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Social interventions using Cognitive Behavioural Therapy for mental distress.


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Abstract

This paper is a critical analysis of relationship-based health and social care work employing interventions using Cognitive Behavioural Therapy (CBT) for a client who is facing mental distress. This work addresses the importance of forming professional relationships, understanding mental ill health and the range of factors contributing to it. Feelings of academic failure primarily due to dyslexia are key points of this work, noting the stressors of difficulties in literacy skills and organisational memorisation. The client was suffering suicidal ideations and found difficulty working and socialising. The implementation of a CBT approach alongside the deconstruction of the factors which were seeming to cause and contribute to negative stress levels and the depressive episode onset and development, proved to be useful in elevating mood and helping the service user develop strategies to more effectively address the challenges of life. In the analyses of work with a client in adult social care, the processes undertaken are synthesised, evaluating from an ecological perspective how CBT was implemented successfully within a Rogerian approach to fostering empathetic relationships to enhance the client’s mood and facilitate a dialogue whereby suicidal ideations were subsided and a new perceptive for future goals were generated. In this case, the deployment of the CBT model was effective in enhancing the service user’s perspective and lifting some of the feelings associated with depression; noting the continual journey they will be making, on the road to what they termed as ‘recovery’. The generalisability from the deployment of this approach offers significant insight into practice and acts as a vehicle for reflexivity and reflection.

Key words: Cognitive Behavioural Therapy; Crisis; Mental distress; Depression and Dyslexia

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Introduction

This paper is an applied reflective narrative account of health and social care practice in a ‘mental health crisis house’. In so doing, it places the service user, Andy (Pseudonym), within a societal context, using pseudonyms to protect the anonymity of those referred to. The structure of the paper being that of the following: a case history synopsis, reviewing the background of Andy; a synthesis of the theoretical overlays employed; planned interventions and review and discussion of the outcomes. The aims of this work are to highlight the importance of relationship-based health and social care, to analyse the implementation of Cognitive Behavioural Therapy and in its impact in reducing stress, challenging negative thinking and forming a clear approach to mental wellbeing on the trajectory of life and the journey of recovery. This personalised narrative is aimed at promoting positive professional relationship-based work, illumining good practice and providing inspiration of other practitioners.
Case history / client background

Andy, in his mid-40s, has a history of depression and is currently signed off work suffering a mental distress. He has been informally diagnosed with dyslexia by an educational psychologist friend. Although she has not completed the specific psychometric tests with Andy and compiled a report but indicated the strong possibility of dyslexia; in particular, the difficulties he has in written work, spellings and some aspects of memorisation; affecting both short and long-term memory, which are indicative of dyslexia (Rooke, 2017).

He also has two teenage children and is married. Andy lives with his family, who are supportive of him, although lack specific understanding of what he is going through at present; currently affecting his ability to interact, work or undertake any task which may cause the slightest distress. Moreover, Ramsay et al., (2002:41) write about depression: ‘It interferes with a person’s relationships and their ability to work effectively.’ Andy has in the last few months been re-diagnosed by the GP with severe depression, referring to the Diagnostic and Statistical Manual of Mental Disorders V (DSM) as the concomitant features of depression are detrimentally affecting his employment and relationships. The Hamilton Depression Rating Scale (HDRS) and Beck Depression Inventory (BDI) and Patient Health Questionnaire (PHQ) were used by practitioners to assess Andy and evaluate recovery. Each assessment tool underlined the extent to which he was suffering mental distress and did not appear to have the toolbox to help himself out of depression or the ability to effectively reduce depression.

Theoretical / empirical background

Work with clients who are facing mental distress is not new and the prevalence of it is substantial. Horner (2009:64) writes: ‘Each year more than 250,000 people are admitted to mental health in-patient facilities and over 4,000 people take their own lives.’ More recently Baker (2018) notes that in 2017 1 million adults in the UK were in receipt of mental health services. The World Health Organisation (WHO) describes mental health as:

Mental ill health includes mental health problems and strain, impaired functioning associated with distress, symptoms, and diagnosable mental health disorders, such as schizophrenia and depression.

The mental condition of people is determined by a multiplicity of factors including biological, individual, family and social, economic and environmental.


Within the umbrella of this description, Andy would be classed as having ‘mental ill health’ due to his diagnosis of depression. Despite this, under the Mental Health Act (1983; 2005) it was not deemed that he should be admitted to hospital for assessment or treatment (sections 2 and 3) and was judged by the crisis team, on referral, to possess mental capacity to make the decision to voluntarily go into the crisis house for the benefit of his health (Mental Capacity Act, 2005).

Having a secure knowledge base of this area is important when working with vulnerable people who are experiencing forms of mental distress (Mills, 1962; Szasz, 1970; Rogers and Pilgrim, 2014). Throughout history mental illness has been viewed through different paradigms, some with disdain, some with acceptance and others have argued its existence. However, ‘knowledge of the subject [of mental illness] is often via political and media presentation and is subject to both bias and spin’ (Bogg, 2008, p.21). Basset (2005) echoes these remarks, arguing that mental illness and mental health are understood by society and among mental health professionals and academic researchers, in different ways, which consequently affects assessment, intervention and review. Social work is a moral activity, based upon values, a knowledge base and application of skills for assessment, intervention and review (Clark, 2000). Clark (2000) suggests that social work is based upon core values; the worth of individual uniqueness, entitlement to justice, the essentiality of community and claim to freedom.

A further principle is that the service user has an explanation for their illness (Golightly, 2013). This needs to be explored too, so that the client’s voice is heard but this does not necessarily mean the service user had a realistic justifiable explanation (Ramsay et al., 2002). In Andy’s case he knew that stress and overworking were significant catalysts for his breakdown. Tilbury (2002:4) states:

People can break down if either their resources leave them unable to cope with ‘normal demands’, or the
demands are so excessive that even the most resourceful would collapse under pressure.

However, he did have other irrational thoughts in managing his depression, which are commonly associated with this type of illness, (Brown et al., 2007). Golightley (2013) argues that the social worker needs to allow the client to express these. An important aspect of mental health social work is that the service user is the expert in their mental health problems, as they are the one experiencing it (Campbell and Davidson, 2012). I sought, as Golightley (2013) argues, not be dismissive of his experiences, such as hearing voices but tried to distinguish how they are heard and how they may be most effectively managed. Some within society may not wish to engage in this type of work and perceive mental health with suspicion, be afraid of it or perceive experiences such as voice hearing as delusions (Cockshutt, 2004; Corstens et al., 2014). McCarthy-Jones (2012) takes the view that hearing voices should not be condemned as a mental health disorder but examines the reality of voice hearing from a neuroscientific and psychological perspective. However, as Buckner et al. (2007:127) note: ‘Many study samples do not include significant representation of diverse populations’. Thus, a limited insight into this matter across cultures exists. In addition, stigmatisation and discrimination can occur, especially in black and Asian communities (Brice et al., 2014; Kwok, 2013; Nguyen and Lee, 2013), which is beyond the scope of this work. However, by valuing the client’s viewpoint and experiences they may be more effectively helped (Larkin and Morrison, 2006). When working with Andy, even if I disagreed with his experiences or had never gone through some of them myself, it was important to empathise with him, making him feel valued and that his experiences could be heard, which was a contributory factor for the effectiveness of my interventions. As a social worker in training I had to be cautious not to collude. Considerations included: What if I disagreed with Andy’s perspectives? What about the perspectives of relevant others in the service user’s life? Or of other professional viewpoints? Against this theoretical backdrop, this paper will synthesise the planned approaches providing rationale for the specific interventions for tasks undertaken.

Planned interventions

My work with Andy used Cognitive Behavioural Therapy social work practice (Beck, 1957), as when I assessed his needs, based upon the referral from the multi-agency collaboration, single point of access and crisis team, it was felt by the practice educator that Andy would benefitted from this approach, aimed at challenging negative cognitive thoughts and feelings. Moreover, Andy expressing suicidal ideations, therefore when drawing upon his faith in God (Matthews, 2009) and his family support, as protective factors to promote reasons to live, Cognitive Behavioural Therapy (CBT) sought to offer a framework for assessing these factors and analysing behavioural patterns as an intervention to enhance thinking, feeling and subsequent behaviour. CBT was selected as it co-operates well within an ecological framework of viewing the whole person rather than a set of symptoms; the psycho-social model for working with Andy was used. Ahmed (2017) writes that the ecosystems approach to working with service users provides information upon transactions between the differing ecosystems and rich evasive sociopolitical factors at the macrolevel. Equally, CBT was designated as Briers and Beckett (2011) argue that CBT can desensitise and is based upon operant modelling / conditioning. The selection of a CBT approach was that Andy seemed to be ‘locked’ into patterns of irrational thinking, which appeared self-destructive and detrimental to his holistic development, especially his emotional outlook. The employment of CBT was to help Andy think more judiciously about his thoughts and feelings. Moreover, as Andy may have difficulty independently assessing the situation and formulating conclusive action, Rogerian approaches
were not pursued and CBT was agreed by Andy and my practice educator. Walker and Beckett (2011:23) write about CBT:

It aims to help them become aware of themselves, link thoughts and emotions, and enable them to acquire new life skills. Using this approach you would decide on the goals / new behaviours to be achieved together with the client, those clear and capable of measurement.

CBT is based on premise that depression arises from negative, self-destructive thoughts. The comorbidity of depression and dyslexia is established (Alexander-Passe, 2012). This can be attributed to the cyclical failure model of stress (Miles, 2004). An individual may have difficulty with particular tasks, develop poor self-esteem, feel comparisons are made to ‘non-dyslexics’ and develop potential stigmatisation with increased stress and depression. Against this background, I sought to understand some of Andy’s frustrations associated with dyslexia was a key to unlocking the feelings of low self-esteem. Andy had been compared to others, felt that he could not write coherently and struggled to retain and assimilate information received, this was particularly difficult as members of his family were university educated and he felt as though he was ‘second-class’. Low mood can also be regarded as a consequence of maladaptive attitudes and beliefs. CBT seeks to alter unsubstantiated, pessimistic thought patterns so that constructive action and improved mood can follow. However, CBT has limitations, critiqued Monti et al. (2014) in its confines to undertake a complete analysis of a situation, from a fuller perspective such as socio-economic factors. The ecological framework-drawing upon Bronfenbrenner’s (1979) schema of selfhood within different contexts, affected by many systems, including micro and mesosystems - could be considered a way of generating a more holistic view of Andy’s life. Adams et al., (2011:213) write:

Individuals do not live in a vacuum, rather they exist within complex systems that include their immediate surroundings, social networks and cultural communities, set within a wider structure.

However, the systems theory and ecological approach (Germain and Gitterman, 1996) although they acknowledge the interrelationship between the individual in their environment and seek to analyse stressors, they fail to give guidance over how to implement change, which is needful for Andy. Furthermore, the over emphasis of the ‘larger picture’ may mean missing details from the more miniscule pertinent points, which CBT may offer (O’Connell, 2005). Marrying these two principles, ecological perspective and CBT, I was able to explore theories, assessment and methods in relation to mental health and mental wellbeing from a more critical social perspective. In a field that is by often defined by the medical model, the potential to explore these approaches in this way was helpful, and perplexing, at times especially when challenging ‘traditional’ medical approaches to understanding mental health.

Moreover, CBT provided insight into Andy’s perceived issues in the ‘here and now’ and sought to provide challenge to address, for example, suicidal intentions, whereas the ecological perspective, helped support Andy by providing scope to analyse the systems in which his life existed within, and how these had impacted upon him. Pardeck (2015:133) writes:

The ecological approach offers a comprehensive theoretical base that social practitioners can draw upon for effective social treatment…

It is suggested that the ecological perspective can be a useful treatment strategy for improving the social functioning of the client system.

Advocates of other approaches such as the Freudian, psychodynamic schema argue that CBT fails to analyse the factors for why a person may be initially be in the situation they are and is disinterested in the past (Bush, 2010; Castonguay and Hill, 2012). However, Owen (2009) suggests that CBT is not flawed in its perception of the past but seeks to rectify the situation the individual is in, which is fundamental for people like Andy, suffering with depression. Where CBT could arguably be limited, in its analysis of past events, the ecological framework theory, used as an overlay provides an undergirding to theorise events which may have been contributory factors to Andy’s mental ill health. By adopting the ecological framework overlay, situated within a CBT model I was able to see Andy situated within structural issues such as, ethnicity, culture and so forth. This
paper seeks to review the outcomes of the effectiveness of the intervention methods adopted.

**Outcomes**

Davies (2013) argues the significance of review in social work, taking an evaluative approach to working with people. This, he argues, is a summation of the work and a review of what has been achieved and works towards next steps; it prevents academic and practical itinerancy, sharpening the focus of intervention and providing benchmarks to evaluate the effectiveness of the methods employed. This is particularly important as an individual life consists of a complexity of unique experiences and analysing the lived life and the effectiveness of intervention can be difficult (Hardwick and Worsley, 2011). Understanding the individual is constantly changing and adapting to the environment (Balgonal and Vassil, 1983), is helpful when seeking to make sense of and work with Andy’s experiences. In Andy’s case there are a number of factors to consider which are beyond the scope of this paper. It is therefore important to be focused upon the overarching goals; in this instance, the intervention was directed at dealing with Andy’s depression and the subsequent impact of this upon his development and the circumstances he was in as a result of this. Andy’s health was having ramifications upon social functioning and interacting with others. Moreover, Fraser et al. (2009:6) assert: ‘In social work, interventions are usually intended to reduce social or health problems.’ My work was also based upon extending the client’s circle of interactions and exchanges, with a view to enhancing mental health. Ilard (2009:56) writes:

How much would patients improve if therapists just helped them become more active and engaged-getting out and socialising and playing and accomplishing things? The answer: they would improve a lot.

The rationale for CBT was, focusing upon extension of social meaning, is that it is well documented by sociologists, who have attributed a range of problems relating to isolation; these include premature death, stress and depression (Brinkerhoff et al., 2014; Giddens and Sutton, 2009). Hall et al. (2013) assert that the self cannot be whole when isolated from society. Moreover, Jodelet (1991:190) writes that ‘an expression of solidarity’ can be seen as a pertinent feature of mental illness. I therefore felt it important to help the client develop and extend a circle of friends, a circle of intimacy, a circle of participation and a circle of exchange, ideas based upon Lymbery and Butler (2004). A circle of friends, relating to good friendships, a circle of intimacy; those closest to, loved ones, a circle of participation, associates and colleagues and finally, a circle of exchange, people paid within our lives such as employers, doctors, teachers and so forth. By using CBT techniques the client and I were able to examine the important people in his life and how working with these people may help enhance his mental well-being. The therapy was also used as a way of challenging him to examine current circles of exchange and seek to sustain contacts with them as well as widening participation within other circles of engagement. This was identified by Andy as something he would like to address.

The tenets of this intervention were based upon Andy losing his structured routine and regular contact with his circle of participation by being signed off by the doctor. One of the challenges I posed to Andy was that he should consider implementing a plan of action, addressing how to use each day. An activity log, given by Nigel, the mental health nurse, highlighted that Andy’s mood was better when he had stimulation and non-demanding work to do. I drew Andy’s attention to this and he agreed that the days were he was more active were often ‘better’ days for his mental well-being. Although from another field, the Roper, Logan and Tierney model of nursing suggests promotion of independence and autonomy helps a patient’s wellbeing (Roper et al., 2000). Moreover, the tidal model of mental recovery focuses upon self-management of their symptoms and devising a plan to achieve wellness through listening to the client (Barker and Buchanan-Barker, 2004). Andy agreed that he would devise a routine in which he would aim to achieve something each day, as a way of motivating him to get out of bed and face the day. This meant using solution focused SMART (Small, measurable, achievable, realistic and timely / time orientated) targets (Owen and Alterman, 2003). Each day Andy agreed to work towards achieving two SMART targets. He would then rate how he felt about doing them after the activity. This served a two-fold purpose: giving a measurable objective each day and providing qualitative and, if he wished, qualitative feedback upon how he felt...
afterwards. This approach consisted of empowerment, as Andy set the targets, with help from me and he was in control of doing them and subsequently evaluating them. Smale et al. (2000:199) write: ‘To empower others, that is to work with them so they analyse their problems and act upon their problems during an assessment ….’

The next strategy employed based upon Smale et al. (2000), was social entrepreneurship, which is the ability to lead and work through problem solving strategies with other people. The approach was based upon responding to the needs Andy seemed to express, based upon formulating an approach to intervene within the situation he was facing. The plan focussed upon the flux of cognitive, emotional, social and developmental needs he had, based upon a holistic view to understanding his identity within the situation. The approach is entrepreneurial as Andy was actively developing resources and solutions to take control of the situation he found himself in; with a view to enhancing his mental health and promote recovery. It was then important to assess its effectiveness and the impact of self upon the work. Andy explained that he felt able to contribute to the problem solving and was in the ‘driving seat’ for exercising the implementation for change. Understanding the web of factors woven upon case study is important to ascertain the impact of my work with Andy. By Andy acting as an entrepreneur, he was able to disclose information which directed his paths and clarified a plan of action. However, it may be wondered to what extent his views were influenced by other people.

Reflection was my ability to pattern and use the information Andy was giving me and to carefully analyse the impact of my actions upon Andy and his situation. Moreover, reflection upon why I had chosen a specific intervention and rejected others was important in shaping my work (Archambeault, 2009; Schon, 1991; Kolb, 1984). Furthermore, consideration as to why alternative explanations had been deemed to have less of an impact than primary ones. In the case of Andy we both concluded, overworking and lack of leisure and family time had significantly contributed to his illness. The importance of this reflection is that Andy was required to take an overall look by stepping back and looking at the bigger picture; identifying times of exhaustion and lack of socialisation.

The penultimate skill discussed by Smale et al. (2000:226) was challenging. This is was an important matter in addressing Andy’s feelings of failure in association with dyslexia. Challenging is: ‘…the ability of staff to confront people effectively with their responsibilities, their problem-perpetuating or creating behaviours and their conflicting interests’. One of the strengths of CBT is that it uses challenge to the individual’s cognition, negotiating ideas and seeking to empower the client with the tools to help themselves. CBT does not impose views rather it allows the practitioner the opportunity to negotiate and facilitate change through working towards solutions (Owen, 2009). I was able to challenge Andy as to what he was actively doing to help himself, such as taking exercise to release endorphins and meeting with friends and joining in social activities.

Finally, reframing according to Smale et al. (2000), is redefining circumstances to promote resolutions to potential problems. The elements used in reframing include presenting alternatives to situations and articulating them in a client friendly way. Also, challenging service users in a constructive way to achieve change, whilst working within a network of competing perceptions about the reality of the situation is a key to reframing in Smale et al.’s view. The holistic approach offered by Smale et al. (2000) and CBT is an approach which appears to have helped Andy make and develop a sense of reality and rational perspective upon the situation, allowing him the ability to successfully implement changes to his life, rather than being ‘trapped’ in a negative cycle of thinking.

Discussion

As a result of the ecological awareness this work has considered Andy’s holistic health operating within an environment. Moreover, Andy operated within interrelationships; self, family, communities and so forth, which recognised that he functioned within a range of ecologies. This recognition was particularly important as it drove the focus for assessment, CBT questions and evaluation. Since these interventions, Andy he has now been discharged from the mental health crisis house, reports decreased levels of stress and has a daily schedule of doing a semi-structured routine. This has helped him avoid periods of lengthy introspection; which were detrimental to his mental health. Andy has recognised the correlation between dyslexia, stress and depression and has now
sought dyslexia help from a support tutor. He currently pays for private tuition on an ad-hoc basis and may review this to become more regular support but recognising obtaining a formal diagnosis may be the most effective way of obtaining appropriate provision. This dyslexia support has enabled him to record his ideas, without reliance upon his wife, which he found patronising, and has given him the openings to explore online Open University access programmes. Next, he has decided to listen to slow, calming music when feeling distressed or go out of the house and exercise. If facing hearing voices or thoughts, Andy sought to discern between God and his own ideas by using a canonical text- The Bible. In this he felt that certainty could be known whereas intrusive thoughts could come from outside of reality and lead him to do and say things he may regret. With this in mind, the aims of CBT appear to be met as the work applied Winston and Seif (2017) as they note that unwanted thoughts may not necessarily mean anything and those which come from low self-esteem should be challenged. Encouraging Andy to take captive intrusive thoughts by not allowing himself to ruminate upon was a positive aspect of this work on the road to enhanced health and mental wellbeing. It is evident from this work- to consider the whole person and not to immediately medicalise dyslexia or depression as an illnesses or condition which require ‘treatment’. In summary, understanding the whole person, taking a psycho-social approach to mental health (social, spiritual, emotional, relational and so forth) provides inroads to effective practice in health and social care improvement.

Conclusion

In closing, this work has emphasised the importance of relationship-based health and social care work. Having a clear understanding of mental distress and its implications upon those who are suffering has been key to engaging with Andy in an empathetic way. The enhanced prevalence of mental ill health, as defined in the introduction, is of note and therefore it may be anticipated that more persons receive such a diagnosis. Being aware and informed of the state of mind of those who are suffering and being able to effectively assess, plan and evaluate as a cyclical process the use of interventions, such as CBT. Therefore, the originality of this work and the benefit to others is of paramount significance, as the specific illumines the general.

The measuring instrument to which practitioner success is evaluated in relationship-based practice is nebulous as all narrative work is multi-faceted and has a degree of subjectivity. It is clear, however, that Andy benefitted from the approach taken due to the qualitative sentiments testifying of enhanced mood and decrease in feelings of depression. Moreover, it is pertinent to evaluate ‘success’ against Hafal’s (2009:31) sentiments; recovery is more than an absence of illness, it is not just reliant on treatment, it can be a journey and have an endpoint, it can be living well with or without symptoms, it is more about locating meaningful ways to improve life, and recovery is defined by service users themselves not the services. But on the other hand, also may also be seen as a ‘constant journey’.
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