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Case Report Open Access

Clinical Intervention with Long Term Anxiety and Depression with a Male Client in a Therapy Resistant Work Culture: Case Study

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Abstract

The present article deals with a case study of a clinical intervention of a male client with long term anxiety and depression in a therapy resistant work culture which effectively deterred self-care, self-awareness and instead encouraged maladaptive coping mechanisms. It explains how a combination of self-assessment, psycho-education and training in self-help and self-analysis methods enabled him to reverse the maladaptive mechanisms and gradually introduce holistic and healthy self-care methods.

Keywords: Mindfulness; Psycho-education; CBASP; MBCT; CBT; Analysis; Culture; Institutionalised; Prison Service; Depression; Anxiety

Introduction

The case in question concerned a male client near retirement age who spent his entire working life in the UK Prison Service as a Prison Officer. He presented having initially enquired via his long term wife. "John" (not his real name) presented as a reluctant client, and not someone who felt comfortable with the culture of talking therapies. He disclosed almost immediately that he would not have attended if it were not for the dual factors of being "brought along" by his wife, and "being desperate".

Case Presentation

John began work for the Prison Service straight out of high school, and initially worked away in accommodation attached to a major Scottish prison in conditions only slightly less restrictive and isolating than the inmates he and his colleagues were there to supervise. The culture was totally immersive and John stated openly that he and his fellow officers were well aware of being institutionalised themselves. Within this culture there was a strong "macho" culture of drink, suppression and very definitely not expressing feelings. Depression was referred to as "the madness".

Many decades later, John had worked at various categories (security levels) of prison and was now at a women only prison with a small prison population characterised by severe mental health and drug abuse patterns. This further encouraged the staff to consider feelings and mental health as something that effected inmates as a matter of course, but could not be acknowledged within the staff group. One enterprising officer purchased a trophy cup, decorated it, and then awarded it to any fellow officer who displayed any symptoms of "the madness". The "madness cup" was passed around as half acknowledgement, half insult and caused furious attempts by the recipient to suppress and deny any further symptoms as rapidly as possible, which would trigger the phrase "the cup has passed from me".

For over a decade John had managed to hide his mental health issues, and was medicated long term with a fairly high dosage of lithium, as well as taking anti-depressant medication and occasionally sleeping pills. Because of the dangers of lithium he rarely consumed alcohol. Clinically he displayed major displays of what he described as depression (confirmed by psychiatric diagnosis) in a cycle which came around once every few years. He joked that the family considered the Olympic games a bad omen since they came around invariably with a similar frequency to his severe episodes. During this episodes John would be bed ridden, almost entirely non-functional and seriously considering and planning suicide. Function in terms of eating, dressing, washing, communicating and other self-care would all almost entirely cease without extensive verbal prompting and support from his wife. On one occasionally John was admitted to a psychiatric ward for a period of around a month.

After taking a case history over two one-hour sessions, and with John's permission taking his wife's observations as well, it became clear that John had the distinct impression that his episodes were sudden and without warning, and were totally impossible to combat. This however did not match clues given by his wife and his work culture which indicated early on that the desire to ignore and repress emotion was causing John to entirely miss normal variation in mood, triggers and contributions to his mental health episodes, and variance which clearly presented as severe anxiety in between and at the point of his episodes. This observation was something John struggled to accept and therefore he and his wife were provided with assessment forms to record daily mood and fluctuation over a two week period.

Discussion

After two weeks John returned with both his forms and the set of forms completed separately by his wife, which as per instruction he had not read. To John's credit, the process of actually monitoring forms enabled him to reveal a little of his daily fluctuation and he was able to acknowledge feelings of anxiety, trepidation and panic, although he was not immediately able to link these to triggers or causes. His wife's forms initially confused him and then caused him great interest, since they indicated almost invariably that mood change was visible before he noticed a change in the way he felt himself. From this John was able to accept that rather than his mood states being totally unpredictable and without warning, actually there were warning signs, only he was not skilled at spotting them.

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We discussed the concept of early warning indicators, and began to discuss some of the signs that his wife had spotted, such as pacing, disturbed sleep and irritation, and some other examples that John began to speculate about, such as becoming socially avoidant. John was able to extrapolate that on a number of occasions in the weeks coming up to depressive episodes, he had cancelled social events, such as watching sports, which usually were a great source of fun and enjoyment to him. He then made a leap of understanding, realising that he was deliberately ignoring these signs, partly because of learnt behaviour through his profession, and partly because of an ingrained belief that if he acknowledged a mood change, he would be "inviting the depression in". We worked on this belief and were able to track a number of occasions when his mood changed, but he was able to recover, helping him to dispel the belief that any acknowledgement of mood would lead to total depressive collapse. John enjoyed the comic analogy of "doing a Nelson" (at a famous naval battle Admiral Nelson put the telescope to his blind eye and claimed he saw no order to retreat). As with Nelson, who kept going but ended up dead, so John kept going but continued down a slippery slope of saving up trouble until the depression overwhelmed him. To my amusement when I asked John what he thought he might consider trying, and whether he could come up with a symbolic expression, he expressed a desire to stick the telescope somewhere quite explicit in the depression instead. This injected symbolism, action and humour in the planning and left John feeling determined and amused. At this point we discussed how he should maintain that enthusiasm, while remembering that battling depression and anxiety was more like a boxing match where you might have the odd tough round, than a single one off result.

Having introduced new self-awareness through self-assessment and discussion, John now had a better understanding of the patterns under the surface. Over subsequent weeks he was able to further develop his "early warning" awareness. He also began searching for key points where he could apply change to disrupt the previous pattern of anxiety and depression worsening, looking for those key moments where tools such as mindfulness and CBT could be applied [1-4] showed reductions of 58% in anxiety (GAD-7), 40% in stress (PSS) and 57% in depression(PHQ-9) using mindfulness. In the UK the National Institute for Clinical Excellence (NICE) recommend CBT and other cognitive behavious based psychological therapies as an intervention for conditions including depression. I provided John with a variety of mindfulness self-help sheets covering mindfulness practices such as short breathing exercises, mindful drinking of tea, mindful washing of hands etc. so that he would be able to introduce deliberate pauses in his routine. John found these extremely helpful, and together with body scanning methods John was able to use these to monitor his physical and emotional stress and tension levels, spotting any increases earlier and earlier. John began introducing humour, short breathing routines and stretching for immediate response, and cycling and meditation for "end of the day" self-help. John was also open to self-analysis, and we practised moving from "participant" to "observer", using this as a way to look at what was "going on in the room". John rapidly realised that by "observing" interactions with colleagues he could identify various types of conversation which were causing him to become defensive, stressed or passive. Once he identified these, he began trying new reactions, choosing to adopt different posture, methods of reply and reactions. Among these was a new found determination to no longer always say "yes" and resent it later. John enjoyed employing the concept borrowed from CBASP (Cognitive Behavioural Analysis system of Psychotherapy) of comparing his options in interpersonal interactions and considering actual versus desired outcomes.

Possibly the most eye opening development for John was when he extended the "observer" method to not only observing his needs and well-being, but also those of his colleagues. Quite rapidly John found that he was able to identify signs of stress and anxiety in colleagues and he was able to understand their behaviours more easily as a result, no longer assuming himself to be at fault. This had the dual benefit of making a more supportive colleague which soon became reciprocal, and also enabling him to recognise that he had been very centric in the past. As with many clients with long term depression and or anxiety, John had learnt that everything happened either to him, or because he was at fault. Recognising the more complex interactions in his environment rapidly freed him from this self-destructive set of assumptions.

John now attends approximately once every two months for a "check-up" where the discussion focuses on his experiences in the intervening time and any adjustments needed to his self-management as a result. John reports having "headed off" a major depressive episode, experiencing instead a "tricky couple of weeks" which he reflected on as being tough, a bit restrictive, but throughout which he continued to eat, work and function, albeit at a reduced level. This dramatically affected John, who is now adamant that he no longer perceives the depression as "all powerful". He has managed to inhabit the middle ground where he can accept that there will be tough days, even weeks where he will be at reduced capacity, but by being proactive early on he is able to prevent major episodes causing complete loss of function. On a shorter term basis, John reports enjoying being "kind to himself", allowing himself a quiet self-nurturing evening, or a tasty take out meal with his wife if he is "feeling blue", and still expresses amazement at how being kind can actually help prevent the build-up of anxiety and depression. Meanwhile his psychiatrist is happy with his progress and is gradually reducing his medication, with Lithium nearly fully withdrawn.

Conclusion

In conclusion, John had been immersed in a work based culture which effectively deterred self-care, self-awareness and instead encouraged maladaptive coping mechanisms. A combination of self-assessment, psycho-education and training in self-help and self-analysis methods enabled John to reverse the maladaptive mechanisms and gradually introduce holistic and healthy self-care methods. It would be naive to offer a prognosis of a future completely free of distress, but John has already been able to report substantial reduction of day to day anxiety and stress, and a far reduced impact from the episodes that used to completely disable him.

The above case is typical of a model of work that I employ with high functioning but repressed clients. Although in John's case I employed mindfulness based analysis of thoughts in a MBCT type process, and taught John to do the same, with other clients CBASP or CBT based methods have been effective. CBASP has been showed in trials in both the USA and UK to be effective in long term treatment resistant cases of depression in conjunction with medication [1-4]. Success rates of 85% in the USA and 60% (30% improvement, 30% remission) in the UK. In those cases where culture or philosophy of the client is more discussion based, psychodynamic methods of discussing patterns of emotions and experiences, sometimes focusing on language in a Lacanian type manner can introduce a similar although methodologically different method of "skilling up" the client in self-reflection. Whatever the core therapy method employed, the combination of increased self-awareness combined with a strong element of psycho-education is in my experience both effective and enjoyable for the client who takes a very active role in their progress.

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