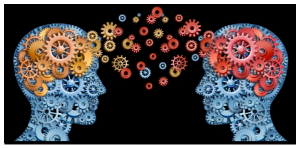
# PSY2016

## Counselling & Psychological Therapies

## Exam Structure & Preparation



# Exam Structure

Two Hours (although you should only need one)

- 5 short questions that will require you to:

1. Complete a formulation for Winnie's case. *(10 marks)*
2. Identify three thinking biases. *(5 marks)*
3. Outline a CBT treatment plan for Winnie. *(15 marks)*
4. What neurobiological changes would you expect as a consequences of your CBT treatment plan for Winnie (citing research support).*(10 marks)*
5. Discuss the likely character of autobiographical memory for Winnie (citing research support).*(10 marks)*

# Winnie Case Details

- 'Winnie' is a 52-year-old widow. Her husband died of a heart attack seven years ago and she has two adult daughters. She recently returned to her job as a nursery nurse, having previously been signed off work with depression. Her parents and siblings live 50 miles away, and her late husband's family live locally.

- Winnie describes herself as 'always being extremely shy and anxious'. After her husband's death, Winnie coped emotionally and practically by increasing her workload but, because of organisational changes, this workload was reduced suddenly. When Winnie was accused of a work-related incident she became anxious and made negative predictions. Despite being cleared of the accusation, she did not receive an apology from her manager or from others involved. After this incident, Winnie became increasingly tired and 'down'.

# Winnie

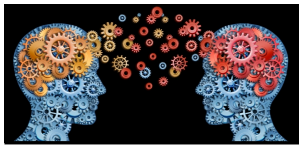
- She referred herself to the Improving Access to Psychological Therapies (IAPT) service. At this stage, Winnie was experiencing tearfulness, loss of interest, irritation, exhaustion, disrupted sleep, poor appetite and increased self-critical thoughts. She was finding it hard to manage daily tasks such as shopping, and had cut down on her social activities. Of difficulties reported, the most troublesome were poor memory, lack of concentration, confusion and slowness.

- She had one previous episode of depression following hysterectomy, had received antidepressants and wore patches to regulate hormones. Winnie said that when experiencing this episode of depression she found her mood improved when she 'got busy' because she was someone 'who was used to coping and juggling everything'. She had never received any form of talking therapy.

# Winnie

- Early experience contributed to Winnie's belief that there was something wrong with her; she was the 'odd one out' at home, a shy child in an energetic, sporty family. Being the eldest child, her parents had expectations that she would be the 'leader' among her siblings but she was uncomfortable with this expectation.

- Family members and her peers teased her for being 'different' and she developed a sense of being odd and unacceptable. Continued sexual abuse by her father compounded these beliefs. When she tried to say no, he told her she was selfish for depriving him. She described her father as 'critical and demeaning' and her mother as 'giving and spiritual'. Winnie craved approval and, because a family motto was 'keeping up appearances', she never told anyone about the abuse. This persisted until she married her husband and left home.



# Winnie

- These experiences contributed to the development of negative core beliefs, for example, believing that she should always put others first, that she must be sympathetic or others will reject her, and that she should always be in control.

- Winnie internalised parental patterns of being giving towards others like her mother but critical of herself, like her father was of her. Life was only bearable if she lived according to her rules and assumptions but, when they ceased to protect her during a trigger event, her core beliefs were activated. She became more vulnerable when her workload decreased because she used work to define her sense of worth and bury her grief.

# Winnie

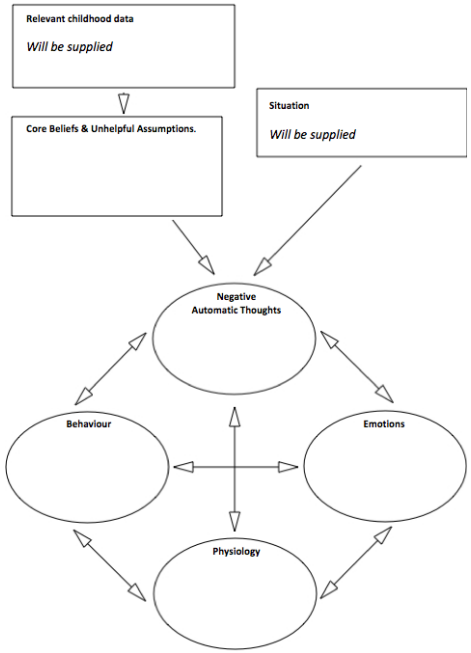
Winnie's day-to-day difficulties are illustrated in the following example. While walking with a friend on what had been Winnie's wedding anniversary, Winnie learned that her friend's partner had been diagnosed with cancer three months previously.

# 1. Formulation

- Also referred to as 'conceptualisation'
- The formulation aims to supply a psychological explanation of the client's problems
- The formulation should help to plan counselling strategy.
- The formulation should be helpful to both counsellor/therapist and client
- A formulation may be revised as counselling progresses

# 1. Formulation

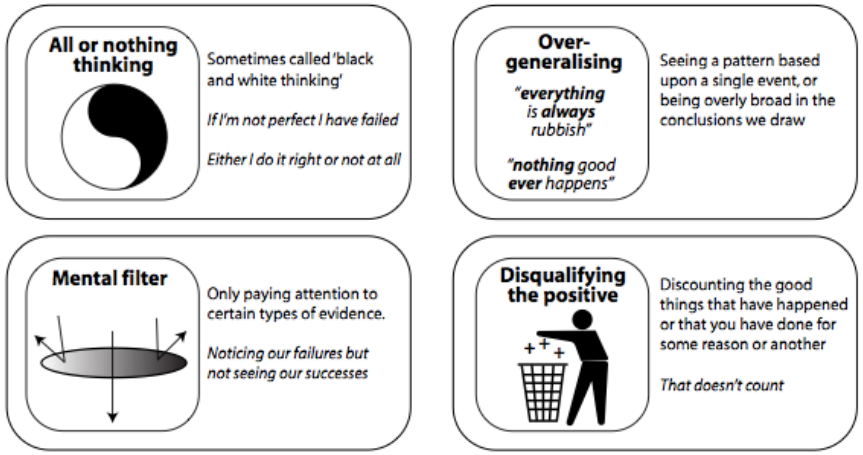
- In the exam you will be asked to identity:
  - Core beliefs
  - Negative Automatic Thoughts
  - Emotions
  - Physiology
  - Behaviours




# 2. Thinking Biases

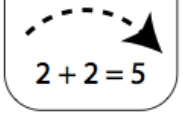
- Patterns of thinking that lead to unhelpful
  - Interpretations of events
  - Expectations of self and/or others

## Unhelpful Thinking Styles



# Unhelpful Thinking Styles

**Jumping to conclusions**




There are two key types of jumping to conclusions:
- **Mind reading** (imagining we know what others are thinking)
- **Fortune telling** (predicting the future)

**Magnification (catastrophising) & minimisation**

Blowing things out of proportion (catastrophising), or inappropriately shrinking something to make it seem less important

**Emotional reasoning**

Assuming that because we feel a certain way what we think must be true.

*I feel embarrassed so I must be an idiot*

**should**

**must**

Using critical words like 'should', 'must', or 'ought' can make us feel guilty, or like we have already failed

If we apply 'shoulds' to other people the result is often frustration

# Unhelpful Thinking Styles

**Labelling**


Assigning labels to oursleves or other people

*I'm a loser*
*I'm completely useless*
*They're such an idiot*

**Personalisation**

**"this is my fault"**

Blaming yourself or taking responsibility for something that wasn't completely your fault. Conversely, blaming other people for something that was your fault.

# 3. Treatment Plan

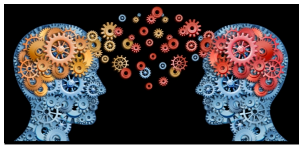
- Establishing therapeutic rapport, reviewing symptoms and providing psycho-education.
- Discussing the influence of thinking on behaviour, physiology and feelings to help Winnie notice relationships between thinking, behaviour and feelings by examining specific experiences.
- Identifying and discriminating emotions

# 3. Treatment Plan

- Monitoring activity level using diary sheets; noticing links between behaviour and mood, withdrawal and avoidance, and balance of pleasurable or achievement-orientated activities.
- Continuing activity monitoring and scheduling using diary sheets.
- Discussing specific thoughts leading to unpleasant emotion. Identifying recurrent or common themes that contribute to formulation.
- Rating NATs and their believability

# 3. Treatment Plan

- Reviewing thoughts, particularly expectations for self and ‘shoulds’ rather than ‘wants’. Identifying rules for living and examining their helpfulness.
- Identifying unhelpful thinking styles that lower mood. Encouraging the client to analyse her thoughts and then step back from them.
- Reviewing alternative explanations for NATs.
- Conducting behavioural experiments to help increase believability of alternative thoughts.



# 3. Treatment Plan

- Considering personal wants or needs rather than thinking in terms of should.
- Analysing self-criticisms with focus on UAs.
- Listing goals with an emphasis on own needs
- and expectations.
- Preventing and managing relapses.
- Considering personal wants or needs rather than thinking in terms of should.
- Analysing self-criticisms with focus on UAs.
- Listing goals with an emphasis on own needs and expectations.
- Preventing and managing relapses.

# Q4. Neurobiological Effects of CBT

- What effect will your CBT intervention have on Winnie’s brain function and structure?
- Key Reading:

  Goldapple, K., Segal, Z., Garson, C. et al. (2004). Modulation of cortical-limbic pathways in major depression: treatment-specific effects of cognitive behavior therapy. *Archives of General Psychiatry*, **61**, 34–41.

- This study used functional magnetic resonance imaging (fMRI) to examine changes in brain activity following CBT.

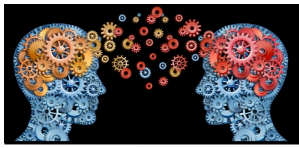
# Q4. Neurobiological Effects of CBT

- Goldapple et al. (2004) showed that following successful CBT:
- Activity increases in *limbic system* structures hippocampus (involved in autobiographical memory) and dorsal cingulate (regulation of emotions).
- Activity decreases in dorsal, ventral, and medial areas of the *frontal cortex*. These regions govern (among other things) self-referential processing and cognitive rumination.

# Q4. Neurobiological Effects of CBT

- Goldapple et al. (2004):
- These findings suggest that successful CBT changes brain activity in a way that allows for better regulation of emotions (limbic system), more positive memories about oneself (limbic system), and reduces the extent to which a person ruminates about their past (frontal cortex).

- In the exam you will need to explain what changes to brain activity occur and why they are important.



# Q5. Overgeneral Memories & Depression

- What autobiographical memory patterns are associated with cases of depression like Winnie's?

- Key Reading: Kuyken, W. (2006). Digging deep into depression. *The Psychologist*, **19**, 278-281.

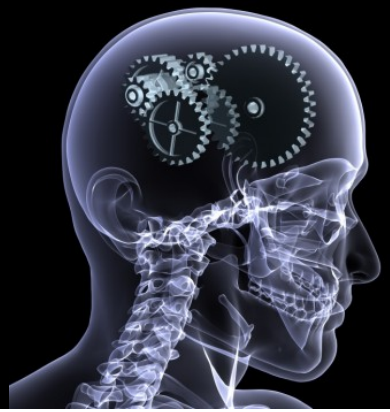
- Overgeneral memories have been linked to risk of developing, and maintenance of depression (e.g. Valentino, 2011; Kuyken, 2006).

- OGMs may develop as a response to trauma and maintain unhelpful beliefs in depressive episodes.

# Autobiographical Memory

"memory for information related to the self"

Brewer, 1986



# Overgeneral Memories & Depression

- Overgeneral autobiographical memories are "memories that do not contain at least one specific detail that identifies an event as a distinct episode." (Valentino, et al. 2012)

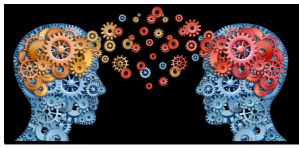
- Overgeneral memories (OGMs) have been linked to risk of developing, and maintenance of depression (e.g. Valentino, 2011; Kuyken, 2006).

- OGMs may develop as a response to trauma and maintain unhelpful beliefs in depressive episodes.

# Case Example: Memory & Depression

Sherry, a 42-year-old married personnel manager, had suffered repeated episodes of quite severe depression since she was 16. Her most recent episode followed an argument with her brother about their parents' finances.

Despite early family hardship, Sherry had done well in her career, was in a stable marriage of 18 years and had two teenage children who were doing well. But Sherry had come to see herself as fundamentally 'flawed,' and said 'I have made terrible mistakes in the past'. Sherry had learned to feel overly responsible for others' problems and would experience feelings of guilt and shame as she repeatedly rehearsed her perceived failings.



# Case Example: Memory & Depression

In therapy Sherry described a specific incident where she had not written a note of condolence to a friend whose father had died. At the funeral, her friend 'humiliated' her in front of others by rebuking her. Instead of seeing this as a result of the high emotions of such a difficult occasion she saw it as absolute proof that she was flawed. She tended to avoid challenging situations out of a fear that she would make a mistake.

Sherry was prone to worry, and once locked in to a depressive mode of thinking would feel quite severely disabled in her ability to be proactive in either her work or her family. The negative self-focus would disable her sense of competence and any number of slights, disappointments, failures and grievances would intrude.

# Case Example: Memory & Depression

Sherry tended to withdraw from life when she noticed the first signs of depression because she was convinced that 'nothing helps'. This primed overgeneralised summary memories like 'None of the things I have tried has worked'.

Only with considerable support would she retrieve a specific memory at odds with the overgeneralised level of representation and the goal of finding stable and global evidence of helplessness, like 'Last Saturday I visited my dad and we went out for a long walk and I seemed to forget all about my troubles'.

# Preparation

3 main sources for exam preparation on UniHub:

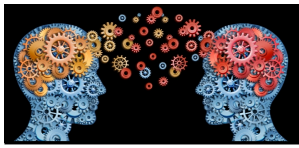
- Goldapple, K., Segal, Z., Garson, C. et al. (2004). Modulation of cortical-limbic pathways in major depression: treatment-specific effects of cognitive behavior therapy. *Archives of General Psychiatry*, **61**, 34–41.
- Kuyken, W. (2006). Digging deep into depression. *The Psychologist*, **19**, 278-281.
- Price, J. (2012). Cognitive Behaviour Therapy: A Case Study. *Mental Health Practice*, **9**, 26-31.

- Additional resources will be put on MyUniHub for those who are aiming for top grades. However, focusing on the core materials is most important.

# Preparation

Give yourself time:

- Depending on how quickly you work you will need at least 5-6 full study days (8 hours a day) to prepare well for the exam. Don't leave until a few days before the exam to start as this may considerably increase your stress levels.



# Preparation

There is no single way to study but consider:

- Mind maps
- Rehearsal
- Multi-sensory
- Switch methods
- Test your self – get others too
- Practice writing under exam conditions
- Take breaks
- Change spaces

In general engaging actively with the material, rather than passively (i.e. just reading) promotes understanding and remembering.

# Avoiding Exam Stress

- In moderation, stress can be productive and enabling.
- If stress is overwhelming then consider attending an exam anxiety workshop (info on UniHub).
- Take care of yourself: Physical wellbeing has a huge impact on psychological wellbeing (they are connected).
  - Plenty of sleep
  - Not too much caffeine
  - Exercise/activity (even in small amounts) reduces stress & anxiety
  - Avoid 'substance' coping
- Use mindfulness or breathing exercises or imagery to reduce stress.

# Avoiding Exam Stress

- Be organised
- Plan a timetable
- Take breaks
- Declutter (switch off phone, email & facebook while studying)
- Believe in your self (we do!)
- Small steps & rewards
- Nothing/no one is perfect
- Perspective – what's the worse thing that could happen?
- Consider being part of a study group (mutual support as well as sharing of information and ideas).