



Notes from the Field: Continuing Education for Social Workers on Autism, Intellectual Disability, and Sexual Health

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Abstract

This work reflects upon personal practice in training using Cognitive Behavioural Therapy in a mental health crisis house while looking after and being involved in aspects of social work in the lives of service users who were facing mental distress. This paper reviews my practice with one service user who had schizophrenia and reflects upon the honing of social work counseling skills and the usefulness of obtaining service user feedback for the iterative process of cyclical assess, plan, and review. This reviews my use of counseling skills through a humanistic counseling framework of unconditional positive regard in approach while using Cognitive Behavioural Therapy. The originality and value of this work is that the specific can illumine the general and has tentative, yet beneficial, implications for generalizability of the development of practice.

Introduction

This paper addresses work undertaken at The Beeches mental health crisis house (not actual name) involving a client, David (pseudonym), and identifying how the fundamental principles of human rights and equality have underpinned my practice, including respectful partnerships with service users and carers. Service users who were admitted were experiencing mental distress, referred as a preventative measure to avoid voluntary or compulsory admission into hospital or a place of safety (136 room) under the Mental Health Act (1983; 2007), sections 2 and 3.

While on duty, a referral came into The Beeches; this was David, diagnosed with schizophrenia. Schizophrenia is a significant long-term mental health condition. The psychological symptoms include hallucinations (hearing or seeing things which are not substantiated), delusions (unfounded, unusual beliefs based upon fantasy and not reality, often contradicting the

evidence), confused thoughts, and alteration of behaviour. David was suffering with thoughts that he was being followed and pursued by people who wanted to harm him. He appeared to be convinced of this and was scared that they would catch up with him and overtake him. David had been given medication (Risperdal) for his condition and takes it intermittently, as he believes that he is being poisoned by the doctors and psychiatrists he is currently under. His family reported some improvement in his condition while taking the medication, but a significant decline in his mental health and general wellbeing when he refuses to take it. While visiting, I spoke with an Approved Mental Health Professional (AMPH) about reviewing the case for a deprivation of liberty (DOLs) under the Mental Capacity Act (2005); discussion was made about enforcing medication as a chemical control to enhance mood and manage paranoia. This dilemma may have led to ‘sectioning’, section 2 under the Mental Health Act (1983; 2007). However, it was agreed that after leaving The Beeches the case would be reviewed by the Crisis Resolution and Home Treatment team (CRHT).

While working with David I had to exercise anti-oppressive practice and behave in a way dedicated to helping him. David expressed some worldviews I disagreed with, and I was conscious that I did not allow my facial expressions, tone of voice, or behaviour to be affected by his remarks. This would have hampered the interactions I had with David and may have prevented this type of therapeutic intervention from occurring. By respecting his values, individual rights, and differences, I sought to negate oppression or stigmatization, while self-reflecting upon my own value base. A dilemma I faced was being unsure as to whether these views expressed by David were firmly held, entrenched views or a by-product of not feeling well. A point of development is how to manage selfhood and continue to manifest excellent practice, something

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I later shared in supervision. As a result, I practiced how to respond to a simulated experience. This proved helpful, and I was able to develop my questioning skills for use with other clients. I therefore sought to adopt the 'skilled helper' model (Riggall, 2012), applying empathetic communicative skills to place the service user at the center of decision making processes.

When asking David some questions, he presented symptoms of confusion and paranoia, suggesting that the 'mind control' he was experiencing was a direct attack upon him, with delusions of being controlled in the mind or body by an exterior source. Moreover, Beck and Rector (2011) write that patients can perceive themselves as the passive objects of others' influence. As I listened I sought to ascertain the nuances of his sentiments, and I asked him how he knew that 'they' were attacking him. In this I sought to unpick how he was feeling and try to work toward a more rational explanation for his thoughts. By addressing his thinking, I was desirous to help him to look at all the factors contributing to how he was feeling. I then used a 360-degree tool adapted from a teaching model used on a middle management course (Rao & Rao, 2014). This tool analyses different perspectives/angles of evidence, similar to the concept of methodological triangulation used within different disciplines of social research (Altrichter et al., 2009). The rationale of this was to help David to articulate how he was feeling about 'the mind control' and forces that were 'out to get him'. By gaining his perspective, I was able to begin to unravel some of the complex web of ideas he held. The perspective of others was valuable, as it made him think about the possibility that they may not have the same viewpoint as he did. The detachment of his thoughts and others (possible reality) helped form a wedge between reality and fiction. Thus, this was useful as it helped me to decide the type of intervention required.

I postulated that Rogerian, based upon Carl Roger's humanistic therapy (Rogers, 1951), may not be helpful when working with David. This is because when in mental distress, he would be

unlikely to formulate rational thoughts about how he might act within the situation. Rather than being a psychodynamic Freudian analysis of past events, Cognitive Behavioural Therapy (CBT) draws upon techniques adopted from behaviourism; cognitive and social learning theories. I therefore sought to use the evidence base of CBT to help him solve his problems, as we looked at the current cognitive perspectives he was having and how these might be altered to benefit his mental health and promote wellbeing. However, the theoretical tenets of CBT may be disputed on the basis that those in distress are unlikely to be able to engage with this type of therapy. On the other hand, CBT is heralded for its success in helping clients with depression and schizophrenia to manage their condition and re-align their thought processes, allowing detachment of selfhood from the 'disorder' or 'condition' and proving to be more positive than, for example, humanistic intervention or the use of medication. Having evaluated the benefits and limitations of this and other approaches, on the premise that David's thoughts and beliefs are images and attitudes shaped by current cognition and thought processes, I adopted CBT. The self-talk model, differing from humanistic notions, enforced by challenging irrational views, is a way of locating and reframing unhelpful beliefs and habits (Winston & Seif, 2017). The consequential ABC system (Activating and event, belief and consequence) assumes that humans work within an activating event, a belief and a consequence. Ellis's schema believed that the ABC model of which includes disputing beliefs, replacing them with effective rational ones, and describing the feelings, would help a person overcome their difficulties (Thompson, 2018). Moreover, the service user / client explains the situation which causes negative emotional arousal (activating), writes down their thoughts (beliefs) and explains the interconnectedness of the beliefs with the outcomes of feelings such as anger, sorrow, distress and so forth (consequences). Challenges are made at each stage which help the person recognise how their thinking impacts upon the feelings they are having and the outcome of the situation.

The usage of crisis intervention was applied in an attempt to manage the immediate issues, which was of high importance for helping David out of his present state of mind. This theory is, however, based upon the flawed pre-supposition that we live in a state of continual stability and have the inner resources (resilience and fortitude) to effectively manage times of turbulence (Barry, 2018). Although crises do provide opportunities to manifest resilience, they may not help a person to do so, as they may draw the person to crisis or depression. The use of this theory is that I was able to help him manage some issues connected to his understanding of the transition of events occurring in his life, and the approach sat appropriately alongside the use of CBT, which is time managed and oriented. The usefulness of a time-specific and task-focused approach was that it helped both him and I to be focused upon resolving the issues he was facing, thus preventing 'idle rambling'. However, a limitation of this approach was that it did not uncover the issues David faced, contained in his notes, about early childhood abuse and trauma. These may have been helpful to analyze using a psychodynamic approach, which on reflection may be useful for work in a similar situation in future.

Although David's feedback to me was that 'this is useful', I could not help but feel that there were still issues of pertinence that may benefit from exploration if he felt able to do so. Sitting in the conservatory area of the center, we took a piece of large paper; I asked him to put his feelings down on paper, and he did so. This was helpful as he was given the opportunity to express himself, which he seemed to enjoy; consequently, his body language became warmer and he started to laugh and smile on occasions. As a trainee social worker, this idea inspired me to use it with other clients, which I also did, and one client said how helpful it was having it 'all there' (everything being laid out on paper helped him see and work through his issues). This was important as the development of rapport with clients is a fundamental feature of good practice, yielding benefits like further disclosure. This is exactly what occurred. David started to make the

transition between his thinking and what others may think. By this he was able to grasp a greater sense of reality; he appeared more relieved to think that other people may not wish to harm him and that this thinking was part of his illness.

Next, I sought to ask him how he perceived the future; I asked him to explain what would be at point B on a visible line marked A and B. A indicated where he was now, and B was futuristic. I asked this to highlight how he may like to be in the future. Afterwards, we examined how he may get from A to B. By doing these things I sought to help him develop perspective upon the situation, helping him to develop his own goals for the future. This proved beneficial, and with some refinement, we were able to generate some clear, tangible goals with objectives and success criteria; this was important for ascertaining whether the objectives had been achieved and to what extent. The use of SMART (small, measurable, achievable, realistic, and time-oriented) goals was laudable in drilling down issues and working towards solutions which could be measured (Prymachuk, 2011). Consequently, David expressed that 'no one had ever used these techniques on me' and he said he felt that by having 'it all down there' he could work towards a solution. This seemed to build upon the basic underlying principles of CBT usage, namely changing the mindset and behaviours (Edelman, 2012).

I used the social work tool of the assessment, planning, intervention and review and evaluation (ASPIRE) model to generate action and to review progress (Haslam et al., 2014). While directed by ASPIRE, from my conversations with him, he explained that he sometimes had paranoid thoughts and was able to, on occasions, recognize the difference between rational and irrational thoughts. However, it did appear that he remained unconvinced of the benefits of his medication. I used the assessment part of the ASPIRE to elicit this, triangulating data from the referral team, the pertinent notes, and the sentiments of his parents. I took the perspective of asking him what medication was used for and why people were given medication. However, when it became more personal, that the medication was for him and the

doctors had his best interests at heart, he refused to comply. At this point I suggested a break, as a point of judgment. Rutter and Brown (2012) write that "professional judgement is now being promoted as a crucial aspect of social work expertise" (p.6). After refreshments, we spoke generally, and, although reluctantly, he said that he would take his tablets for the duration of his stay. We then agreed that on the day he was discharged, if he felt no better, then the medication had not worked, but if it had, he would consider taking it after his discharge. I felt that this was a significant breakthrough, achieved by use of CBT techniques within the ASPIRE model, although I need, as a developmental point, further opportunities to critically compare and contrast its usage with other clients and in different contexts.

On his discharge we reviewed the situation; after lengthy discussion, he admitted to feeling somewhat better because of his stay at The Beeches. From analyzing his mood diary (journal) we looked at his 'ups and downs'; the more 'ups' were later in the stay and seemed to indicate the effect of taking his medication. I asked him whether this would be a regular thing that he did; David responded in the affirmative. This intervention proved to be successful. We looked at how to continue the use of medication even if he felt paranoid, and he agreed that the paranoia got worse when the effects of his medication wore off or when he had refused to take his medication or inadvertently left off taking his tablets. Therefore, part of his recovery was that his parents and girlfriend would remind him to take his medication and that even if he felt anxious he would do so. We also spoke about using 'Shine' (a localized Mental Health Support Network) and receiving text messages of support and words of affirmation on a weekly or daily basis. His partner was going to set this up, and when leaving the center both agreed to this action. On his discharge, he was much calmer and rational, with a clear vision of the future and a strong commitment to take his medication even when he did not feel like it.

On reflection, these successes can be attributed to the careful, judicious use of CBT within the

ASPIRE framework and careful use of crisis intervention as well as the positive rapport I generated with him. As a result of this work with David I was asked to be involved in formulating some staff training and produce materials summarizing the outcomes of good practice. I drew upon my research experiences, my work with David, and Doctoral level work I have previously undertaken in informing staff about the nature of a range of conditions, including schizophrenia. In so doing I was able to use my experiences to help train, mentor, and develop other practitioners, taking responsibility for both my learning and the learning development of others and identifying specific learning needs and targets for enhancing my practice. Moreover, by storying these experiences, it is anticipated that this will be of benefit to other practitioners and help them hone skills and develop practice.

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