

Is CBT Enough? A Case History

by Courtenay Young with Elisa Kazim

Abstract:

A detailed and in-depth case history (9 sessions) is given of a seriously depressed man with Parkinson's disease and a number of other complications. The psychotherapist counsellor initiated a parallel course of computer-based CBT, also available in the department of Clinical Psychology. The article illustrates the complexity of some people's lives and raises a number of issues both about CBT (computer-based and otherwise) and about whether a more eclectic style of working can be facilitated by using computer-based CBT. The efficacy of such a dual approach is indicated.

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“Colin” is 57 years old¹, with a long history of depression, anxiety and panic attacks. He was referred by his GP to the Adult Clinical Psychology department in August 2004. There was an 18-month waiting list.² He used to be married, despite being bisexual, but became somewhat acrimoniously divorced several years ago. He currently lives alone in a Housing Association terraced upstairs flat.

In 1999, he developed Parkinson's disease (possibly drug-induced): soon after that he stopped being able to work regularly. Initially he coped well, helping to start-up a local Depression Alliance group, and he joined a local Parkinson's support group, learning and then giving alternative therapies (Reiki) to other group members, and benefiting from the social contact and the committee work. However this latter group also allowed him to meet a number of people who were worse off or further advanced in their disease than he was then and this increased his anxiety about his future. He later was in receipt of some considerable antagonism from one of the other committee members, and eventually broke off all relationships with that group.

He attended some counselling, but the depressive episode persisted and deepened, and was then exacerbated by the break-up of his marriage. His wife had become quite aggressive and occasionally violent. He left the marital home and started divorce proceedings. Just as they were concluding a financial settlement, his wife installed new windows throughout their house (now becoming hers), and he got stuck with the bill of several thousand pounds. His doctor wrote: *“His anxiety and panic attacks seem to be increasing over the last 6-9 months due to an increasing bitterness and resentment towards debts he has had to pay which he feels are not his fault.”*

He was put on one drug for his Parkinson's disease that seemed to have an 'interesting' side effect: it created a gambling addiction and he went further into debt. This debt increased with local Council Tax arrears and some credit card debts, eventually totalling about £8,000. He went to the local Council debt advisor who suggested he declare himself bankrupt. A legal / medical claim against the drug company failed.

He had enjoyed regular contact with his adult daughter and his two, then three, grandchildren. When she became a single mother, he helped her out by being involved in lot of regular childcare, almost on a daily basis. He said he enjoyed this immensely. His ex-wife then 'interfered' and managed to alienate their daughter from him. All contact with his daughter and grandchildren then ceased for about 3 years. His bitterness increased.

As regards other family: his mother is still alive, in a residential home, with Alzheimer's. He reported that one of his brothers was a drug addict; another was an alcoholic. He has 2 sisters; one lived locally and was supportive; the other younger one much less so.

I was employed to work in the department of Adult Clinical Psychology, as an experienced Counsellor, on a fixed 6-month contract, to help them to get their waiting list down. He was one of the first clients referred to me. In February 2006, he had been waiting 17 months for an appointment. I spent the first session mostly just getting the above sequence of information and details.

When I started to see him he was effectively disabled and needed some daily care. He said that he was sleeping very badly. He stated that his mobility was reasonable between 11am and 3pm and that he tried to walk every day. He has a neighbour who comes in as a 'carer' and Colin gives him some money regularly from his small pension, disability allowance, incapacity benefit, etc. to help him around the house, clean, cook, etc. His BDI score was 44/63 and his BAI score was 34/63. I rated him at about 40 on the Global Assessment of Functioning (GAF) Scale: *Some impairment reality testing or communication OR major impairment in several areas.*

During the session I noticed some tremors and spasticity in his hands and remembered reading something about Parkinson's disease many years ago in a Reader's Digest article. One sufferer had written how she had improved (or maintained) the physical strength in her hands by scrunching up sheets of newspaper using just one hand at a time. So, right at the end of the first session, I suggested that he try this exercise as some sort of homework. We also arranged for him to get a taxi to and from the sessions at the department's expense as the hospital was some considerable distance (about 8-10 miles) from where he lived, involving at least two buses and a half-mile walk: well beyond his physical capabilities.

Given the two-day per week contract, a case-load of about 30+ clients, the 6-month contract and the system of making and arranging appointments in the department, sessions at 2 to 3 week intervals seemed an appropriate way of working.

In the second session, three weeks later, he reported that the first session had really given him some hope. He very much enjoyed doing the newspaper crumpling exercise. He also reported that he was not gambling a lot at that time: "just a few pounds here and there." Several people in the bookies apparently owed him bits and pieces of money, totalling about £300. I suggested that he stop lending these 'mates' any more money, and that he stayed away from the bookies. So we discussed other ways of him getting out and meeting people. He talked about his current medication for Parkinson's: he was being given a new tablet to try to help his mobility. He had just received a letter as a professional medical opinion saying the gambling addiction was a side effect of the medication he had been on, and wondered whether he could re-instate his claim

against the drug company. We also discussed several ways in which he could improve his sleep pattern.

A fortnight later, in the third session, I suggested that he might benefit from a computer CBT programme called “Beating the Blues” that was available in the department. He liked the idea and agreed to this. He had been doing a vocational computer course at the local Day Centre. The “Beating the Blues” programme would be for 8 weekly sessions, and so I suggested that I would continue having sessions with him at about 2-3 week intervals as well, following directly on to one of these programme sessions.

He reported that had not got his sleep pattern worked out yet and we discussed the benefits of a siesta to ‘top up’ any sleep deficit: quite an alien innovation in central Scotland. We also discussed his gambling and he told me he still had a telephone account with the bookies. He reported that he had just won £100 on the Grand National and he said he was going to give some to his carer and they were also going to take his mum out for a meal. I replied that that sounded like a very good idea and also I suggested that he close this bookie’s account and transfer any balance to his bank account. He did not have any credit cards. We spent some time discussing his other debts; the money people owed him and his attitude towards them. He said that he felt he would like to write all these latter amounts off and that he was quite happy to be made bankrupt, if anyone actually forced this situation on him. The Council debt advisor had seemingly got the main creditors off his back. There was another complicated court case that he had been involved in and he felt someone still owed him about £2,500 from this, but as we discussed this, he decided not to continue with the case as he did not want any further stress. This was not due to any suggestion of mine. We also discussed the lack of contact with his daughter and grandchildren. In the session, he wrote a short letter trying to re-establish contact with them and we put it in an envelope so that he could deliver it on his way home in the taxi.

In the next session, he was quite enthusiastic. He had enjoyed his first two “Beating the Blues” sessions, which took about 45 minutes each: I saw him for the fourth counselling session immediately after his second BTB session. He said that hadn’t managed to deliver the letter to his daughter after the last session with me as the taxi driver had been in a hurry, but he would do so when he felt right about it. He reported that his sleep pattern was still very disturbed, with him going to bed at about 2am and then waking at 7 am. The physical numbness he felt from the Parkinson’s made lying in bed quite uncomfortable. In the session, I taught him a simplified version of the Autogenic Therapy relaxation technique³ and we again focussed on a few simple techniques to improve his sleep pattern. He said he was doing well with his hand exercises, scrunching up newspapers. He had closed his account with the bookies and we discussed whether he could even start to save the amount that he had been spending on his gambling. One of his neighbours kept several dogs and other pets and he had started to exercise one or two of these for her. He enjoyed the social contact with this neighbour and her husband, and also enjoyed helping her to look after the animals.

In the fifth session, he reported that he had now had four BTB sessions and they were going very well. He especially mentioned that he was enjoying changing his thought patterns from negative to positive ones. He had posted the letter to his daughter and then seen her: she had stopped her car and given him her new telephone number and taken his. There had then been a breakdown in communications as her phone didn’t accept calls from any unlisted numbers. I felt that his mood was definitely improving, and so were his insights about himself. He said: *“I am my own worst critic – a perfectionist.”* We then discussed the more pragmatic concept of being “Good Enough”. We looked at some exercises he could do in his chair, as his balance was, by now, getting a little wobbly. He said that his younger sister had recently phoned him. She had always been jealous of him (for some reason) and maintained the antagonism, even though she had managed for her daughter to get their mother’s house when their mother had moved into a home.

He didn't really welcome this call, especially when she told him he hadn't really got Parkinson's and that she thought he had something else. But it was another family connection, and he seemed to be somewhat pleased about that.

At no time did we explore the complicated dynamics and relationships in his family of origin. That felt too remote; too chronic; and not relevant to his present day situation, which had more than enough material to work on. Neither did we ever discuss, in any depth, the bitterness that he felt towards his ex-wife, nor towards all those other people that he felt had taken advantage of his generosity. He had indicated an ambivalence here in that he seemed partly to be hanging on to the bitterness (as a form of self-justification for being 'wronged') and partly wanting to get rid of all these past debts, stresses, etc. He was possibly more bitter towards her for alienating his daughter and cutting him off from his grandchildren, but that contact was possibly now becoming restored, so it did not seem appropriate to go further into this.

In the sixth session, by now three months after we had started, he reported that he had been "knocked back a bit" with flu. He was still quite shaky. He had written again to his daughter; got their phone numbers sorted out and had been invited to go to dinner. His paper scrunching was going fine, strengthening his hands. He mentioned (again) that he didn't go to the local Parkinson's group as one person had been really bossy and he felt it was quite cliquey now: he still seemed a bit hurt and bitter about that. Providentially his sleep pattern had improved as a result of him having the flu: he was going to bed now about 12.00, waking at 6.00am, going to the toilet, then going back to sleep for another hour or so. He was also having a nap in the afternoons. We discussed the concept of "Less is More" and him not trying to do too much, not setting himself up for disappointments, and being content with doing just a little and then perhaps doing something else, somewhat spasmodically, rather than trying to do lots and then getting overtired. He had brought a synopsis of his financial situation that had been worked out with the Council Debt Officer, though it was about 2-3 years old. I suggested that he go through his bills etc. possibly with his carer and up-date the figures to see whether he was financially OK now: especially with the income & expenditure figures. I told him of Mr Micawber's maxim⁴ from Dickens' *David Copperfield*, which he liked a lot. He asked for it on paper and I printed out a copy. He later said he had had it framed. I also suggested he explore the possibility of him getting a walking stick with a tripod end (tripod cane) that might give him greater stability. He reported that he had gone out with his carer and his mother and they had had a slap-up meal: his mum had had a steak, he said with pride. She was 92. All this sounded very good progress.

He came into the next session with a tripod cane and he said was really pleased with it. It seemed to help a lot and he said it gave him a lot more confidence. He reported that he now had some new neighbours and they were waking him up at 3 am. He was frightened to complain because they were threatening him – and others in the street. According to him, they dealt in drugs, and there were people shouting in the street outside at all hours. Other people around had complained to the police, but there was very little response. The effects of the Parkinson's disease seemed much worse this session. His involuntary movements were much more exaggerated, but this (he said) was due to the new medication. He had seen his doctor and got an appointment to the Movement Disorder Clinic to get his medication changed: they were going to try him on 'patches'. He also said that he had had a meal with his daughter and grandchildren, and then seen them again, and had taken the children out, and he felt that things were now much better in that area. We discussed his other finances a little and he was again of the opinion that he was best shot of all these old issues, debts, court cases, disputes with his ex-wife about the windows, unit trusts and whatever. *"I am going to write them all off, and if they make me bankrupt, so what!"* The remaining problem seemed to be his housing situation: he had already wanted to move as he was increasingly unable to manage the stairs up to his flat and the new "neighbours from hell" confirmed that decision. He wanted to get his GP to write a letter to the Housing Association and get his 'points' upped on the grounds of physical necessity.

By the next session he had finished his 8-session “Beating the Blues” programme and had had his follow-up session. He said: *“It was great! Everyone should do this. It really helped with my positive thinking.”* He was going to change his medication in about 3 weeks and had already been taken off the previous medication that was making him very twitchy. His sleep pattern was still being disturbed by the neighbours: the police had been called several times; the drug dealing was going on; in the hot weather, he said they walked around naked with the windows open and curtains not drawn; they were always shouting at their children; the complaints were endless. All this was causing him considerable agitation and distress, he said. He really wanted to move, or have them moved. He had got a letter from his GP and I added in with a letter from myself, stating how the disturbances were detrimental to his mental and physical health. He had seen his grandchildren again and that contact was going well: he had taken them to a super-playground, where they could have a great time and be supervised, and he had stayed with the youngest one. He was being careful not to do too much. He reported that he had given up trying to get a grant for a visit to a specialist and would pay the travel costs of this himself. There was still a bit more work needed to do on his finances with accurate up-to-date figures. He was thinking of going to a different Parkinson’s group as soon as he got his Travel Pass. Finally the really good news was that he had met with his ex-wife and she had admitted, with his daughter present, that she had been unreasonable towards him and had even lied about some things. They had made up and he’d forgiven her, and written off that debt for the windows. He was feeling a lot better and he felt the depression had lifted. At this point I decided to give him another BDI and BAI assessment as well. His BDI had dropped to 8/63, well within “normal” levels; and his BAI score was 24/63. This was probably artificially a little high as it is based on physical symptoms that would also be affected by the Parkinson’s disease; and anxiety was still present because of the situation with the neighbours and lack of sleep. However the drop from 44 to 8 on the BDI scale was very impressive.

In the final (ninth) session, five months after he started, he was noticeably physically frailer and shakier. He reported that occasionally a neighbour had to help carry him upstairs to his flat. He had seen his doctor and was going to be put on the ‘patches’ next week: he hoped it would help. However his eyesight was also deteriorating: he was seeing five of everything, which was worrying him considerably. Apparently this is a side effect of the Parkinson’s disease. He was seeing an optician the next day and said there was a treatment for this: an injection into the muscles of the eyes. The good news was that the noisy neighbours had been evicted. He still wanted to move house to a downstairs apartment: there was one available, but he had to get his doctor to increase his ‘points’. His ex-wife was being very nice to him now and even wanted him to move back in with her: something that he didn’t want to do. He had had a treatment with a local spiritual healer, which he felt good about, and was going to go again. During the session, he had spontaneously burst into tears and *“let all the bitterness and resentment out”*. He had got his Travel Pass and was going to go to another Parkinson’s Support Group in a nearby town. He said he had also sorted out his current finances with his carer (monthly income to monthly expenditure) and that everything was OK. He had had a credit check and apparently owed only 5 amounts (he didn’t specify the total). The Council debt advisor was following up on these. He talked a little about his ex-wife and how he had been “out of his mind” for three years with unhappiness. He also mentioned that he had been given drugs for depression and for spondylitis, which he didn’t have, and that he had had Parkinson’s all the time, which was undiagnosed. There was a hint of the tendency to get back into the possibility of litigation, so I reminded him of the ‘benefits’ he had experienced in letting go, and suggested that he might not want to get into another situation of stress and anxiety again. He said that he had had a slight panic attack in Tesco’s and been unable to say anything specific: the First Aider then panicked and called an ambulance. We discussed him carrying a card for emergencies with details of his name, address, and contact numbers, illness and medications. Colin said he was overjoyed with his treatment: *“This has changed my life”*. I had to resist his suggestion that he send a bottle of

champagne to my leaving-party. *“Thank you very much, Colin.”* I said, *“But keep your money for yourself and for your grandchildren.”* He was then discharged from the service and appropriate letters written to his GP. Colin gave his written approval for this case history, having been read a first draft. *“If this can help anyone else ... It’s been marvellous for me.”*

Addendum:⁵

Beating the Blues (BtB) is a computer-based Cognitive Behaviour Therapy (CBT) course for mild to moderate anxiety and depression. It helps people to pinpoint and change unhelpful ways of thinking and to learn more effective ways of solving problems. The participants work on the computer by themselves, being met, and signed out by an assistant who also compiles the progress reports and records and monitors the person’s sessions. The course consists of 8 sessions, which take about an hour each to complete. After each session, printouts are provided including; a session summary, assignments to do and a progress report (PR). It is recommended that people complete a session once a week as it gives the person time to work on and think about the assignments given to them. Assignments involve the use of CBT tools such as ‘thought recording’, ‘recognising and challenging negative thoughts’, ‘activity scheduling’, ‘problem solving’, and ‘positive internal and general attributional styles for success. Options for ‘sleep management’, ‘graded exposure’, and ‘task breakdown’ are given. The PR provides information about how the person has been doing over the past week including; a rating of how anxious and how depressed they have been on a scale of 1 to 8 (with 8 indicating the worst they could feel), and whether they have had thoughts of suicide. If a person answers ‘Yes’ to having suicidal thoughts, a rating of how many times during the week they have had such thoughts and the seriousness of the intention to act on the thoughts (with 8 being the most serious intention) is also provided.

Colin was referred to the BtB course by his counsellor/therapist in conjunction with regular one-to-one therapy sessions. When greeted on his first BtB session, he appeared to have very low mood and appeared withdrawn, with minimal conversation and eye-contact. After his first session Colin’s PR revealed very high levels of depression and anxiety, being 6 and 7 out of 8 respectively. It also revealed that he had thoughts of suicide 3 times during the week and that his intention to act on these thoughts was 4 out of 8. This was the only occasion on which he expressed suicidal ideation.

As the course progressed, he became more cheerful and talkative before and after the computer sessions, saying how much he was enjoying the course and how much benefit he was receiving from working with the CBT tools. By his 8th session, Colin’s depression level had dropped from 6 to 2 and his anxiety level from 7 to 2. During the follow-up session on completion of the course, he said that he had found the course ‘extremely useful’ and said he would ‘recommend it to anyone’ as he felt it was ‘expertly done’. It was great to see him smile!

Summary:

For several years, CBT has been the ‘therapy of choice’ for the NHS, mainly because of the body of research evidence, despite the fact that several meta-studies show no appreciable difference between psychotherapeutic methods. Recently CBT is being complemented by adjuncts such as EMDR and Mindfulness courses. Many (or most) of my colleagues in the NHS privately confess that they do not do ‘just CBT’. It is thus my experience, and my contention, that CBT, by itself, is not enough to deal with the complexity of some people’s problems. I hope that this case history illustrates this and the different levels of intervention, support, and perceptions involved.

It is also clear from several research studies that computer-based CBT is reasonably effective.⁶ Does this mean that we should replace CBT psychologists with computers? No, of course not! But it does mean that psychologists and CBT therapists could be freed up to explore other

aspects of their patients' lives, and use other interventions when this sort of parallel therapy is available. My last point is that this case indicates an extremely efficient use of time and resources and there are indications that this dual usage was of considerable benefit to the patient.

(Word count: 4,202)

References:

¹ Colin's identity has been protected: names and locations have been changed and he has seen a draft of this article and has approved it for publication.

² Whilst this is quite common a length of time for a waiting list in Clinical Psychology departments in this area, it is also considered as totally unacceptable. In this particular department, firstly I was being employed for 6 months to help get the waiting list down, and we were also moving towards a 'triage' system with a 'stepped care' series of interventions that would hopefully eliminate the 'waiting' part of the waiting list considerably.

³ I teach the principles of this relaxation method to a lot of my clients, as it is simple and can be done anywhere, though I make it clear that I am not a proper Autogenic Therapy teacher and I give them information about how to contact a registered teacher if they feel that they need further help.

⁴ "Income twenty pounds; expenditure nineteen pounds, nineteen shillings and sixpence; result happiness. Income twenty pounds; expenditure twenty pounds, eight shillings and sixpence; result misery."

⁵ This section is written by the Assistant Psychologist who worked with the patient on the "Beating the Blues" course.

⁶ Research Studies on "Beating the Blues" :

Proudfoot, J., Ryden, C., Everitt, B., et al (2005) Clinical efficacy of computerised cognitive-behavioural therapy for anxiety and depression in primary care: randomised controlled trial. *British Journal of Psychiatry*, 185, 46 -54.

Proudfoot, J., Goldberg, D., Mann, A. et al (2003) Computerized, interactive, multimedia cognitive-behavioural program for anxiety and depression in general practice. *Psychological Medicine* 33(2), 217-227.