PSYC 2200 LECTURES NOTES

Week 1 - Person Centred Therapy

- Few person centred therapy practices; has been core for recent methods however; **psychoanalysis – the first force;** psychological problems were caused by hidden disturbances in the unconscious mind; due to unresolved developmental issues or repressed trauma; **Behaviourism;** all behaviours are learned from your environment; (conditioning); genetics + innate factors not considered; (all about observable behaviour; **Humanism – third force;** simpler, warmer, more optimistic; → Maslow's Hierarchy of Needs (1943); natural desire to grow and self-actualised but is disrupted by conditional love from others; (act a certain way to be accepted); **goal of person centred therapy to align real self and idealised self and to be okay with that;** (congruence)
- **The Therapeutic Relationship;** necessary and sufficient conditions for therapy; client conditions and core conditions

Client Conditions

- **1.** Psychological contact (relationship – must be present psychologically); 2. State of Incongruence (Client Vulnerability); 3. Perception of Congruence (Genuineness)

Core Conditions

- **1.** Unconditional Positive Regard; 2. Accurate Empathy; 3. Actual Congruence (Actual Genuineness)
- **Early evidence;** Miller, Taylor, and West (1980);
- Concepts hard to measure – less evidence; too much emphasis that client has answers within; hard to achieve in short time frame; being too non-directive means you may fail to gather key information to help clients reach goals; are all humans fundamentally good?; seems simple but incredible difficult to be truly humanistic; challenging due to lack of techniques;

Week 2 – Motivational Interviewing (Sally Hunt)

- Motivational Interviewing Background; (life is full of tough decisions; **ambivalence**; fig tree – (making up your mind and making sacrifices); (guiding approach mix between following and directing; (instead of no advice like person centred therapy you give advice and guide them;
- **Trans-Theoretical Model (or stage of Change model)**;

Precontemplation→ contemplation→ preparation→ Action→ Maintenance (Relapse/ Recurrence at and stage

- The righting Reflex; trying to fix client's problems; comes from a good place; can reduce likelihood of change; ambivalence plays a role;
- **Key Concepts**; **MI spirit** + **Change Talk** + **Oars**; **Compassion** - **Acceptance – Absolute worth – Autonomy – Accurate empathy – Affirmation – Partnership – Evocation (**from the client's own life)
- **Change talk;** hypothesis; the more clients talk in favour of something, the more likely they are to do it.
- **Oars**; these are the core skills of MI Intentional and directional- steer; **Open-ended** questions - **Affirmations** (optimism is essential for change;) – **Reflective Listening** – **Summaries** (help clients organise their ideas, feelings and experiences, summaries are brief and targeted; acknowledge ambivalence, but focus on change talk
- **Reflective Listening** – core skill to show empathy and understanding; statement; key for preventing interrogation vibe (2;1 ratio)
- **Four Processes**; engaging, focusing, evoking planning (Miller and Rollnick (2013); establishing a safe environment; *focusing what's important for the client; *evoking - how do we find a change for them to make * Planning – making active steps to change behaviour;
- **Engaging** – the processes of establishing mutually trusting and respectful helping relationships; relationship is the foundation; **Fostering engagement;** comfort, safety and empathy – **creating disengagement;** Assessments; expert trap; premature focus (not what seems to be wrong first); **labelling**; chatting; should be purely about client; **Focusing;** the WHERE; set the tone; balancing expertise and developing shared goals; develop and agenda, uncover client's true goals; recognise when things evolve; **Evoking;** the WHY; change is hard, the goals of MI is to elicit the client's own change; **Planning;** the HOW; moving from possible to actual changes; sign of readiness; increased change talk, decreased sustain talk, taking steps, questions about change, resolve, envisioning

Actual Lecture

- Use MI if someone can't talk about changes; change is complex and require efforts; just because big events occur doesn't mean it'll be enough the change; **does the person want to change; ought they to change?**
- **Layperson's**; MI is a collaborative conversation style for strengthening a person's own motivation and commitment to change
- **Practitioner's**; MI is a person-centred counselling style for addressing the common problem of ambivalence about change' (**wanting both**)
- **Therapeutic definition**; MI is a collaborative conversation style for strengthening a person's own motivation and commitment to change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring

the person's own reasons for change within the atmosphere of acceptance and compassion. – not information loaded – work with them;

- **MI** is a set of verbal strategies to draw out and then harness a person's own knowledge about their behaviour and reasons for change; MI is also a vibe, a way of approaching and engaging with clients that priorities respect, compassion and non-judgment.

Week 3-Working With young People

Pre-Lecture Materials

- Variations in kids and young people; 10-20% of young people will face Mental Health disorders; **identifying abnormal behaviour;** persistent and interfere with daily life;
- Young Minds Matter; major finding 86% of 4-17 yr. did not experience mental disorders in previous 12 months (14% = 560,000) → ADHD and Anxiety the most prevalent disorder. Social gradient; family type; household income; parent education; employment. Functioning;

Problem Development

- Presenting problem; **Pre-disposing factors** (Personal +contextual) → Precipitating Factors (Bulling and other problems) → **Presenting Problem**
- **Perpetuating Factors** (feed the problem; Personal + **Contextual;** biology; having sense of no control in one's own life; treatment factors and parent styling → social disadvantage → **Presenting Problems**
- **Protective Factors** (child is protected from increased mental health; **Personal + Contextual**; biology such as health; family being involved in the treatment of the individual

Key People; Child Psychotherapy

- Sigmund Freud (Personality development; id, ego and superego; unconscious processes and defence mechanisms; free association vs resistance; transference
- Anna Freud (Psychoanalysis through play; interpreting unconscious motivations behind play and art;
- Melanie Klein (Non-directive free play; alternative to free association; attachments to toys rather than people
- Alfred Adler (Originally part of Freud's crew; highlighted influences on child development; Natural/ logical consequences rather than rewards/ punishment,
- Jhon Bowlby (attachment theory; emotional behaviour is informed by the attachment style
- Virginia Axline; (mother of play therapy; in a positive environment, children can express and explore their challenging and confusing emotions.

Play therapy

- Psychotherapy for childhood difficulties; emotional, behavioural, social → usually 3-12 years; honours children's developmental level; varies on child needs; can start with observations and assessments; outcome better when child is involved
- Techniques; story telling; arts and crafts;
- Benefits of play therapy; confidence and self-efficacy; release emotion with action; creative problem solving; making sense of their lives; communication and behaviour skills; trust in others and self; escaping reality for a bit.

Week 3-Working With young People – Lecture

- Case study; peter was 8-year-old boy; extreme violence towards his younger, disabled brother, difficulty separating from his mother, distracted, in playground couldn't give up control. Anxiety (internalising issues); violence and peer + teacher difficulties (external)
- Treats to younger brother;
- **Observations;** very energetic and engaging boy; all subsequent session occurred over game of handball; loved to be helpful especially at home; he also stated he hated when his mom talked to jack.
- **Tangent No. 1**; defines the whole purpose of the sessions; why are they coming; one factor that helps prevent over servicing; psychometrics help answer the referral question; prevents post-hoc reasoning;
- Does the child suffer from the diagnosed mental health problems; what can be done to help him manage the problems; → Peter would ask how he can reduce his anger and being separate from the family with Jack.

Case Formulation Approach

- Developed in response to the medical model; explanatory in nature; informs treatment; in the medial model, diagnosis informs treatment; problematic in psychology; e.g. depression items; most common model uses the 4 P's, **predisposing, precipitating, perpetuating, protective;**
- **Predisposing factors**; Natalie described their parenting as permissive in style, they would often give in to Peter's tantrums because they felt it was easier to deal with that way, Natalie had history of anxiety;
- **Precipitating Factors;** the birth of jack, peter was sent to his grandparents for two weeks; this may have damaged his attachment with Natalie
- **Perpetuating Factors;** seeing the connection between jack and Natalie seems to trigger intense jealousy in Peter. Possible sense of rejection? Natalie and Stephen's permissive style of parenting may perpetuate the problems; the two other children are doing fine with the style of parenting, but it does not seem to work for peter.
- **Protective;** Natalie has had a difficult life but is a caring, warm, and resilient mother; Natalie and Stephen seem to have a caring and supportive relationship; Natalie seemed to be highly motivated to attend sessions; Natalie was very intelligent in her application of the psych principles we discussed in novel ways; peter seemed really keen to make a connection with me from the beginning,

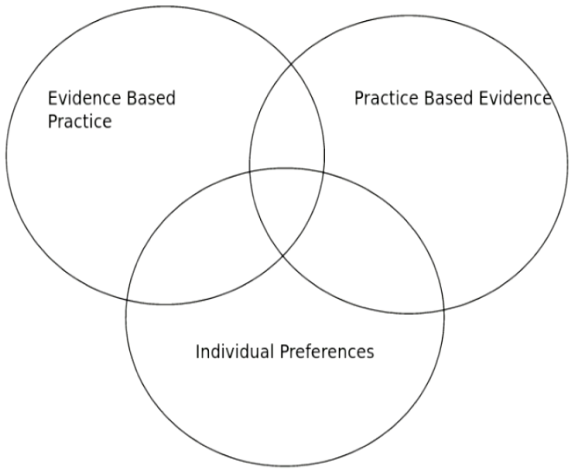
Formulation

- Natalie described her family as being permissive to the tantrums he would through because it was easier to deal with. His tantrums and acting out increased as his brother Jack as born. His brother had both physical and mental disabilities in which Natalie become closer to Jack and made peter left out of the family. Along with the permissiveness of the parents Jack began to resent his brother and act out more. Natalie has the ability to properly care and show affection towards peter and peter has the encouragement to become better.

- Peter felt like a boy who didn't belong in his family

Tangent No 2

- Studies based on homogenous group and on averages; case formulation approach can deal with the paradox;



Treatment Goals

- Psychoeducation about the PACE model of parenting; psychoeducation aimed at basic limit setting principles; solution focussed brief therapy aimed at goal setting to improve Peter's response to anger; individual (handball) therapy for peter aimed at improving his emotional and behavioural regulation.
- **Treatment outcomes;** PACE model fit well for Natalie, gave her guidance, decreased anxiety; Natalie asked him to help her do a job when she was with Jack; doing jobs made him feel a part of the family; behaviourism principles applied by Natalie improved peter's behavioural and emotional regulation; highlights and lowlights around the dinner table; increased empathy and a sense of family identity; peter started sticking up for jack;
- **Scored Normal in all Post Psychometric Assessment;**

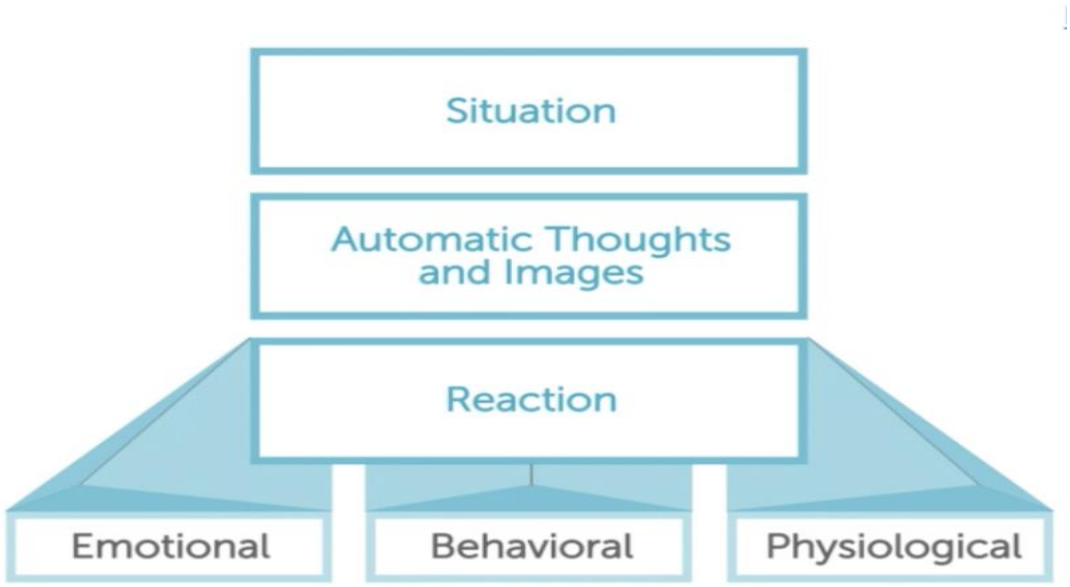
How to be a real psychologist

- When working with children and adolescents; establishing and being focused on the referral question; a case formulation approach; incorporating fun into the practice-based evidence and individual preferences in the case formulation approach; knowing the science/ evidence
- Treatments that are simple and fun that come out of the referral question and formulation.

Week 4- Cognitive Behavioural Therapy

- Best thought as a family of different therapies; two key figures; Albert Ellis; Aaron Beck;
- **Rational Emotive Behaviour Therapy (REBT);** Albert Ellis; leading figure in the 'cognitive revolution' of psychotherapy; **frustrated psychoanalyst;** irrational forces impact people's mental health, but are they unconscious? Influenced by Greek philosophy; men are not disturbed not by things, but by the view which they take of them. A new therapy approach; changed approach to directly challenging client's unhelpful beliefs systems; (it worked!); as a therapist – quick witted, plain talked, loved debate, wicked sense of humour; very direct -no beating around the bush, no fear of making client upset. Maximising pleasure, minimising pain;
- Conversation about change; (**following**; follow client's lead; listen and understand; avoid giving advice; **Guiding**; work as a team; suggest options, client choice; **Directing**; five advice; provide plan on action, solve problems.
- **What is REBT?** Formalised approach into REBT – 1995; help understand emotions; behaviours and goals; identifying unhelpful beliefs sabotaging happiness; challenge and replace more functional beliefs; **Irrational belief systems;** General demandingness (shouldn't feel pain at an older age); **Demand for love and Approval; Demand for Success (**things that are important to you); **Demand for comfort and ease** (life should be easy);
- **REBT relationship;** unconditional positive regard, tolerance and acceptance; the person is not evaluated, but nonsensical thinking is fair game; too much warmth can be counterproductive
- **The ABC model;** core element of REBT;
- **A = activating events;** Anything that happens to us, could probably just be called events (EBC)l big or small we experience these all day every day;
- **B =. Beliefs;** our thoughts about the activating event; occur immediately afterwards, two people can have completely different beliefs about the same event;
- **C = Consequences;** what we feel (emotions) or do (behaviours) because of our beliefs.
- **Therapist role;** Conscious raising; downward arrow; identify irrational beliefs, dispute them vigorously, work with client to develop an effective new philosophy;
- **ABC-DE; Disputing unhelpful thoughts**; **Effect new philosophy;**
- **Behavioural concepts; Contingency** management; e.g. client-therapist contract; **Re-evaluating consequences**; (de-awfulsiing (, awkward) – social experiments; feedback from group role plays, or even own imagination. **Counter- Conditioning;** shame attacking exercises; turn unwanted responses (shame) into desired response (no shame) by pairing stimulus (doing something really stupid) with positive actions (e.g. laughing, positive reinforcement)
- **Cognitive Therapy;** Aaron Beck (1921 -) psychoanalyst – fully trained and registered; scientist at heart; put psychoanalysis to the test; dreams of depressed patients; noticed two streams of thinking; free association and constant negative self-evaluations; client's got better when they could identify, evaluate and respond to these thoughts;

The cognitive Model



- Thoughts, feelings, and behaviours all have effects on each other;
- **Thoughts vs Beliefs;** Core beliefs – fundamental, global, overgeneralised/ **Automatic thoughts;** superficial, situation specific, word or images.

Ten principle of C(B)T

1. **Evolving formulations** of problems in cognitive terms
2. Sound **therapeutic alliance**
3. Collaboration and **active participation**
4. **Goal Oriented**
5. Emphasises the **present**
6. **Educative** (client becomes the therapist)
7. **Time limited**
8. **Structured**
9. Focus on **dysfunctional thoughts**
10. **Variety** of techniques

Common Negative thinking patterns

- **Filtering** (Magnifying negative details from a situation and filtering out all positive aspects;
- **Discounting** the positive; similar to filtering, but instead of ignoring positive experiences or personal achievements, you thought.
- **Should Statements** (Holding and others to flexible, and often unhelpful, rules – stem from our values; and causes us to judge others
- **Black + white thinking** (seeing things as one extreme or another, with no middle ground, ignoring the shades of grey that exist in everything.
- **Overgeneralising**; drawing sweeping conclusions based on one incident, frequently associated with the words 'always' and never'.
- **Catastrophising**; expecting the worst to happen, no matter what. -