

Cbt case study

Education



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Identifying Information

For the purposes of the case study the client will be called Jane. Jane is a 22 year old single white British female who lives with her parents in a house outside the city. She is heterosexual and has had a boyfriend for seven years. She feels unable to discuss her issues with her boyfriend. Her parents both have mental health issues and Jane does not feel able to talk to her mother about her problems. She has an older brother she has a good relationship who lives with his girlfriend, a four hour drive away.

Jane is educated to degree level, having studied Criminology and is currently working part-time for her father managing his client accounts for a business he runs from home. A typical day involves organising all receipts and creating spreadsheets for each client's accounts. Jane states she would like to get a full time job and be normal like her friends. Jane has a small circle of friends from university who she states have all gone onto full time employment. Jane also has a puppy she spends time looking after and taking for regular walks.

Assessment Jane was referred following a health check at her GP surgery. She had been prescribed Citalopram 20mg by her GP for anxiety symptoms and panic attacks she had been having for two years. Jane has no previous contact with mental health services. Jane's father had a diagnosis of Bi-Polar Disorder, her brother has Depression and her boyfriend has a diagnosis of Obsessive Compulsive Disorder which he is continuing treatment for. Jane's anxiety/panic has increased over the past two years.

She had read about Cognitive Behavioural Therapy on the Internet and was willing to see if it was help ease her anxiety symptoms. Jane stated that the problem started due to family issues in 2007. Her brother and father were estranged due to a financial disagreement and this resulted in Jane's brother leaving the country with his girlfriend, causing Jane to become very distressed. Also during this time she was taking her final exams at University, Jane states this was when she experienced her first panic attack.

She had spent the evening before her brother left the country, drinking alcohol with friends, she remembers feeling ' hung-over' the next day. While travelling in the car to the airport, with her brother and his girlfriend, Jane states she started to feel unwell, she found it difficult to breathe, felt hot, trapped and felt like she was going to faint. Jane stated she felt " embarrassed" and " stupid" and had since experienced other panic attacks and increased anxiety, anticipating panic attacks in social situations.

Jane had reduced where she went to, finding herself unable to go anywhere she may have to meet new people. Her last panic attack happened when Jane visited her GP for a health check and fainted during the appointment, Jane has blood phobia and she stated she had not eaten since the day before and was extremely anxious about the any medical interventions. Jane believes it was a panic attack that caused her to faint.

The GP prescribed her 20mg of Citalopram, a few weeks prior to her initial assessment with the therapist. When Jane and the therapist met for the initial session Jane described herself as feeling inadequate and as if she was trapped in a cycle of panic. Although Jane felt unhappy she had no suicidal ideation and she presented no risk to others. Jane stated she had become

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more anxious and that she had panic attacks at least twice a week. Prior to and during therapy, Jane was assessed using various measures.

These enabled the therapist to formulate a hypothesis regarding the severity of the problem, also acting as a baseline, enabling the therapist and Jane to monitor progress throughout treatment. (Wells, 1997). The measures utilised in the initial assessment were a daily panic diary, Wells (1997) and a diary of obsessive- compulsive rituals, Wells (1997) a self rating scale completed by the client Jane. Other measures used were, The Panic Rating Scale (PRS) Wells (1997), the Social Phobia Scale, Wells (1997), used by the therapist to clarify which specific disorder was the main problem for Jane.

Having collated information from the initial measures, a problem list was created so the therapist and Jane could decide what to focus on first. This list was based on Jane's account of the worst problems which were given priority over those problems which were less distressing. Problem List 1. Anxiety/Panic attacks 2. Obsessive hand washing. 3. My relationship with my family. 4. Not having a full time job. 5. My relationship with my boyfriend Having collaboratively decided on the problem list, the therapist helped Jane reframe the problems into goals.

As the problem list highlighted what was wrong, changing them into goals enabled Jane to approach her problems in a more focused way (Wells, 1997), the therapist discussed goals with Jane and she decided what she wanted to get from therapy. It was important for the therapist to ensure that any goals were realistic and achievable in the timeframe and this was conveyed to Jane (Padesky & Greenberger, 1995). Jane wanted to reduce her anxiety and expressed these goals:- 1. To understand why I have panic attacks. 2. To

have an anxiety free day. 3. To reduce the amount of time worrying . To reduce obsessive hand washing at home. Case Formulation Jane stated that for about a year she had been repeating certain behaviours, which she believed prevented her from having panic attacks. This involved Jane washing her hands and any surrounding objects at least twice. Jane had a fear of consuming alcohol/drugs/caffeine/artificial sweeteners, she stated she had had her first panic attack the day after drinking alcohol and had read that all these substances could increase her anxiety. Jane had not drunk alcohol for 18 months as she felt this caused her anxiety and made her unable to control the panic attacks. Jane stated she feared that if any of these substances got on her hands and then into her mouth she would have a panic attack and faint. These beliefs increased Jane's anxiety when Jane was exposed to any environment where these substances were present. This unfortunately was most of the time, Jane stated that every time she saw any of these substances consumed or even placed near her, she became anxious and had to wash her hands and any surrounding items which she may come into contact with again.

These safety behaviours maintained the cycle of panic, Jane would always continue the routines that she believed prevented a panic attack. The worst case scenario for Jane was “ the panic would never stop and I will go mad, causing my boyfriend to leave me”. Jane felt this would make everyone realise what she already knew, that she was worthless. Her last panic attack happened when Jane had visited her GP; this caused Jane feelings of shame. “ There's all these people achieving, doing great things and I can't do the most basic things”

The therapist used the Cognitive Model of Panic (Clark, 1986), initially developing the three key elements of the model to help socialise Jane to the thoughts, feelings and behaviour cycle (see diagram below) Cognitive Model of Panic Bodily sensations Emotional response Thought about sensation Clark (1986) Using a panic diary and a diary of obsessive-compulsive rituals, Jane was asked to keep a record of situations during the week where she felt anxious, and this was discussed in the next session.

Jane stated she had not had any panic during the week, when discussing previous panic attacks during the session, Jane became anxious and the therapist used this incident to develop the following formulation. Heart beating fast/increase in body temperature Fear/dread I feel hot, I can't control it Clark (1986) Jane stated she felt like she was sweating, she had difficulty breathing; felt faint, had feelings of not being here and felt like she was going crazy.

All these symptoms suggested that Jane was experiencing a panic attack and Jane met the criteria for Panic Disorder, defined in the DSM IV and states that “panic attacks be recurrent and unexpected, at least one of the attacks be followed by at least one month of persistent concern about having additional attacks, worry about the implications or consequence of the attack, or a significant change in behaviour related to the attacks” (APA, 1994). During the sessions the therapist continued to socialise Jane to the model of panic (Clark, 1986); together Jane and the therapist looked at what kept the cycle going.

The therapist continued to use the model formulation, with the addition of Jane's catastrophic interpretation of bodily symptoms, to illustrate the <https://assignbuster.com/cbt-case-study/>

connection between negative thoughts, emotion, physical symptoms. Social situation I will be unable to stay here Everyone will notice I am not coping I'm going to faint Sweating/breathing fast/dizzy Clark's (1986) Cognitive Model of Panic.

Progress of Treatment The therapist hypothesised that Jane's symptoms continued due to Jane not understanding the physiological effects of anxiety. The results were a misinterpretation of what would happen to her while being anxious, and this maintained the panic cycle. Although Jane tried to avoid any anxiety by using safety behaviours, she eventually increased the anxiety she experienced. Session 1 After the initial assessment sessions, the therapist and Jane agreed to 8 sessions, with a review after 6 sessions.

Jane and the therapist discussed that there may only be a small amount of progress or change during the sessions due to the complexity of Jane's diagnosis and agreed to focus on understanding the cycle of panic (Clark, 1986) From the information gained from the formulation process, the therapist tried psychoeducation. The therapist was attempting to illicit a shift in Jane's belief about what, how and why these symptoms were happening. The therapist discussed with Jane what she knew about anxiety and from this the therapist discovered that Jane was unsure of what anxiety was and the effects on the body.

For the first few appointments the therapist knew it could be beneficial to concentrate on relaying information about anxiety, (Clark et al, 1989) focusing on Jane's specific beliefs anxiety, the therapist wanted to try to reduce the problem by helping Jane recognise the connection between her symptoms. As Jane believed, " she was going mad", the therapist was trying

to help Jane understand the CBT model of anxiety and to alter Jane's misunderstanding of the symptoms. The therapist and Jane discussed Jane's belief that she would faint if she panicked, Jane had fixed beliefs about why she fainted.

The therapist attempted to enable Jane to describe how her anxiety affected her during a 'usual panic'. Instead Jane began to describe symptoms of social anxiety, this suggested to the therapist that the main problems could be a combination of /social phobia and obsessive behaviours; the following dialogue may help to illustrate this. T. When you begin to become anxious, what goes through your head? J. I need a backup plan; I need to know how to get out of there. Especially if it's in an office, or a small room. T. What would happen if you did not get out? J. I would panic, and then pass out

T. What would the reasons be for you to pass out? J. Because I was panicking. T. Have you passed out before when you have panicked? J. I have felt like it. T. So what sensations do you have when you're panicking? J. The feeling rises up, I feel hot and I can't see straight. I get red flashes in front of my eyes, like a warning. My vision goes hazy. I think everyone is looking at me. T. Do you think other people can see this? J. Yes. T. What do you think they see? J. That I'm struggling and I cannot cope or, I try to get out of the situation by pretending I feel ill before they notice. T.

What would they notice, what would be different about you? J. I stick out like a beacon, I'm sweating, loads of sweat and my face is bright red. T. How red would your face be, as red as that "NoSmoking" sign on the wall? J. Yes! I'm dripping with sweat and my eyes are really staring, feels like they stick out like in a cartoon, it's ridiculous. T. How long before you would leave the

situation? J. Sometimes the feeling goes, like I can control it. But I could not leave. There would be a stigma and then I could not go back, the anxiety would increase in that environment or somewhere similar.

The therapist persisted with this example and tried to use guided discovery to help Jane get a more balanced view of the situation. (Padesky and Greenberger, 1995) T. So you would not go back? J. I would if I felt safe, like with my boyfriend or I could leave whenever I wanted to. It's the last straw if I have to go. It makes it even harder. T. You say that sometimes it goes away. What's different about then and times when you have to leave? J. It's like I just know I have to leave. T. What do you think may happen if you stay with the feelings? J. That I will pass out. T. What would that mean if you passed out? J. It would be the ultimate. It would mean that I could not cope with the situation. T. If you could not cope what would that mean? J. I can't function, I can't do anything. I'm just no use. T. How much do you believe that? Can you rate it out of 100%? J. Now. About 60% if I did faint it would be about 100% T. Have you ever fainted due to the sensations you have described to me? J. No. I have fainted because I'm squeamish. I don't like blood. Or having any kind of tests at the GP. T. So do I understand you? You have never fainted due to the panic sensations?

J. No. I've felt like it. T. So you've never passed out due to the symptoms? What do you make that? J. I don't know, that would mean that what I believe is stupid. It's hard to get my head around it. Session 2-3 The therapist used a social phobia/panic rating scale measures to ascertain the main problem; this was increasingly difficult as throughout each session the patient expanded on her symptoms. The therapist managed to understand

that the patient avoided most social situations due to her beliefs about certain substances; this caused the obsessive hand-washing.

This then had an impact on Jane's ability to go anywhere in case she could not wash herself or objects around her. Jane also believed fainting from blood phobia had the same physical effects as panic, and she would faint if she panicked. It was complicated and the therapist attempted to draw out a formulation.

Session 4 The formulation shows the extent of Jane's panic and how her safety behaviours were impacting on all aspects of her life. The therapist attempted again to use information about the causes of anxiety and its effects on the body. The therapist explained what happens when you faint due to blood phobia, this was an attempt to supply Jane with counter evidence for her catastrophic interpretations of her panic. The therapist also used evidence to contrast the effects on the body when fainting and when panicking.

After two sessions, the therapist continued to provide and attempted to relay the facts about the nature of anxiety/panic/fainting with the inclusion of behavioural experiments. Educational procedures are a valid part of overall cognitive restructuring strategies, incorporated with questioning evidence for misinterpretations and behavioural experiments (Wells, 1997) The therapist asked Jane to explain to the therapist the function/effects of adrenalin, to see if Jane was beginning to understand and if there had been any shift in her beliefs about panic.

The following dialogue may help to illustrate the difficulties the therapist encountered; T. Over the last few sessions, we have been discussing anxiety and the function of adrenalin. Do you understand the physical changes we have looked at? Does it make sense to you? J. Yes. Something has clicked inside my head. I feel less insane now, I understand more about what's going on. It makes things a little bit easier, but it takes time for it to sink in. T. Do you think you could explain to me what you understand about anxiety/adrenalin? J.

As I interpret it is, I like to think of it as, “ I'm not anxious it's just my adrenalin, It's just the effects of adrenalin effecting my body” but it's hard to get from there, to accepting the adrenalin is not going to harm me. I know logically it's not. But it's still hard. T. That's great you're beginning to question what you have believed and are thinking there may be other explanations for your symptoms. J. Yes. But I still think it's to do with luck. I have good or bad luck each day and that predicts whether I have a panic or not. I think I'll be unlucky soon.

Session 5-6 The therapist continued to try use behavioural experiments during the sessions to provide further evidence to try to alter Jane's beliefs about anxiety. The therapist agreed with Jane that they would imitate all the symptoms of panic. Making the room hot, exercising to increase heart rate and body temperature, hyperventilation (ten minutes) Focusing on breathing/swallowing. This continued for most of session 5. As neither the therapist nor Jane fainted, they discussed this and Jane stated it was different in the session than when she with other people.

Jane also stated she felt safe and trusted the therapist, she did not believe she could be strong enough to try the experiments alone, as it was “ too scary” The therapist asked Jane to draw a picture of how she felt and put them on the diagram of a person, this then was used to compare with anxiety symptoms, while talking through them with the therapist. The therapist and Jane created a survey about fainting and Jane took this away as homework to gain further evidence. The survey included 6 different questions about fainting e. g. - What people knew about fainting/how they would feel about seeing someone faint, etc. Treatment Outcome The treatment with Jane continues. The next session will be the 6th and there will be a review of progress and any improvements. There has been no improvement in measures as noted yet. The therapist intends to use a panic rating scale (PRS) Wells, (1997) during the next session. The therapist will continue to see Jane for two more sessions, looking at what Jane has found helpful/unhelpful. Discussion Overall the therapist found the therapy unsuccessful.

Although Jane stated she found it helpful, it was difficult for the therapist to see the progress due to the many layers of complexity of Jane’s diagnosis. The therapist has grown more confident in the CBT process and understands that as a trainee, the therapist tried to incorporate all the new skills within each session. The therapist was disappointed that they were unable to guide Jane through the therapy process with a better result. The therapist would have like to have been able to fully establish an understanding of Jane’s complex symptoms earlier on in the therapy.

The therapist believes that Jane's symptoms were very complex and the therapist may have been more successful with a client with a less complicated diagnosis. The therapist would then be able to gain more information via the appropriate measures to enable the formulations in a concise manner. This has been a huge learning curve for the therapist and has encouraged them to seek out continuing CBT supervision within the therapist's workplace. This is essential to continue the development of the therapist's skills.

The therapist feels that although this has not had the outcome that the therapist would have wanted, it has been a positive experience for Jane. There appeared to be a successful therapeutic relationship, Jane appeared comfortable and able to communicate what her problems were to the therapist from the beginning of therapy. The therapist hopes this will encourage Jane to engage with further CBT therapy in the future and the therapist over the final session hopes to be able to support Jane in creating a therapy blueprint, reviewing what Jane has found helpful.

References

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