phase doesn't define who you are as a person or as a mother. Feelings rise and fall, but your values and your love remain. Lord Krishna encourages Arjuna to endure these passing dualities without becoming unsettled, underlining their temporary nature as they arise and fade away.

Later through cognitive exploration, she recognized that this thought was strongly influenced by societal expectations equating "loving your child" with being emotionally and physically present 100% of the time. Further discussion focused on her early motherhood experiences and previously held beliefs about motherhood, which contributed to the internalization of this rigid belief.

Using cognitive restructuring, the client evaluated the accuracy of this belief by reflecting on her actual availability to her child. She acknowledged that while she may not be present all the time, she has been emotionally and physically available 70% of the time. This led to a shift in perspective, allowing her to consider a more balanced and compassionate appraisal of herself. By the end of the session, the client demonstrated emerging insight that

being imperfectly present does not equate to being a "bad mother," and she tentatively reframed the belief to "*My feelings do not define my worth or my love"* and "*I may not be available all the time, but I am still a good mother."*

This thought was normalized as a burnout-related cognitive distortion rather than an accurate reflection of emotional reality. The client was guided to differentiate between emotional exhaustion and lack of attachment.

Homework assignment: The client was asked to complete a thought record worksheet whenever the thought "*I don't love my child"* or "*I am a bad mother"* occurred.

Session 6
The client presented with heightened emotional distress, primarily characterized by anxiety, sadness, guilt, and feelings of helplessness. These emotional reactions were elicited in response to her son expressing emotional dissatisfaction ("*You are not there for me"*), which led her to experience intense self-critical thoughts such as" *I am failing as a mother"* and "*I must be fully responsible for his emotions."*

The client also expressed emotional ambivalence, simultaneously perceiving her son as emotionally demanding while feeling deeply motivated and hopeful about supporting him. She reported frequent self-blame and guilt regarding her caregiving role and described feeling emotionally unavailable at times while demonstrating growing insight by acknowledging the presence of external sources of support.

Through guided cognitive restructuring, the client was able to identify and modify maladaptive beliefs related to excessive responsibility and self-criticism. The reconstructed belief articulated was: "*I am an exhausted mother under immense stress.*" *I am doing 100% of what I can, and I am available around 70% of the time."* This cognitive shift led to a noticeable reduction in guilt and facilitated a more balanced and compassionate self-appraisal.

Assessment of Progress
The intervention has been carried out for over 6 sessions which resulted in significant cognitive, emotional, behavioral, and relational benefits. The caregiver expressed that she was able to reflect better on situations and was able to separate personal feelings from caregiving role. She also added that she was able to think rationally and find answers within herself. The reduction of maladaptive automatic thoughts and core beliefs related to incompetence and maternal failure was observed. Feelings of guilt, shame, helplessness, and emotional numbness were reduced, which led to improved emotional awareness and self-compassion. There was a decrease in avoidance behaviors, along with enhanced boundaries and an increase in self-care practices. Overall functioning, resilience, confidence in caregiving, and self-efficacy showed improvement.

Complicating Factors
The therapeutic journey was made particularly challenging due to considerable time limitations stemming from the client's considerable caregiving and work obligations. As the main caregiver and manager of the household, along with overseeing her small business, she indicated that she had little time to focus on self-care or devote specific time to therapeutic activities.

Access and barriers Care
There were no evident barriers to care given the online nature of this intervention. The caregiver had an internet connection at home and accessed the online modules of the program through her computer. Additionally, the caregiver was offered the possibility to reschedule any session when necessary.

Follow up
A follow-up session took place a month after the intervention. Rita indicated that for the past 15 days she had been experiencing breathing difficulties and asthma exacerbations attributed to high pollution levels in her area, resulting in multiple hospital visits. These health issues adversely impacted her energy levels and hindered her ability to concentrate on her psychological well-being, as well as her caregiving duties for her son. Despite these hardships, Rita noted a gradual improvement in her cognitive and emotional state since the intervention, and she expressed that she has been intentionally trying to focus more on her own well-being while still caring for her son. She mentioned trying to prioritize self-care and achieve a better equilibrium between her personal health requirements and her responsibilities.

Treatment Implications of the case
Based on the case discussed above, Rita reported reduction in presenting complaints of stress, sadness, frustration, and helplessness. This decrease in complaints indicates that Cognitive Behavioral Therapy has been effective for the caregiver of individual with traumatic brain injury. Certain techniques needed to be modified to align with her understanding for enhanced clarity.

The therapeutic impact observed in the caregiver can be meaningfully understood through the parallel between Arjuna's psychological crisis on the battlefield and the caregiver's emotional state following the traumatic injury of the patient. Much like Arjuna, who experienced emotional paralysis, anticipatory anxiety, and cognitive distortions regarding duty, loss, and moral responsibility, the caregiver in the present case initially exhibited overwhelming distress, self-blame, and catastrophic interpretations of the future. Krishna's guidance to Arjuna involved a process of cognitive restructuring, wherein distorted beliefs were challenged, alternative perspectives were introduced, and the focus was shifted from emotional overwhelm to purposeful action (Prabhupada, 1986). Similarly, the intervention enabled the caregiver to reinterpret her role not as one of the helpless sufferings, but as a meaningful and adaptive responsibility grounded in acceptance and realistic expectations. By internalizing the Krishna-Arjuna narrative, the caregiver was able to detach from excessive guilt, regulate emotional responses, and engage in caregiving with greater psychological stability. This culturally embedded CBT framework thus functioned not only as a symptom-focused intervention, but also as a therapeutic metaphor that facilitated emotional resilience, role clarity, and adaptive meaning-making in the caregiving experience.

Rita had formed strong beliefs about motherhood, the caregiving responsibilities, and situations that induce intense stress. For coping she adopted behaviors such as emotional distance from everyone and shutting herself off. Cognitive Behavioral Therapy was beneficial in her situation through cognitive restructuring, psycho education, and strategies that emphasize self-compassion. This study implies a necessity to offer caregivers sufficient support and develop effective strategies to facilitate a smooth and easy transition phase.

Recommendations to Clinicians and Students

Literature supports cognitive behavioral therapy as an evidence-based approach for addressing caregiver burden, distress, anxiety, and depression among family members of individuals with traumatic brain injury (Beck, 2020). Currently, there is a notable scarcity of standardized, structured CBT protocols and empirical evidence to guide tailored treatment plans for TBI caregivers (Shepherd-Banigan et al., 2018). There is a requirement for more research to be able to generalize the results of the current study.

We suggest that mental health professionals utilize a culturally tailored Cognitive Behavioural Therapy (CBT) approach that integrates culturally and spiritually relevant analogies to improve therapeutic connection and cognitive change. Similar to how psychoeducation for children often employs age-appropriate storytelling, effective engagement with adults may be enhanced by using analogies drawn from culturally significant philosophical or religious stories. This contextual approach can boost understanding, strengthen the therapeutic relationship, and improve cognitive openness without undermining the evidence-based framework of CBT. In the Indian cultural milieu, insights from the Bhagavad Gita may provide a valuable illustrative guide.

Within the context of Indian culture, insights from the Bhagavad Gita can provide a valuable framework. In Chapter 2 of the Bhagavad Gita, Arjuna faces intense psychological turmoil before the battle of Kurukshetra, marked by emotional turmoil, avoidance behaviour, and ethical dilemmas. His inaction arises not just from the external circumstances but from his interpretation of them particularly his views on duty, loss, and the implications of his choices. Through their conversation, Krishna encourages a cognitive transformation by reframing actions in terms of dharma (duty), a sense of detachment from results, and a connection to a broader moral context (Prabhupada, 1986).

This narrative closely resembles fundamental principles of Cognitive Behavioural Therapy (CBT). CBT suggests that emotional suffering is influenced by dysfunctional thoughts rather than the events themselves; therefore, the process of therapeutic change includes recognizing, assessing, and modifying distorted interpretations to align them more closely with reality. Arjuna's evolution in illustrates a systematic cognitive reappraisal approach: transitioning from catastrophizing and emotional reasoning to adopting new perspectives, clarifying values, and realigning thoughts.

Integrating culturally significant narratives into Cognitive Behavioural Therapy (CBT) does not involve teaching religion, but rather employs familiar metaphors to explain cognitive processes like appraisal, distortion, and restructuring. When patients identify similarities between therapeutic ideas and culturally rooted teachings, the interventions can become more credible, lessen resistance, and improve the adoption of positive cognitive frameworks. Thus, we suggest that culturally tailored CBT models should consistently include relevant philosophical or spiritual analogies when suitable and ethically compatible with the patient's beliefs as supplementary tools to aid in cognitive restructuring and foster psychological care that aligns with cultural values.

Ethical Considerations

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki Declaration of 1975, as revised in 2000.

Informed consent was obtained from the caregiver prior to the study and a general outline of the study was explained. An ethical approval letter was obtained from the university before the initiation of the research.

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