



A quarterly broadcast of things helpful and interesting in local clinical psychology.

Literature Digest: The role of Cognitive Rumination

Some recent studies have reinforced the potency of rumination as a modifiable cognitive trait that causes and maintains psychological distress. In cognitive therapy, one of the main effective interventions is teaching patients to identify and alter unhelpful thinking content. However, it is not just what you think but the way that you think it that has the greatest effect. 'Rumination' is a perseverative way of thinking certain thoughts and is mainly focused on the past (regrets, losses, trauma and the like). Imagine a person after a motor vehicle accident that has left them with physical pain and emotional trauma. They could not dispute the content of the thought "I wish I did not drive that way on that day", but they would profit well from learning how to disengage from such automatic thoughts if they keep persevering.

Since some early landmark studies, rumination has been known by cognitive therapists to contribute to the

chronicity and severity of depressive disorders, worry disorders (GAD) and post-traumatic stress (Ehlers & Clark, 2000; Papageorgiou & Wells, 2003). In a paper studied last month Newman and Nezelek (2019) demonstrated that it is not just a tendency to ruminate (as a trait) that is problematic but actual moments of rumination do contribute to lower mood and life satisfaction. They also sought benefits of rumination, such as a greater sense of meaning in life, but found that rumination is not helpful. In the same month a Chinese team of researchers found further evidence that ruminating over injustice and loss increases the chance that anger will manifest as aggression (Quan et al., 2019).

You can assess rumination by asking questions such as, "during an average day, how often does that thought come to mind? And how many minutes do you think about that when it does come to mind?" Then you can ask questions such as: "What effect does that have on your mood? If there was a way to reduce that impact, would you be

interested in learning about it?".

From our resources page on the Basten website you can download free information sheets for patients on CBT, trauma, anxiety disorders and depression.

1. Ehlers, A., & Clark, D. M. (2000). *A cognitive model of posttraumatic stress disorder. Behaviour research and therapy, 38(4)*, 319-345.
2. Newman, D. B., & Nezelek, J. B. (2019). Private self-consciousness in daily life: Relationships between rumination and reflection and well-being, and meaning in daily life. *Personality and individual differences, 136*, 184-189.
3. Papageorgiou, C., & Wells, A. (2003). An empirical test of a clinical metacognitive model of rumination and depression. *Cognitive therapy and research, 27(3)*, 261-273.
4. Quan, F., Yang, R., Zhu, W., Wang, Y., Gong, X., Chen, Y., ... & Xia, L. X. (2019). The relationship between hostile attribution bias and aggression and the mediating effect of anger rumination. *Personality and Individual Differences, 139*, 228-234.



Interview with a Clinical Psychologist

REBECCA STERN *B.Psych.(Hons); M.Psychol.*

Rebecca completed her Masters in Clinical Psychology at Macquarie University and has subsequently worked in various settings, including homeless refuges with women and children, Butterfly Foundation for Eating Disorders, Wesley Private Hospital and a university counselling service. Her current focus is working with adults experiencing eating disorders, anxiety, and depression, including addressing traumatic experiences.

Q: You do a lot of trauma work, is CBT over-rated in the treatment of post-traumatic stress?

A: There are two evidence-based treatments for post-traumatic stress disorder, trauma focused cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR). One key elements of CBT for the treatment of PTSD is imaginal exposure, which involves confronting trauma memories in a safe environment. CBT also involves in vivo exposure, which is graded exposure to places, activities

and situations that are avoided. The other elements of CBT involve de-arousal strategies such as breathing retraining and cognitive restructuring to challenge unhelpful beliefs associated with the trauma. Whilst TF-CBT has a strong evidence base, particularly for single incident trauma it is not always helpful in treating complex trauma or multiple incident trauma. For trauma processing to be effective, dual awareness needs to be established; this means that the individual can stay present focused whilst recalling the past. This is one reason that

EMDR can be of assistance, as bilateral stimulation which involves focusing on eye movements whilst recalling a trauma assists in maintaining dual awareness.

Q: How do you see the role of rumination in maintaining psychological conditions like trauma?

A: Rumination is the attempt to make sense of a distressing event or solve a problem through repeatedly playing over the causes and nature of the problem. This could include analysing a perceived mistake or misfortune and wondering what it means about them - stating something like "I always make bad decisions" and then replaying over "bad decisions". This kind of thinking actually impairs problem solving, strengthens traumatic memories and exacerbates low mood. For example, an individual with chronic pain may bring up the most recent incident that triggered pain and tell themselves over and over again that they "wish they had not overdone it" or how angry they are about an accident they had. **Continued on next page.**



“But it is a melancholy of mine own, compounded of many simples, extracted from many objects, and indeed the sundry contemplation of my travels, which, by often rumination, wraps me in the most humorous sadness”.

- William Shakespeare

Interview with a Clinical Psychologist (continued)

By repetitively wishing something bad didn't happen or blaming oneself or others, they are actually increasing feelings of sadness or anger. The problem is the nature of repetitive thinking that is abstract, analytical, evaluative and overgeneralised. This is why we often assist clients to engage in experiential exercises, behavioural experiments and discuss the chain analyses of events that recall the specific sequences. These interventions assist people to move away from rumination and also promote problem solving.

Q: What hints can you share with other health professionals about how you engage in self-care?

A: Sometimes, the simplest interventions are the most effective, such as exercising regularly, eating well, starting a mindfulness practice, seeking social support and find work-life balance. I recommend these to clients and find that these same strategies are also vital to my self-care. I have endeavoured to establish work-life boundaries so that work doesn't leak into my downtime. I strongly recommend formal collegiate supervision or peer review as well as informal supports. Wherever possible, try to align your work hours with your personal circadian rhythm.

Motivating patients to change behaviour:

Part 9: When fear works and when scare-tactics fail

As health professionals, we try to help people improve their health and yet it can be hard to motivate patients to do potentially helpful treatments or lifestyle changes. This is a serialised account of numerous strategies to increase motivation for change in our patients.

Broadly speaking, humans are motivated both by fear of negative consequences and by the potential for positives. Those negatives and positives can be emotional (guilt; sense of failure; pride; accomplishment etc...) or material (health; fitness; money; work) or status-oriented (accepted; admired; employed in a certain role; in a team and the like). Much is written about the role of fear as a motivator. We know it works but other research has shown it can backfire. Let us briefly examine the implications for doctors with their patients.

Sometimes fear is a great motivator for health behaviours such as quitting tobacco, altering diet or adhering to prescription advice. At other times, instilling fear can fail to achieve the desired effect or may even do some harm. If we say to a patient, “you are definitely heading for a life of diabetes and all its consequences unless you can drop some weight and do some exercise” some people will actually respond with behaviour change. However, a certain percentage will cope with their fear through cognitive suppression and they are less likely to return to you or any doctor. Others do not respond to fear because they feel that a very scary message cannot apply to them. Young people tend to ignore the

gory picture on cigarette packages for such reasons.

Alternatives to ‘fear appealing’ messages are ‘pursuit of positive’ messages. Here are some examples:

Confidence inducing: “You know what - I think you can do this. Let's set a goal”.

Starting monitoring: “Please keep a record of what you do and don't do, and I will repeat the same test in 14 days. Together, we'll measure the effect of some behaviour changes”.

Give directions: “Let's pick two actual behaviours that you feel that you can commit to doing in the next seven days”.

Link to Future: “You will notice measurable benefits in less than two months if you start now. Is that in line with the outcomes that are important to you?”.

How can you tell if your patient will or will not respond to fear messages? The best way is to ask them. A three-minute conversation about this can pay dividends for months. When a person is asked whether they are usually more motivated by fear or reward, they often do not know straight away – but it puts the topic of motivation on the agenda and now motivation is declared as something to work on! One or two more questions and they will start to know. You could ask them to recall a time when they did change a health behaviour and then enquire what motivated them to do this (was it fear or reward?). You could give some personally relevant examples of motivators that are fear-appealing and pursuit of positives for their target behaviour and ask them what is more likely to help them successfully tackle the change.

Basten & Associates
Westmead
Sydney
Chatswood
ph 9891 1766

Resources:

The Basten and Associates website has plenty of resources for GPs interested in emotional wellbeing and there is a free downloadable page on “The Psychology of Motivation” to give to patients.

Email Chris if you are interested in one of our motivational interviewing or mindfulness training days for GPs in 2019.

chris@bastenpsychology.com.au