

Case Vignettes: Practicing Presenting Clients

Case #1:

Julie's experience of depression:

Julie is a 32 year old graphic designer. In January she started feeling low in mood and was finding it difficult to get motivated to go to work. For the first couple of weeks, she put this down to 'post-Christmas blues'. Over the next few weeks, she began struggling more with motivation and everything seemed like a huge effort. She began having thoughts like "I am stuck in a rut", "Everyone else is doing better than me", "I'm going no-where". Things she previously really enjoyed doing like swimming and seeing her friends were no longer enjoyable. Since everything was such an effort to Julie, and when she did make the effort she didn't enjoy it, she began doing less and less. Her friends called regularly and invited her out, but she started to refuse these invitations because she no longer enjoyed being out socially and she felt like a burden to her friends. By the end of February, Julie was no longer going out other than for work, she was struggling to get out of bed in the morning and when she was at work, she found it a huge effort and thought everything she produced was "useless". She began to feel hopeless about the future, her mood became lower and she decided to take two weeks off to "try and sort herself out". She went to her GP and was prescribed an antidepressant medication. Three weeks later, nothing had changed and Julie realised she had to do something or she would risk losing her job and her friends.

When you met Julie for assessment in March, she told you how her problems had developed over the previous three months. She said she couldn't understand why she was feeling this way as she has a great life with lots of friends, a close family and a good job. She said that nothing significant had happened in the past few months to explain the way she is feeling and that she is "just being pathetic".

Julie completed some questionnaires to assess the severity of her depression and she scored in the moderate range. Cognitive-behaviour therapy has an extensive evidence-base for the treatment of moderate depression and is recommended by the National Institute of Clinical Excellence (NICE) as the treatment of choice. You discussed this approach with Julie and we agreed to meet for 6 sessions in the first instance followed by a review. Julie's sessions included the following:

1) Understanding how the problem developed and was being maintained:

This is a very important part of therapy as it increases understanding and self-compassion as well as identifying areas that may require attention in therapy. We talked about a number of events that had happened in the last six months of Julie's life which helped make sense of why she was feeling low, such as the break-up of a relationship, her best friend becoming pregnant and her sister moving away for a promotion at work. Julie learned that while none of these events alone explained her low mood, together they triggered a life review which resulted in her having thoughts that she was stuck and not moving on as others were doing. These thoughts

triggered feelings of low mood and lack of motivation. We also spoke about factors that were maintaining the low mood such as not going out, not seeing friends and self-critical thinking. This understanding helped Julie see the importance of the next phase of therapy.

2) Re-establishing previous levels of functioning:

Lack of activity was identified as one of the maintaining factors in Julie's depression. Research has demonstrated that activities which provide an individual with a sense of pleasure and mastery are most helpful in terms of improving mood. Therefore we spent two sessions thinking about activities that Julie enjoys and finds worthwhile and began working on increasing these in a gradual way that felt manageable to Julie. For example, Julie identified that while she found it difficult being out in a group, she found it easier in a 1:1 situation. Therefore she started to increase her activity levels by meeting a good friend for a coffee and a walk a couple of times a week and gradually built up the frequency of going out over the next few weeks. Julie had always enjoyed swimming and while she was reluctant to start going again, with some information about the benefits of exercise for mental health and a little therapist encouragement, she managed to go. While she didn't enjoy the first few swims, she got a great sense of achievement from going and over time she enjoyed it more. Engaging in these and other activities resulted in a significant improvement in her mood.

3) Managing self-critical thoughts:

Next we moved onto Julie's thinking style. Julie was having a lot of self-critical thoughts such as "I am useless", "No-one wants me around, I am a burden". These thoughts were having a negative impact on her mood and self-esteem and as they were maintaining her depression, we agreed they needed to be tackled. We spent three sessions working on self-critical thinking and increasing self-compassion. This work focused on learning to identify negative and self-critical thoughts, evaluating the truthfulness of these thoughts and developing more balanced and helpful ways of thinking. Julie realised that she was constantly telling herself off, even for things that were not her fault and that speaking to herself in this way was holding her back instead of moving her on. By developing a more balanced and compassionate way of thinking, she focused on what she was doing well and her mood improved.

4) Review and relapse prevention

At session 6, we had a review and Julie said she was getting a lot from therapy. As there was still work needed on her thinking style, we agreed to 2 more sessions to complete this part of the work and develop a relapse prevention plan. We worked on thinking in session 7 and used session 8 to develop the relapse prevention plan which consisted of identifying skills and strategies she had learned to manage her mood, considering potential triggers in the future and planning how she will manage these. At the end of therapy, Julie completed the same questionnaires and her scores showed that she had minimal depression. Julie was delighted with the outcome of therapy as she not only felt better but also had the skills to manage any future occurrences of low mood.

Case #2

Joe's experience of panic:

Joe is a 34 year old forestry worker. One day he had a panic attack out of the blue while queuing in a supermarket. He started sweating, his heart was beating very fast and he was extremely dizzy. He was convinced he was going to pass out and so he ran out of the supermarket, leaving his shopping behind. As soon as he got out of the shop, he felt better. Joe was very confused about why that had happened to him, and also embarrassed that he'd had to run out of a shop. He began to worry that he might have another panic attack and started to feel anxious at the thought of going to supermarkets. He decided that there was no need to go to supermarkets and instead went to his local shop when he needed something. A couple of weeks later, Joe was driving to work on the motorway when he started to feel anxious and panicky. As he was scared he might lose control of the car and cause a crash, Joe came off the motorway at the next junction. Joe felt better straight away and decided that from then on he would not risk driving on the motorway. Joe reasoned that since he might have a panic attack and need to leave places suddenly, it would be best to avoid busy places where it might be difficult to get out such as supermarkets, shopping centres, lifts, cinemas and the motorway. Joe's wife began to get annoyed with him because the whole family had to make allowances for his anxiety. In addition, Joe was becoming worried because he was avoiding more things over time and he wondered where it would end, and so he made the decision to come for a psychological assessment.

During the assessment, you and Joe discuss how his difficulties had progressed. You talked about what he wanted to gain from attending therapy and set his therapy goals, which included things like gaining confidence, using the motorway again and going for a date to the cinema.

Cognitive behaviour therapy (CBT) has a strong evidence-base for panic disorder and is recommended by the National Institute of Clinical Excellence (NICE) as the treatment of choice for this condition. This approach was discussed with Joe and we agreed to meet for 8 sessions of CBT.

1) Understanding the problem and what keeps it going

You began by considering what was causing and maintaining the panic. You went through Joe's experiences of panic in detail and learned that his panic attacks consisted of a) physical sensations and b) misinterpretation of those sensations as dangerous (this is called catastrophic thinking). More specifically, the first time Joe had a panic attack, he was in a busy queue in a supermarket. He was feeling stressed at the time because he had left work late and was worried he was going to be late home again, possibly resulting in an argument with his wife. He was thinking about how he needed to get out of there as quickly as possible and he began experiencing a number of physical symptoms associated with stress and anxiety, such as increased heart rate and sweating and dizziness. When this happened, Joe started to think about how faint he felt and how embarrassing it would be if he did so in front of the other people in the supermarket. These thoughts resulted in increased anxiety, further physical symptoms and further catastrophic thinking, with Joe thinking he was going to pass out for sure. In order

to prevent this happening, Joe left the supermarket and found that he felt better immediately, as he was no longer at risk of passing out and embarrassing himself. While getting out worked to decrease his anxiety in the short-term, Joe then began to worry about going back to the supermarket, and so in the longer-term, the avoidance only served to increase his anxiety levels and likelihood that he would panic. Therefore the areas we identified as important for intervention were catastrophic thinking and avoidance.

2) Managing catastrophic thinking

You began by getting Joe to identify his thinking processes when he was stressed and anxious. By doing so, Joe was able to recognise that when he noticed symptoms of anxiety, he started having a lot of catastrophic thoughts such as, "I am going to pass out", "I am going to lose control". Next you looked at these thoughts in detail and considered how accurate these were. For example, Joe was worried he was going to faint because his heart rate had increased and he felt dizzy. We investigated fainting and learned that people faint when their heart rate decreases and therefore it is almost impossible to faint when you are anxious and your heart rate is elevated. As well as information about anxiety and panic, Joe was provided with techniques to help him evaluate his thinking and come up with more balanced alternatives and test these alternatives out. Joe said he felt more in control as he realised that anxiety is a normal part of life and panic only occurs when thinking about sensations becomes distorted.

3) Tackling avoidance

Now Joe had the necessary information and skills to manage his thoughts, the next step was for him to start doing the things he had been avoiding. Joe was very anxious about the idea of this and so he did it in a graded way. Joe was asked to think about all of the things he was avoiding and rate how anxious each one made him feel. These were then placed on a list and Joe tackled them one at a time in order of difficulty. Before doing each one, we would use the session to prepare for the task by predicting what he thought might happen and how he would manage if it did. As a result of this preparation, Joe had the confidence to try things out as he had a detailed plan of what he would do to cope if he did become anxious. He began by going into supermarkets when they were quiet and when he coped well with this, he went in at busier times. Joe kept a record of his progress which also helped increase his confidence and spurred him on to try the next item on his list. When doing the early tasks, Joe continued to feel anxious but he learned that he could cope with anxiety and that it did not harm him. By repeatedly doing the tasks, he became more confident in his ability to manage anxiety and panic and the sensations gradually reduced.

Joe attended 8 sessions in total and had achieved all of his goals by the end of treatment.

Case #3

Gerry's experience of bi-polar disorder:

Gerry was 21 when he experienced his first episode of mania while at University. After a night out, he was unable to switch off and found it difficult to get to sleep. Over the next couple of days, his friends noticed that he was becoming more and more hyper in that he was very excitable and was speaking really quickly about all sorts of plans and ideas. Gerry's friends began to get worried on the third day when Gerry came to chat to them about his ideas at 4 in the morning. By the following evening, Gerry was becoming increasingly paranoid and began accusing his flatmates of spying on him. Gerry's flatmates called his mum who in turn called their GP. Gerry was referred to a psychiatrist and it was agreed he needed an in-patient admission to stabilise his mood. Gerry spent two weeks in hospital where he was treated with medication and his mood stabilised. After a couple of weeks, he felt ready to return to University but things began to get difficult again. He was struggling with motivation and was unable to keep up with the workload. His friends were managing well and he began to feel like the odd one out. Over the next few days, his mood became lower and so he went back to see his GP, who prescribed a course of antidepressant medication. The period of low mood lasted three to four months and eventually lifted. Over the course of the next four years, Gerry had a further two episodes of mania and one episode of depression and was diagnosed with bi-polar disorder. He was becoming increasingly worried that he might lose his job in sales as he had had a number of periods of absence, and this is the reason he sought psychological help.

When you met with Gerry, he outlined his experiences with mood instability and we discussed his current mood, which was stable. The National Institute of Clinical Excellence (NICE UK) recommends a combination of cognitive behaviour therapy (CBT) and medication for the treatment of bi-polar disorder. You outlined the CBT approach to Gerry and you highlighted the treatment rationale, namely that the aim of treatment is not to eliminate the condition but to help reduce the likelihood of relapse and minimise the impact of an episode should one occur. Gerry understood this and we agreed to meet for 16 sessions of CBT.

Understanding the difficulties

You began by developing a psychological understanding of the difficulties Gerry was experiencing. We discussed predisposing factors (such as a family history), current stressors that increased the likelihood of having an episode of mania or depression (such as a heavy workload in University and relationship problems) and poor coping strategies that further increased the risk of having an episode (such as staying up all night to catch up on work and drinking alcohol to forget about relationship problems). This was important not only because it helped Gerry to understand why he was experiencing these episodes, but also because it identified areas that required attention during therapy.

Liaison with other professionals

Since bi-polar disorder requires a multi-professional approach to manage medication, psychological therapy, mood monitoring and possible in-patient stays, an important aspect of the treatment is close working between professionals. With Gerry's permission, contact was made with the other professionals involved in his care and a coordinated care plan was developed. Once Gerry had developed his relapse prevention plan, this was circulated to the other professionals in his network with his permission.

Gaining insight into the signs and symptoms of a manic or depressive relapse

The next step was to gather information to develop detailed insight into the signs and symptoms of an episode of mania and depression. In order to do this, Gerry had to think about his episodes in detail and list all of the thoughts, feelings, behaviours and physical symptoms he noticed during an episode. In order to make this more comprehensive, Gerry asked his girlfriend and family members for their recollections. Once this was complete, we outlined in detail what a period of wellness looks like and then considered the period in between wellness and an episode, from the first signs that something is changing to the period just before an episode. By doing this, Gerry was able to track a number of behaviours across the mood spectrum. For example, when Gerry was really depressed, he didn't care at all about his sales targets and often didn't attend work, when he was well he wanted to achieve the targets which had been set and so worked from 9-5, and when he was going high, he became obsessed with being the best performing salesman on the team, meaning he stayed late most nights and skipped meals to ensure this happened. In this way, Gerry was able to monitor 4-5 activities which would give him insight into his mood at the time. If Gerry noticed that things were changing, he would then be able to take the appropriate action.

Providing a range of skills to manage signs and symptoms of a relapse

Once Gerry had a clear sense of the signs and symptoms of a relapse, we discussed and practiced a range of psychological strategies which he could use to manage these symptoms, including mood monitoring, behavioural activation and deactivation strategies (depending on whether Gerry was going low or high) and cognitive techniques to manage unhelpful thought processes. When Gerry noticed changes in his mood, he was able to use these techniques to manage these changes.

Developing a relapse prevention plan

The next step was to draw all of the information together in a relapse prevention plan. This took the form of a traffic light signal, with green meaning Gerry was well and what he should keep doing to maintain this, amber indicating that things were changing and what he could do to manage these changes and red indicating that he was in an episode and what he could do to manage this. This plan was printed out for Gerry and sent to other professionals involved in his care so that everyone in his network were aware of what Gerry could do at different stages.

At the end of therapy, Gerry reported feeling more confident in his ability to recognise signs of a relapse and more confident in his ability to manage these symptoms should they arise. As a result, he reported feeling more confident and in control of his future.

Attending for top-up sessions

While Gerry had the necessary understanding and skills to manage his condition, at times when he felt at risk of relapse, he requested a top-up session to refresh his skills. Having these top-up sessions meant that Gerry could revise his skills and ensure he was using all of the skills available to him to manage his symptoms.

Case #4

Brian and Anna, Couple's Work:

Anna and Brian came to Couples Therapy with you, they are on the verge of a relationship breakdown.

Why Anna and Brian came to Couples Therapy

Anna felt that she was doing everything to keep the relationship going, and that Brian took her for granted. Brian felt isolated and neglected, and often found himself lacking the motivation to do the things he felt Anna nagged him to do.

Anna was thirty and worked full time as a personal assistant while completing a Master's degree part-time in the evenings. Brian was also thirty and had completed his degree. Since graduating five years ago, he had held a variety of temporary jobs and was unemployed when the couple first scheduled an appointment with you. Although she wished Brian would put efforts into finding a job, Anna noticed that he spent most of his day playing video games.

The couple had not had sex for over four months; Anna would attempt to initiate sex, but Brian did not have the desire. The couple were engaged to be married, and had set a date for their wedding six months from when they first contacted you. Anna would like children, but she was now feeling that Brian would not be a fit husband or father.

Working Together to Uncover the Issues

In Couples Therapy, you began to explore the couples' backgrounds.

Anna was the eldest of four children. Her father died suddenly of a heart attack when Anna was twelve, and her mother became depressed following his death. Anna looked after her younger siblings, and was responsible for completing the majority of the household chores. She worked very hard academically because she saw this as a way to eventually support her family financially.

Brian was raised by a single mother. He had no ongoing relationship with his father, who left when Brian was one. He was close to his mother when he was little, but as he grew up his mother had to spend more time working outside of their home in order to support them both.

She trained as a nurse and did shift work. Brian was often left to fend for himself in the house while his mother was working.

Putting the Pieces of the Puzzle Together

Over the course of their work together, you helped Anna and Brian to notice ways in which their early lives were now shaping their current relationship patterns. They came to the conclusion that the couple were repeating different aspects of their pasts unintentionally, and each were feeling resentful about it.

Anna found herself in a position where she was once again under pressure to provide and care for her loved one. She had not been able to express her upset at her family of origin because her mother was depressed and her siblings were younger than her, and she felt responsible for keeping them from any further hurt or distress. Anna had experienced rage at her experience of growing up that it was not possible for her to express or work through safely at the time, and this was now being experienced and expressed in Anna's relationship with Brian.

Anna was also scared that she was marrying into the difficult family situation she had grown up in, as she was worried that Brian, like her mother, was depressed. As you helped Anna to make sense of her experiences and her emotional responses, Brian began to understand some of Anna's frustration with him. As they explored Anna's early life and experiences, Brian was able to view Anna's reactions to his own behaviour in the context of what she had been through previously, helping him to be more understanding and sympathetic when she felt threatened.

During the work together, you discovered that what Anna perceived as Brian's "depression" had first become apparent around the time that Anna had started her Master's degree. Brian remembered that while his mum was away working when he was a child, he occupied his time mostly by playing computer games and eating frozen pizza; a pattern of behaviour he now repeated while Anna was out in the evenings.

Brian recalled his experience of sadness at his mother's working hours despite his understanding even at the time that she was working hard so that he could have a better life. As a child, he was often lonely, and felt that his mother didn't want to spend time with him. Brian admitted to Anna that he felt she preferred her work to spending time with him.

Brian also acknowledged that he was angry at Anna about her decision to apply for her Master's, which he felt she had chosen seemingly without considering the impact this may have on Brian and their relationship. Anna had learned from her experiences that others were unreliable – something which her discussion with Brian and you helped her to realise – she was used to making decisions by herself and rarely relied on anyone for advice. Anna admitted that she hadn't considered talking to Brian about applying for the Master's, and she began to understand his experience of neglect.

Building connection through understanding

Working together over a number of sessions, Brian and Anna began to develop a better understanding of their own and each other's perspectives. When placed in the context of their past experiences, the ways in which they each responded to the challenges in their relationship seemed more understandable and relatable.

Once they began to understand their own and each other's behaviour, and how it had functioned for them in their lives up to that point, they were able to think more practically about how to address their relationship issues in ways that were more considerate and functional. You set about helping the couple to identify ways of working through their differences that felt respectful of both partners' needs.

Making Meaningful Changes

Anna and Brian both agreed they wanted to stay together, and recognised that they would need to commit to ongoing maintenance of their relationship. They spent time giving serious consideration to what they needed to change in order to improve the relationship. A first step that they agreed to was reconnecting to each other by spending more time enjoying each other's company. They started by scheduling a regular "date night" each week, which they both began to look forward to.

After highlighting some of the barriers to his job search together with you, Anna began helping Brian to look for suitable employment. Brian recognized how his behaviour contributed to the strain on Anna's resources – her little free time was often being spent tending to things Brian had been distracted from, so she had limited energy left to address his need for companionship when she was home. Brian began taking responsibility for more of the household chores, freeing up Anna's energy to enjoy their time together.

Looking to the Future

The couple noticed improvements in their relationship, including fewer, more productive arguments and an increased experience of intimacy and mutual regard. They decided to continue working together with you following their agreed sessions to explore the possibility of starting a family together.