Working with neurological client groups.

DCoP
Annual Conference, 2017
Stratford on Avon.
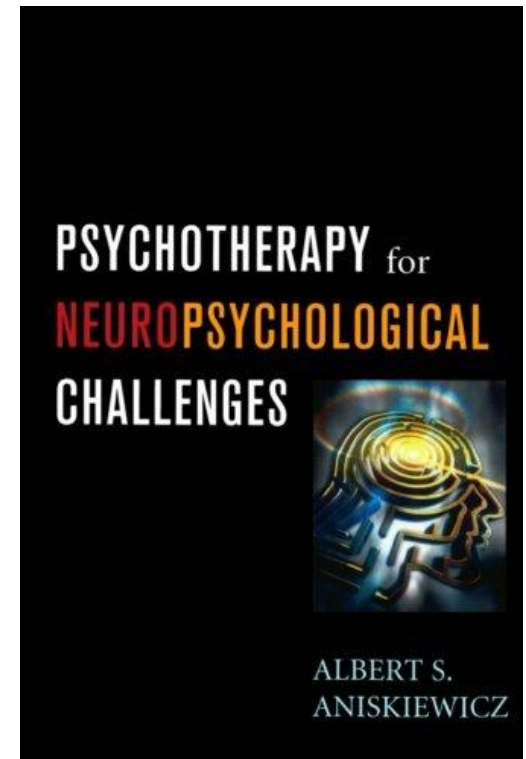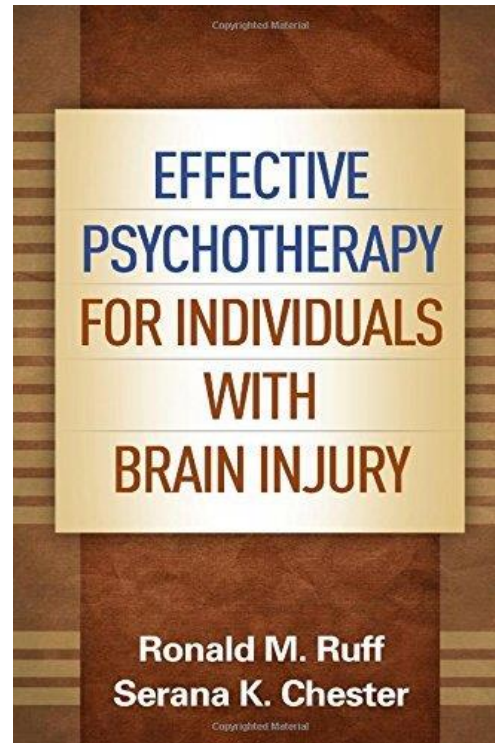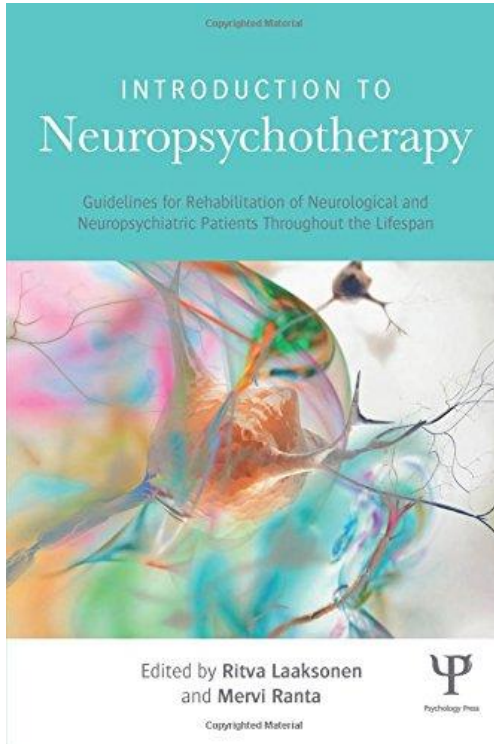

For today's handout and slides please go to:

http://www.copsy.org.uk/resources.htm

And click on the DCoP 2017 links.

Some useful readings.

INTRODUCTION TO
Neuropsychotherapy

Guidelines for Rehabilitation of Neurological and
Neuropsychiatric Patients Throughout the Lifespan

Edited by Ritva Laaksonen
and Mervi Ranta

EFFECTIVE
PSYCHOTHERAPY
FOR INDIVIDUALS
WITH
BRAIN INJURY

Ronald M. Ruff
Serana K. Chester

PSYCHOTHERAPY for
NEUROPSYCHOLOGICAL
CHALLENGES

ALBERT S.
ANISKIEWICZ

Psychotherapy Following Traumatic Brain Injury: Integrating Theory and Practice

Rudi Coetzer, DClinPsy, CPsychol

Psychotherapy is now an approach used within several models of neurorehabilitation. However, a core theoretical model to guide psychotherapeutic practice is lacking. This article attempts to illustrate how the Generic Model of Psychotherapy of Orlinsky and Howard, which emphasizes the common factors shared by many psychotherapies, can be applied in neurorehabilitation settings. A case report is presented to illustrate how this model can potentially inform psychotherapeutic practice. The use of a theoretical model to underpin psychotherapeutic interventions in neurorehabilitation settings has the potential to facilitate our understanding of the psychotherapeutic process following traumatic brain injury in this evolving area of professional practice. **Keywords:** *psychotherapy, traumatic brain injury*

TABLE 1 *The 6 facets of Orlinsky and Howard's Generic Model of Psychotherapy*

Dimension	Definition
The therapeutic contract	The roles of the patient and the therapist, practicalities, for example, length of sessions and duration of treatment as well as the therapist's treatment model, including a psychodiagnostic scheme
Therapeutic operations	A collaborative process where the patient presents information for evaluation by the therapist to determine which psychotherapeutic intervention or technique is indicated
The therapeutic bond	The relationship that develops during therapy and that is manifested by each person's investment in his or her respective roles as well as the personal rapport that develops over time
Self-relatedness	An intrapersonal process, including self-awareness, reflecting how people respond to themselves during interactions with others and the environment; in therapy often referred to as openness vs defensiveness
In-session impacts	Therapeutic realizations representing the more immediate experiences of patients during psychotherapy sessions, including emotional relief and insight, among others
The phases of treatment	Events during sessions that combine over both time and individual sessions to form the phases of psychotherapeutic interventions or treatment

Case report

Ms. C.

Severe TBI. Unconscious for 36 hours. In hospital for 1 week.

Struggled with school exams and return to education. Was seen as quite academic previously.

Consequences include anxiety, poor initiation, not wanting to venture too far from parents.

Process

Lots of psychoeducation.

Ms C want to understand what happened to her, what the consequences are, what the future will be.

Very flat initially, but over time, comes to process the emotion and loss.

Pragmatic case studies.

Using Client-Centered Psychotherapy Embedded Within A Pluralistic Integrative Approach to Help a Client With Executive Dysfunction: The Case of "Judith"

TONY WARD [a,c] & KEVIN HOGAN [b]

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[b] Newman University, Birmingham, England

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http://pcsp.libraries.rutgers.edu/index.php/pcsp/issue/view/284

Table 1. Mean (and SD) for Process Scores for Sessions 1-5 Versus 39–43

Process Rating	Sessions 1-5	Sessions 39-43	Significance
Positive coping statements	1.6 (2.3)	12.4 (3.9)	p <0.05
Negative coping statements	62.4 (8.9)	33.0 (9.1)	p <0.05
Suicidal ideation statements	6.2 (3.8)	0.8 (1.1)	p <0.05

Table 2. Before and After Average Item Scores on the CORE# Dimensions

Dimension	Before	At 1 Year	Change from Before	At 2 Years	Change from Before	Clinical Threshold	Reliable Change Level
Well-Being	3.5	2.5	1.0	1.8	1.7*	1.72	1.34
Problems	2.8	2.0	0.8	1.4	1.4**	1.59	0.84
Function	2.4	1.4	1.0*	1.0	1.4**	1.29	0.85
Risk	1.5	0.5	1.0*	0.3	1.2**	0.31	0.97
All items	2.5	1.6	0.9*	1.1	1.4**	1.48	0.52

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM; Evans et al., 2000). Higher scores indicate greater pathology.

* The degree of change on these items can be judged as "reliable change," according to Jacobson et al. (1984), with subsequent correction by Christensen and Mendoza (1986).

** In addition to reliable change, these items show a change from above to below the clinical threshold, meaning these changes meet the criteria for "clinically significant change," according to Jacobson et al. (1984).

RESEARCH ARTICLE

The experiences of counselling for persons with ME

TONY WARD, KEVIN HOGAN, VIKI STUART, & ELIZABETH SINGLETON

Department of Psychology and Counselling, Newman University College, Birmingham, UK

Abstract
A number of studies have evaluated counselling interventions for people with myalgic encephalitis, but few report client perceptions in any detail. This study seeks to explore client perceptions using a qualitative methodology. A sample of 25 individuals with myalgic encephalitis were interviewed about their experiences in counselling. The interviews were transcribed and subjected to thematic analysis using grounded theory principles. The analysis showed that people with myalgic encephalitis endure significant changes to their lives, often involving great loss and trauma. After seeking help through counselling, participants had experienced a wide variety of approaches and there were positive and negative perceptions of each. Other perceptions related to therapist characteristics and the way in which interventions were carried out. Recommendations for practitioners are given.

Keywords: *Myalgic encephalitis, chronic fatigue syndrome, counselling, user perceptions*

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

Psychotherapy with brain injury survivors: An investigation of the challenges encountered by clinicians and their modifications to therapeutic practice

D. JUDD[1] & S. L. WILSON[2]

[1]*Northamptonshire Healthcare NHS Trust, UK and* [2]*University of Glasgow, Glasgow, UK*

Abstract

Objective: The aim of this study is to elicit practitioners' views and experiences of the challenges to forming a therapeutic alliance with brain injury survivors, with a view to informing current psychotherapeutic practice.

Methods: The present research utilised the data-display method, a qualitative technique, to examine the questionnaire responses of 21 psychologists who provide forms of psychotherapy for brain injury survivors at rehabilitation units in the UK. An anonymous postal return questionnaire was used for data collection.
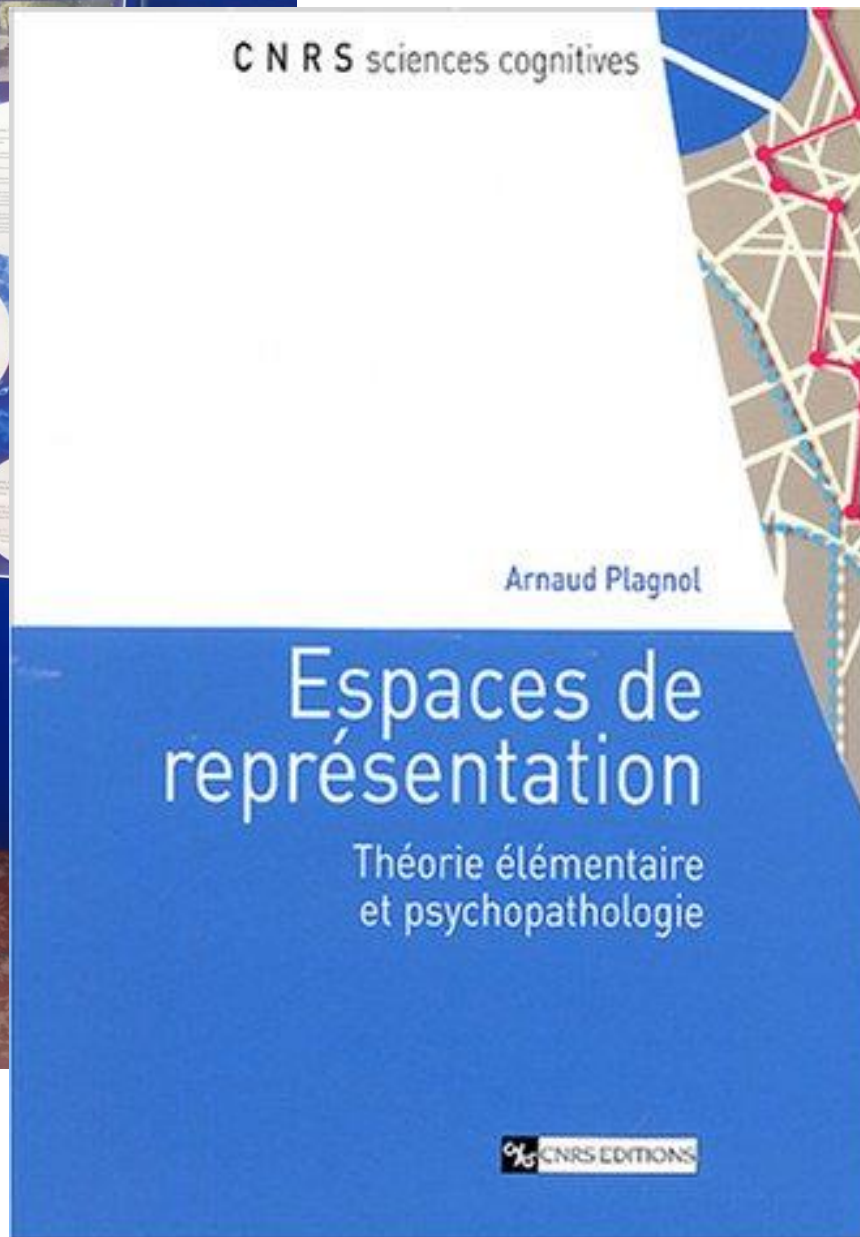
Results: The main challenges to forming a working alliance comprised a range of cognitive, behavioural and emotional sequelae. A combination of educational, psychosocial and cognitive strategies were identified as being most effective in addressing the challenges encountered.

Conclusions: A qualitative research approach has proved useful in identifying challenges to the formation of a working alliance and also the modifications to psychotherapeutic practice these challenges have engendered.

Keywords: *Psychotherapy, brain injury, working alliance, data display method*

Table I. Therapeutic strategies used to address challenges in forming a working-alliance with brain injury survivors.

| Strategies to address challenges | Main challenges to forming a working-alliance | | | | | | |
| | Cognitive | | | | | Behavioural | Emotional |
	Lack of insight (14)	Impaired memory (16)	Inflexible thinking (13)	Poor attention/ concentration (8)	Language difficulties (8)	Disinhibited behaviour (3)	Emotional ability (9)
Education and information about TBI and its effects (13)	Promotes under-standing and awareness (9)	Promotes under-standing and awareness (9)	Promotes under-standing and awareness (3)	Promotes under-standing and awareness (5)	Promotes under-standing and awareness (5)	Promotes under-standing and awareness (1)	Promotes under-standing and awareness (6)
Behavioural experiments—reality testing (18)	Provides evidence of deficits and abilities (10)	Provides evidence of deficits and abilities (5)	Provides evidence of deficits and abilities (7)	Provides evidence of deficits and abilities (2)	Provides evidence of deficits and abilities (1)	N/A	N/A
Memory aids—written summaries, visual cues (14)	N/A	Record information, helps learning (10)	N/A	Record information, helps learning (4)	Record information, helps learning (1)	N/A	N/A
Shortened, focused sessions (9)	Accommodate cognitive impair-ments (2)	Accommodate cognitive impair-ments (5)	Accommodate cognitive impair-ments (1)	Accommodate cognitive impair-ments (5)	Accommodate cognitive impair-ments (2)	N/A	Does not overload client's coping abilities (6)
Involvement of clients' significant others (8)	Promotes under-standing and support of client (7)	Support client's use of cognitive strategies (6)	Support client's use of cognitive strategies (4)	Support client's use of cognitive strategies (4)	Support client's use of cognitive strategies (3)	Support work in behaviour management programme (1)	Support/ comfort client at home (5)
Behavioural management programme (3)	N/A	N/A	N/A	N/A	N/A	Raises awareness and modifies inappropriate behaviour (3)	N/A

CNRS sciences cognitives

Arnaud Plagnol

Espaces de représentation

Théorie élémentaire et psychopathologie

CNRS EDITIONS

Group exercise – looking at some vignettes which illustrate the kinds of issues presented by clients with neurological conditions.

Next steps

- BPS CPD on neuropsychology, plus assessment (WAIS4 and WMS4).
- Consider working with relevant client groups – find a good supervisor.
- Look for and apply for relevant positions
    - "Counselling psychologist in neuropsychology"
- Join the DoN!
    - If you are chartered and work in a relevant setting for 2 years, you are elegible to join as a full member.

- Keep your eyes open for future developments
    - The DoN is slowly moving to a position where it will recognise and Allow practitioner psychologists to engage in further relevant training. The starting point is likely to be a MSc in Clinical Neuropsychology or Paediatric Neuropsychology, followed by the BPS QiCN.

- Look out for the December issue of CPR!
    Special edition on "Neuroscience in counselling psychology"
    Contributions from all of todays facilitators.
    Papers on working with neuro clients, neuroscience, impacts on practitioners, book review, etc.