

# Continuing Professional Development for Psychiatrists in Sri Lanka

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**The Asia Foundation**

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## Message from the President of the Sri Lanka College of Psychiatrists

As the President of the Sri Lanka College of Psychiatrists(SLCPsych), it is my pleasure to write this message for the book “Continuing Professional Development for Psychiatrists in Sri Lanka” published by the Sri Lanka College of Psychiatrists, in association with The Asia Foundation.

The SLCPsych Continuing Professional Development(CPD) program was launched in 2015 as the first program launched in the country to promote CPD amongst psychiatrists. It consisted of two planning workshops and six content workshops. The content workshops were especially designed to cover the core CPD areas recognized by the College as essential for professional development namely skill development, personal development, changing attitude and behavior, reflective learning and knowledge development. Under these thematic areas the CPD committee of the College conducted several workshops on ‘couple therapy’, ‘leadership training’, ‘scientific writing and gender issues’, ‘reflective learning and post-traumatic stress disorder’, ‘current developments in psychopharmacology’, ‘assessing for psychological consequences of trauma’, ‘testamentary capacity’, ‘parental capacity assessments’, ‘medical negligence for psychiatrist’ and ‘claiming points for CPD activities’. The content book contains a compilation of material gathered from six CPD workshops conducted by the College between 2015 and 2016.

The topics of these workshops were determined after careful consideration of the CPD needs of practicing psychiatrists in the country, specially those who work in peripheral regions. They were also designed to address the need to update knowledge on child, adult and old age psycho-pharmacology, improving skills in common therapies in psychiatric practice, changing attitudes related to gender sensitivity in service provision and knowledge on reflective practice amongst practitioners.

The book consists of six chapters; each contains learning outcomes, information regarding the relevant topic under discussion incorporating ways of improving the quality of the practice of psychiatry with relevance to Sri Lanka, practice points, a Summary and suggestions for further reading.

I acknowledge with gratitude the hard work of the writers, editors and proof readers who have worked tirelessly to produce invaluable material for the book. I also thank the resource persons for their contribution, the CPD Committee, The Asia Foundation Coordinator of the program and the printer for their support in making this endeavor a success.

**Prof. Samudra Kathriarachchi**

President, Sri Lanka College of Psychiatrists

Chairperson, CPD Committee

## Message from the Country Representative of The Asia Foundation

It is my pleasure to extend a message to the publication “Continuing Professional Development for Psychiatrists in Sri Lanka”

The Sri Lanka College of Psychiatrists commenced a Continuing Professional Development (CPD) program for Medical Officers in collaboration with The Asia Foundation in 2012. The program was aimed at strengthening the skills and knowledge of Medical Officers of Mental Health to work at grass root level. Following the success of this program, in September 2015, the Sri Lanka College of Psychiatrists felt the need to conduct Continuing Professional Development for Psychiatrists. This too was conducted as a collaboration with The Asia Foundation. The program had as its objectives to ensure that practitioners knowledge was up to date with modern international developments in the field and as well to facilitate the personal and professional development of practitioners for optimum service provision. This publication is a compilation of the materials used at the CPD programs organized for Psychiatrists.

The Asia Foundation is a non-profit international development organization committed to improving lives across a dynamic and developing Asia. Informed by six decades of experience and deep local expertise, the Foundation’s programs address critical issues affecting Asia in the 21st century—governance and law, economic development, women's empowerment, environment, and regional cooperation. We are committed to Asia’s continued development as a peaceful, just, and thriving region of the world.

During the past ten years, the Foundation has been committed to helping Sri Lankan communities overcome the lasting effects of conflict related violence through our Mental Health and Psychosocial Program by collaborating with both non-governmental and government organizations. The Asia Foundation is proud to be associated with this professional development program and to have been able to contribute to the growth and development of the mental health and psychosocial support sector in Sri Lanka.

**Dinesha de Silva Wikramanayake**

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# CHAPTER 1

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# Sri Lanka College of Psychiatrists Continuing Professional Development - Information and Guidelines

## 1.1 PROGRAM REQUIREMENT

### Statement of Purpose

The SLCPsych continuing professional development (CPD) program intends to establish a sustainable CPD scheme for Sri Lankan psychiatrists, to improve their knowledge and skills and foster a favorable attitude on clinical and relevant non-clinical areas that need to be strengthened. It ensures optimal patient care and good practice standards.

Participation in the CPD program has multiple benefits. It facilitates overseas liaison work, helps in gaining recognition by peer groups and the public, enhances self-growth and satisfaction, develops growth in professionalism and improves the outlook of the discipline.

### Annual and Triennial Program Requirements

Program requirements were set by studying the Sri Lanka Medical Association (SLMA) guidelines on CPD for specialists, the Royal Australian and New Zealand College of Psychiatrists (RANZCP), and the Royal College of Psychiatrists (RCPsych). The SLCPsych CPD scheme has a three-year cycle with annual cycles of planning and review.

Annual submission requirements are as follows:

- Minimum annual requirement of 50 credits,
- Minimum of three core outcomes to be met within a year,
- All five core outcome categories to be covered within the three-year cycle,
- One audit per three-year cycle,
- One abstract or research publication within the three-year cycle,
- E-learning to be limited to 20 credits per year,
- Evidence of participation to be produced for each credit claim.

## Core Outcome Categories

Categories that need to be addressed in the three-year cycle have been identified as:

- Knowledge development,
- Skill development,
- Change in attitude and behavior,
- Personal development,
- Self-directed reflective learning.

The activities which come under each core outcome category will be dealt with in detail in the Credit Point Scheme (page 8) section of the book.

## Registration

In order to register, one must fill in the registration form that is found on the College website ([www.slpsych.com](http://www.slpsych.com)) under the CPD section and send it to the Sri Lanka College of Psychiatrists ("Wijerama House", No. 6, Wijerama Mawatha, Colombo 07).

## Professional Development Plan (PDP)

The Royal College of Psychiatrists (RCPsych) describes PDP as a “series of personal statements linked to the individual objectives that the psychiatrist has identified which will help to improve the quality of care for patients that he or she provides while at the same time ensuring that there are some personal developmental gains”. It is a process designed to enable you to think about and plan for your own personal, academic and career development. It will aid in identifying skills that you possess and those that you need to acquire and enable you to methodically achieve your aims. Preparing your PDP is the first step towards achieving CPD. When drafting your PDP, it is necessary to take into account the elements in current practice which need to be enhanced. Your PDP should be realistic, achievable and relevant to the professional needs of your post. It should reflect the role of the psychiatrist and primarily work towards setting best possible standards and providing optimal care for patients. A PDP should be approved by the peer group at the beginning of each yearly cycle and renewed at the end of the year. Each individual’s professional development needs are unique and the responsibility of identifying and achieving these needs and addressing obstacles to its completion is each individual’s responsibility. The PDP form summarizes the learning outcomes covered within the yearly cycle. This plan can be used both as a summary of initial planning and as a review at the end of the year.



## PDP Plan template

Triennium: 2015 to 2018

Plan/Review

Year 1 2 3

Learning outcome	Core outcome category	Activity	Time duration	Points claimed	Application to practice
1. Enhance my knowledge on cognitive behavior therapy	Knowledge development	Attend seminars and conference sessions and read articles	Participant: 10 hours Resource person: 2 hours	14	Keep up to date with new developments in CBT (Cognitive Behavior Therapy)
2 Improve communication skills	Personal development	Attending seminars and workshops on communication skills	Participant: 8 hours Resource person: 4 hours	16	Better communication with patients and colleagues

## 1.2 PEER GROUP

### Guidelines

As described by RANZCP, a peer group is a small self-selected group of peers who meet to promote reflective practice in an educational environment. The members of the group should view each other as their peers and must feel comfortable to openly discuss work issues and receive feedback from their group members. Group meetings should be held in a supportive environment where individuals learn and develop from sharing each other's work related experiences. A peer group has two main responsibilities: review each member's PDP for its feasibility and help each member achieve his or her CPD goals; and facilitate discussion among members on difficult cases and work related issues. Case review is a cornerstone of peer group review and each peer group meeting should allocate sufficient time for difficult case reviewing. However, the confidentiality of the patient must be protected at all times. It must be noted that a peer group review should not be considered as a formal second opinion. Peer group activities should aim at excluding discussions on practice management or systems and non-clinical research or education. However, if discussions on practical management issues are required to improve patient care and standards, it could be allowed by the coordinator, after consulting the other members of the group. Each peer group needs to elect a coordinator. SLCPsych CPD program requires at least 10 hours spent in peer review activities annually. CPD credits can be claimed for peer group activities.

## Registration for Peer Group Membership

The membership of the group should be limited to psychiatrists. However, each individual is free to choose his or her peer group. The success of the peer group could depend on the power dynamics within the group. There should be no power imbalance within the group. The members should feel comfortable with each other to openly discuss their work experiences. It is encouraged to form groups with members of similar work circumstances and experiences. It is also encouraged to invite a member from another peer group to observe the proceedings of a peer group meeting at least once a year in order to prevent the meetings from becoming stagnant. Once a peer group is formed, the coordinator should register the group membership at the College. A form for registering a new group can be downloaded from the SLCPsych website ([www.slcppsych.lk](http://www.slcppsych.lk)).

## Role and Responsibilities of the Peer Group Coordinator

Each group should appoint its own group coordinator. The coordinator will act as the intermediary between the College and the peer group, coordinating all communications. A new coordinator could be appointed at the beginning of each year. The main responsibilities of a coordinator are as follows:

- Register the group at the CPD committee of the College,
- Convene peer group meetings and facilitate discussions of PDPs,
- Certifying the PDP,
- Facilitate discussions on difficult patient management problems and difficult issues in providing patient care,
- Maintenance of summary points discussed at the meetings,
- Maintain records of attendance for CPD claims and audits,
- Complete annual report and send it to the CPD committee of the College,
- Inform change of membership to the CPD committee of the College,
- Issuing of the certificate verifying the attendance for the year.

## The Size of a Peer Group

A peer group should be of a size that allows each individual member sufficient time and space to present their work to his or her peers and receive feedback. A large number of members might prevent individuals from being able to frequently present their work at meetings or to sufficiently allocate enough time for each individual member. Therefore,

the College recommends 4-8 members as the optimal number of participants for a group. However, there can be exceptions. If a group of 4-8 members cannot be formed due to geographical and/or practical reasons a 'Peer dyad' or a group of two can be formed. Peer-dyads are allowed only when there are practical difficulties in forming a group and are recommended only for a limited time period.

## Meeting Frequency and Mode of Meeting

A peer group should meet frequently enough to adequately provide a sense of group continuity for the members. The College recommends that a peer group meets at least four times a year for an accumulated period of 10-15 hours over the four sessions. Face to face meetings are seen as the most effective mode and are recommended by the College CPD committee. However, where there are obstacles which prevent members from meeting face to face, discussions can be conducted via other options (telephone, Skype, etc)

## Peer Group Activities

- Discussions on PDP plans of individual members
- Case discussions on patient management issues
- Difficult clinical judgement of patients
- Ethical aspects of patient care
- Response to relations on difficult patient issues
- Response to administrators in difficult situations
- Issue of statements if required
- Facing inquiries on patient management issues
- Contributing to Medical Boards
- Complexities in shared care
- Complex issues at a practice/ organizational level and at a team level which has an impact on patient care
- Collaboration and partnership with government and non-government agencies  
ie. professional boundaries, limits, dealing with difficult people, managing meetings, and difficulties encountered in partnership, conflict resolution, etc.
- Ethical practice in collaborative care
- Working with administrative set-up to improve standards

## Documentation

The peer group coordinator should maintain a record of attendance at each meeting in addition to a record of summary points of the topics discussed at the meeting. Consideration needs to be given to how confidential material is to be handled, such as de-identification of clinical material. At the end of the year, each member can receive, from their group coordinator, a summary of the number of meetings attended and the amount of CPD credits accumulated according to the number of hours.

## Credit Point Scheme

As a general rule, one hour of participation in a professional development activity equates to one credit for a participant and two credits for a resource person. Exceptions to this rule are stated below under respective categories.

Credit points allocated under each category is listed below.

### Outcome 1: Knowledge Development

#### Maximum 20 credits/ year

- Designated activities: lectures, seminars, academic sessions of a professional college or association, international conferences, regional meetings, etc.
- Non-designated activities: local meetings, journal club activities, academic meetings conducted at the hospital, case conferences, peer review meetings, non-routine teaching, etc.

### Outcome 2: Skill Development

#### Maximum 20 credits/ year

- Skills training workshops related to the discipline of psychiatry [i.e. workshops on psychotherapy, psychological interventions, stress reduction strategies, counselling, ECT, ethics, behavior therapy, etc.].

### Outcome 3: Change in Attitude and Behavior

#### Maximum 20 credits/ year

- Any activity conducted towards change in attitude and behavior in relevant psychosocial issues [i.e. mental health, child abuse, elder abuse, gender-based violence, sexual harassment at workplace, domestic violence, reduction of drugs and substance use, stigma associated with mental illnesses, etc.).
- Any activity to promote ethical behavior of psychiatrist's professional conduct.

## Outcome 4: Personal Development

### Maximum 20 credits/year

- Any activity related to the development of soft skills [i.e. presentation skills communication skills, interpersonal skills, research skills, writing skills, etc.].
- Research and publications of books, articles, papers, etc.
  - Recognized bi-annual peer-reviewed journals
    - Article: 10 points per item
    - Abstract: 5 per item
  - Local journals/ books/ contribution to scientific documents
    - Article: 5 points per item
    - Abstract: 3 points per item
    - Chapter: 5 points per chapter
- Contribution to non-professional publication or a lecture to such group:
  - 1 item: 2 points

## Outcome 5: Self-directed Reflective Learning

### Maximum 30 credits/ year

- Self-learning activities [i.e. reading on a related topic and writing a summary of what you have learnt, critical analysis of your own practice noting mistakes or drawbacks and formulating methods for improvement, etc.]
  - 1 item: 2 points
- Audit
  - 10 points per audit

## Bibliography

Royal College of Psychiatrists. *Continuing Professional Development: Guidance for Psychiatrists*. 2015.

Sri Lanka Medical Association. *National CPD Certificate: Information and Guidance Book*. 2010.

The Royal Australian and New Zealand College of Psychiatrists. *Continuing Professional Development: Program Guide*. 2013.



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# **CPD RANZCP and Self-directed Reflective Learning**

This chapter is compiled based on the workshop conducted by Prof. Samudra Kathriarachchi, President, Sri Lanka College of Psychiatrists, Prof. Malcolm Hopwood, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Ms. Elaine Halley, General Manager, Education and Training, RANZCP on May 31st, 2016 in Colombo Sri Lanka.

## **Learning Outcomes**

- To understand the concept of Continuing Professional Development (CPD) and its importance in clinical practice.
- To inform about the CPD program of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) which can be used as a valid model on which Sri Lanka College of Psychiatrists' (SLCPsych) CPD activities can be based, if necessary.
- To appreciate the impact of self-directed reflective learning practices on CPD.
- To improve knowledge of the Royal College of Physicians and Surgeons of Canada (CanMEDS) professional competencies with relevance to Sri Lankan context.
- To understand the role of peer review groups and factors contributing to successful peer group functioning.

## **Continuing Professional Development (CPD)**

Continuing Professional Development is a process by which an individual takes control of his/ her professional development related learning by ongoing reflections and actions leading to self-empowerment and development. It involves acquisition of new knowledge, skills and experiences. It is an integral part of professional medical education.

## **CPD Program of the Sri Lanka College of Psychiatrists**

This program is launched following the guidelines established by the Sri Lanka Medical Association, with discipline specificity achieved through research and a needs assessment survey conducted among the psychiatrists. The RANZCP, the Royal College of Psychiatrists UK (RCPsych) and the CanMEDS framework were included in the review.

Readers are advised to refer to the Sri Lanka College of Psychiatrists Continuing Professional Development Information and Guidelines book.

## **Continuing Professional Development (CPD) program of The Royal Australian and New Zealand College of Psychiatrists (RANZCP)**

The RANZCP CPD program provides a pathway for participants to review and further develop their professional practice so that their knowledge, skills and performance are maintained and enhanced in all areas of professional responsibility, in order to achieve the best attainable quality of psychiatric care and patient outcomes.

### **Why a CPD program is necessary**

- To ensure quality of care and patient safety
- As a requirement of the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ).
  - Australian Medical Council (AMC) jointly accredits with Medical Council of New Zealand (MCNZ).
  - Programs must satisfy AMC standards for specialist medical education programs and professional development programs.
  - Additional MCNZ standard ‘cultural competence’.
- To satisfy public and stakeholder expectations.
- For the purpose of revalidation of the academic program.

In order to provide RANZCP Fellows with a robust program and provide the public and stakeholders the assurance of professionalism of the Fellows, the CPD program underwent a period of review and redevelopment to create a more dynamic program whilst maintaining the requirements of the Medical Board of Australia (MBA) and the Medical Council of New Zealand (MCNZ). Commencing from January 2017, the CPD program will be reflective of those changes.

The Medical Board of Australia is currently in the process of developing a revalidated CPD program across Australia. An expert advisory group has been appointed to provide the Medical Board with technical advice. All members of the advisory group are active participants in specialist college activities. As a first step, one or more CPD models will be developed as a pilot project in order to evaluate its effectiveness, feasibility and acceptability. Subsequently, the most suitable model will be decided. However, the revalidated program will not include periodic re-certifying examinations currently required in the United States

of America. The advisory group had their first meeting in January 2016 and planned to provide a final report by the end of 2016.

The revalidated program will be guided by international experience and the best current evidence, but will be modified to the Australian context. The main aim is to develop and enhance the evidence based strengths of current CPD practice while reducing emphasis on activities that are not well supported by evidence and to support practitioners to obtain the best outcome for their time spent.

## CPD Membership in Australia and New Zealand

Details of the members attached to the CPD program are summarised in Table 1, and the details regarding CPD claims and audits in the year 2014 are illustrated in Table 2.

**Table 1: Details of the members attached to the CPD program**

CPD Membership Snapshot (March 2016)	
Total number of CPD participants	4108
Number of Fellows (AU and NZ)	3715
Number of Fellows overseas	53
Number of Affiliates and Associates	195
Number of individuals	145

**Table 2: Details regarding CPD claims and audits in the year 2014**

2014 CPD Claims and Audits	
Total number of claims submitted	3875
Total numbers of claims audited (10%)	387

## 1. CPD and CanMEDS

CanMEDS is an educational framework that identifies and describes the abilities that should be developed by physicians in order to effectively meet the health care needs of the people they serve. It is the basis for the educational and practice standards of the Royal College in Canada. The RANZCP CPD program supports the CanMEDS medical practitioner competency framework by enabling the planning, recording and reporting of activities completed across all CanMEDS roles. These roles are grouped thematically under seven competencies. A competent physician is expected to integrate the competencies of all seven CanMEDS Roles.

## Figure 1: CanMEDS roles

- The Medical Expert
- The Communicator
- The Collaborator
- The Leader
- The Health Advocate
- The Scholar
- The Professional

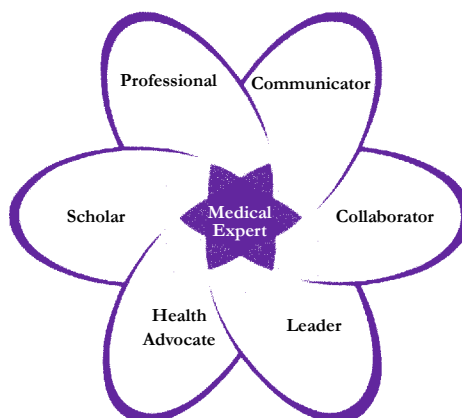


Figure 1 thematically illustrates the seven CanMEDS roles.

## Aims of the CPD Program

The CPD program focuses on fulfilling the following objectives:

- To facilitate the participation of Fellows and other College members in ongoing professional development, ensuring that a proportion of this participation is conducted with peers,
- To facilitate compliance for both the College and the participants with the requirements of the Australian Medical Council (AMC), the Medical Council of New Zealand (MCNZ), medical boards and other authorities in various jurisdictions,
- To encourage a culture within the college to review and reflect on professional practices,
- To monitor and audit the CPD process by reviewing participation in the program and the effectiveness and the relevance of the program to its participants.

The program embraces adult and lifelong learning principles and includes a wide range of activities which are practice based, incorporating peer interaction and review to reflect the collegiate nature of learning in medicine. It is also flexible and supportive to the participants. The program is receptive and responsive to feedback and research in the evolving field of CPD.

## Eligibility Criteria

Fellows and Affiliates of the RANZCP are automatically enrolled while the registered Australian and New Zealand medical practitioners and trainee psychiatrists may join the College CPD Program for a fee. Other medical practitioners may join as individual CPD participants of the College.

## CPD Program Outline

Table 3 and 4 summarise the current program requirements and revised program requirements respectively.

**Table 3: Current program requirements**

<b><u>Current program requirements</u></b>
<p>A minimum of 50 hours annually (55 credits) including:</p> <ul style="list-style-type: none"> <li>• A Professional Development Plan (PDP) (5 credits),</li> <li>• At least 10 hours (15 credits) of peer reviewed activities,</li> <li>• At least 20 hours (20 credits) of self guided learning,</li> </ul> <p>An audit of medical practice for New Zealand participants.</p> <p><b>Triennium Option:</b></p> <p>Participants who are unable to meet the annual program obligations of 50 hours (55 credits) may enroll in the three year cycle to make up any shortfall in a particular year with the proviso that:</p> <ul style="list-style-type: none"> <li>• A minimum of 20% annual completion in any one year,</li> <li>• A maximum of 60% of the three year plan may be completed in any one year of the triennium.</li> </ul>

**Table 4: Revised program requirements**

<b><u>Revised program requirements (Effective January 2017)</u></b>
<p>A minimum of 50 hours annually including:</p> <ul style="list-style-type: none"> <li>• A Professional Development Plan (PDP) (Standard 5 hours),</li> <li>• At least 10 hours of peer reviewed activities,</li> <li>• At least 5 hours practice development, quality improvement and review,</li> <li>• At least 25 hours of self guided learning,</li> </ul> <p>An audit of medical practice of New Zealand participants.</p> <p>The revised program only takes ‘hours’ in to consideration, and not the ‘credits’.</p> <p>The triennium option is not available under the revised program.</p>

## Self - Directed Reflective Learning

Reflective practice is the capacity to reflect on an action so as to engage in a process of continuous learning. The ability to offer and receive feedback and to reflect on practice both as a trainee and as a fellow, is considered as a cornerstone of Psychiatric practice. Reflection and feedback is embedded in both the Royal Australian and New Zealand College of Psychiatrists (RANZCP) training program and the Continuing Professional Development (CPD) program.

## Reflection

Reflection is a form of personal response to experiences, situations, events or new information. It is a ‘processing’ phase where thinking and learning takes place. There is neither a right nor a wrong way of reflective thinking as it is based on unique individual subjective perspectives.

## Process of Reflective Thinking

As illustrated in Figure 2, the reflective thinking process starts at an individual level. Before an individual starts to explore the ideas of others, he/she needs to pause and identify and examine their own thoughts and ideas. This involves revisiting prior experiences and knowledge of the topic. It helps to recognize and clarify the important connections between what is already known and what is about to be learnt. The prior examination of one’s own beliefs, values, attitudes and assumptions form the foundation of understanding of a particular concept and helps active and critical learning. In essence, reflective thinking demands adding of valuable knowledge to every life experience.

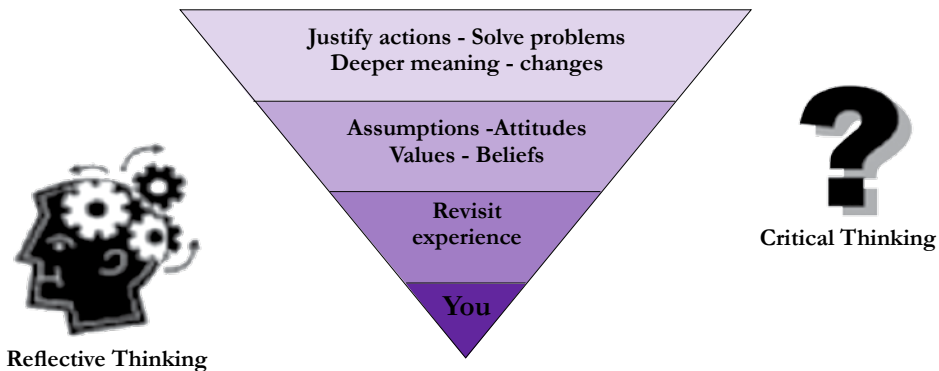


Figure 2: Reflective thinking process (Adopted from Mezirow 1990, Schon 1987, Brookfield 1987)

## Reflective Writing

Reflective writing is another way of exploring one’s thoughts, feelings, opinions and experiences in the form of writing, in order to achieve clarity and better understanding. It is an innovative way of adding meaning to what is being studied and also helps to improve writing skills. It involves critical appraisal of the experience and is different from straight forward presenting of facts.

## Scope of Reflective Practice

Reflective practice should be incorporated to all the domains in professional practice. Reflective practice may be adapted to the clinical practice domain without much difficulty, however, incorporating reflection to other domains such as patient problems, teaching, administration and leadership may be a challenging task as it requires sources of feedback outside the peer group, which may upset the power balance.

## End of Training Reflection

On completion of the training, trainees are required to submit a qualitative personal overview of their advanced training, directly to the Director of Training (DOT).

This includes:

- Evaluation of training experience and personal development during advanced training,
- Feedback on supervision,
- Perceived strengths and weaknesses of advanced training experience.

## Royal Australian and New Zealand College of Psychiatrists (RANZCP) Professional Development Plan (PDP)

The development of an annual PDP is a requirement of the RANZCP CPD program. PDP allows for consideration of the many facets of the practice of psychiatry and of how each element may be enhanced through Continuing Professional Development (CPD).

It utilizes a cycle of four steps consisting of:

- THINK
- PLAN
- DO
- REVIEW

### Steps in the development of the PDP of RANZCP

- Reflection on the current practice and gaps in practice
  - Considering individual strengths and experiences as a practitioner, concerns, shortfalls and input from feedback such as peer review groups and practice audits.

- Considering information gained from learning activities undertaken previously that may be incorporated into the practice.
- Reflection on models of excellence
  - Considering models of excellence in practice and resources such as the CanMEDS Roles.
  - Identifying possible areas for practice improvement.
- Formulation of learning outcomes.
- Implementation of the PDP.
- Review of the PDP and reformulation.

## Peer Review Groups

There is a long history of psychiatrists meeting with peers in order to review practice, obtain support and assistance with issues experienced as practitioners by way of Peer Review Groups (PRG), practice visits and supervision.

### Peer Review Groups (PRG)

PRGs are small, self-selected groups of peers who meet regularly to review their work conducted in their professional capacity. This takes place in a setting which is supportive, enabling them to present and learn through exploration of issues raised amongst peers. PRGs are regarded as the ‘cornerstone’ of the RANZCP CPD program and are highly valued by the participants. More than 95% of registered CPD participants include this activity as a component of the annual CPD program. Peer review provides an opportunity for participants to actively review their practice with the assistance of their peers. PRGs are encouraged to incorporate opportunities for members to report incidences of practice improvement as a result of the peer review process within group meetings.

The current CPD program requires a minimum of 10 hours of PRG meetings per annum. A brief confidential record of the things discussed at each meeting is maintained. An annual update and review is forwarded to the College CPD Office.

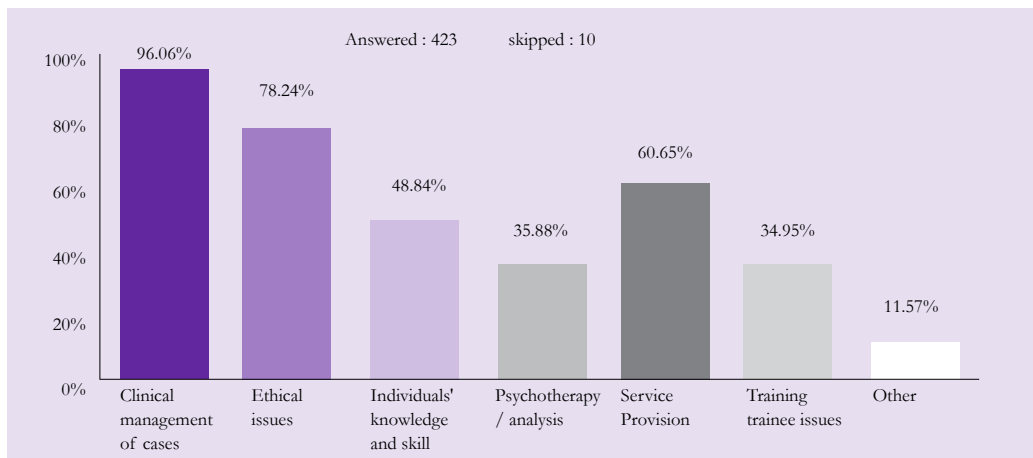
### Recurring Themes and Issues Discussed in Peer Review Groups

A survey of the main themes and issues discussed by 432 peer review group members during the past 12 months revealed that clinical management of cases was the most popular topic of discussion by 96.06% of the group members. Ethical issues, service provision issues and individual knowledge and skills were the other common themes of discussion which



consisted of 78.24%, 60.65%, and 48.84% of the discussions respectively. Psychotherapy and trainee issues were less popular topics compared to the above.

Figure 3 illustrates the topics of discussion and their frequency as a percentage. The “Other” category in the illustration consisted of business issues, clinical governance, research priorities, medico legal issues, leadership and management, work life balance etc.



**Figure 3: Main issues / recurring themes discussed by PRGs during past 12 months**

### Factors Contributing to Successful Group Functioning

Shared commitment, diversity of experience, mutual respect, friendship and compatibility were identified as the strongest factors which predict successful group functioning. Educational opportunities, shared interests, venue and timing were considered as less predictive factors compared to the above.

Figure 4 illustrates the factors contributing to successful group functioning as viewed by 431 group members. The “Other” category in the illustration denotes factors such as meeting requirements, similar stage in career, working in the same locality etc.



**Figure 4: Factors contributing to successful group functioning**

## PRGs of RANZCP

### Membership and size of a PRG

- A registered PRG must include at least three psychiatrists or College members as a minimum.
- A PRG must primarily consist of a majority of psychiatrists, although non-psychiatrists, particularly those who work within the same field may also be encouraged to join.
- A group size of six to eight members is regarded as the optimal number.

### Meeting frequency

- A PRG should meet frequently enough to adequately provide a sense of group continuity for members.
- The majority of RANZCP PRGs meet monthly for at least one hour.

### Mode of meeting

- Face to face is the preferred method.
- Teleconference and videoconference for psychiatrists in geographically isolated areas

## **Registration of PRGs**

- All PRGs are registered with the College and nominate a group coordinator who acts as the main conduit of communication between the College and the PRG.

## **PRG Coordinator's role**

- Being responsible for keeping an attendance record and member participation in case of an audit.
- Completion of the annual update and review report on behalf of the group.
- Updating the College on any change in group membership.

## **Goals for the PRG**

- Each PRG should consider a goal/s and how they will be achieved.
- Groups should regularly review and reflect on their goals.

## **Documentation of PRG meetings**

- Meeting notes should be maintained during each meeting. When the notes are no longer required by the group, there should be a mechanism of safe disposal of the notes.
- Individual members should record their hours of participation in their CPD log book.

## **Finding a new PRG to join**

- The College CPD office can help members find a suitable group to attend.

## **Practice Visits**

One psychiatrist visits the practice of another to review how well the practice meets appropriate practice guidelines. The visiting psychiatrist undertakes training and must act as a host prior to undertaking a visit. During the visit, the host and visitor reflect on their practices and review the way in which they work. The visiting Psychiatrist should conduct a structured interview with the host and further discussions as to how practice may benefit from improvements or fine tuning. A plan for further amendments / developments with appropriate strategies should be developed based on these discussions. A follow-up visit and review 6 – 12 months after the initial visit should be conducted to ensure that the strategies are implemented.

## **CPD Program of RANZCP - Annual processes**

- Current revised program runs annually over a calendar year.
- Claims should be lodged online from December (of the CPD year being claimed) to March 31st of the following year.
- Statements of claim are available immediately after online claim submission.
- Certificates are issued after claims period.
- 10% of participants are audited annually, in addition to those who failed or did not complete an audit in the preceding year.
- New Fellows who attain Fellowship after 30th June will be enrolled in the CPD program but will not have to lodge their claim for that year. Their first CPD claim will be due for the first full calendar year of Fellowship.

## **Working part-time**

- Members working part time are expected to maintain the minimum level of 50 hours of CPD activities per year.

## **Retirement**

- Retired Fellows may continue to participate in CPD if they wish to, but it is no longer a requirement.
- Members working even a few hours a week after retirement, are required to participate in CPD.

## **Leave of Absence from the CPD Program**

Fellows who are unable to complete the requirements for participation in RANZCP CPD because of illness or other reasons for absence from practice may notify the CPD Office to have their participation in the program suspended. Implications of this should be checked by the Fellow with their Registration Authorities. Absences of leave for more than 1 year will be assessed on an individual basis by application in writing to the CCME.

According to the Medical Board of Australia CPD registration standards for Medical Practitioners' temporary absence from practice:

- For the period of one year: no CPD activities are required.
- For between one and three years: a minimum of one year's pro-rata of CPD activities are required to be completed prior to recommencement.

- For more than three years: not regarded as temporary absence and Fellow/Participant CPD status will be updated to inactive status on the College database.

### **Legal Implications for Non Compliance with CPD**

- The Medical Board of Australia and the Medical Council of New Zealand registration standard require regular participation in CPD.
- All medical practitioners will be asked to declare annually on registration renewal that they have met the CPD standard. This declaration will be subject to audit.
- Failure to comply with CPD standard is a breach of the legal requirements for registration and may constitute behavior for which health, conduct or performance action may be taken under the National Laws. 128(2).

### **Refresher and remediation program**

- The RANZCP offers a specialist refresher program to Fellows or Affiliates who have taken an extended break from active clinical practice (due to ill health, family commitment, etc.)
- The specialist performance remediation program is designed to assist Fellows or Affiliates who have been identified by regulatory authorities as requiring remediation to meet the standards expected by the College.

### **RANZCP CPD Online**

The RANZCP CPD Online is an online program that has been developed in partnership with The Royal College of Psychiatrists, UK, which provides College members with interactive modules covering a range of topics relevant to practice of psychiatry. The learning modules covered online are all peer-reviewed and provide dynamic and rich information in order to acquire new skills and be up to date with research and best practice in psychiatry.

Each module consists of 30 to 90 minutes worth of educational experience and interactive activities and tests are incorporated to engage users. Completion of modules gives an opportunity to apply for RANZCP CPD claim. At present there are 165 learning modules and over 100 podcasts on CPD Online.

### **Learning Management System –LEARNit**

Learnit is the new learning management system for all College members, Fellows, Trainees, CPD participants, and College staff which provides direct access to CPD activities using College login. It is a one-stop platform with all modules: modules developed by the College and available on the Royal College of Psychiatrists CPD Online. It provides an easier way

of searching and enrolling in modules. Another feature is that it keeps track of participants' progress and the ability to continue a module from where it was last left.

### **Online CPD Tool**

From 2017 with the introduction of the revised CPD program, a proposed Online CPD Tool is scheduled to be made available to CPD members. Some of the proposed functions of this tool are:

- Mobile friendly device,
- Ability to track CPD hours which in turn would be connected to the College database,
- Automatic registration of College events,
- Real time updates and progress reports,
- Automatic reminders regarding points and months remaining,
- Self-auditing,
- Able to upload documentation for claim and audit purposes,
- Continuous accessibility throughout the year,
- MCNZ and AMC able to access CPD information for paperless audit,
- Accessibility across different College platforms,
- Follows on from a trainees use of LMS.

### **CPD Endorsement of Events**

From 2013 internal and external educational activities could be endorsed for CPD by the Committee for Continuing Medical Education (CCME) of RANZCP. This process recognizes courses and other educational activities that may be suitable for CPD. The endorsement process is optional but endorsing an event gives added weight to the activities and is viewed as having educational merit verified by the College.

## Summary

- Continuing Professional Development provides a pathway for clinicians to review and further develop professional practice to maintain and enhance their knowledge, skills and performance in all the areas of professional responsibility, in order to achieve the best attainable quality of psychiatric care and patient outcomes.
- Most CPD programs have adopted the CanMEDS medical practitioner competency framework by enabling the planning, recording and reporting of activities completed across all CanMEDS roles.
- Professional Development Plans, Peer Review Groups, self guided learning and auditing of medical practice are important components of CPD.
- Reflective practice which is the capacity to reflect on an action in order to offer and receive feedback is embedded in most CPD activities.
- Peer Review Groups are small, self-selected groups of peers who meet regularly to review their work conducted in their professional capacity.
- Shared commitment, diversity of experience, mutual respect, friendship and compatibility were identified as the strongest factors which predict successful peer group functioning.
- The RANZCP CPD program provides a valid model which shares commonalities with the SLCPsych program and could be used as a useful platform to assist members to prepare for future revalidation requirements and to support continued quality improvement of clinical practice.

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# CHAPTER 3

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This chapter is compiled based on the pre congress workshops of the 13th Annual Academic Sessions of the Sri Lanka College of Psychiatrists and the International Congress of the Asian Federation of Psychiatric Association conducted by Prof. Norman Sartorius, Prof. Mohan Isaac and Prof. Yongyud Wongpiromsarn on May 27th, 2016, Sri Lanka.

## **3.1 LEADERSHIP SKILLS FOR EARLY CAREER PSYCHIATRISTS**

### **Aim**

To provide early career psychiatrist skills that help in professional development

### **Objectives**

1. To improve professional skills as a psychiatrist
2. To improve and develop leadership skills as a psychiatrist

### **Contents**

- a) How to introduce one's self
- b) How to make a presentation
- c) How to prepare a curriculum vitae (CV)
- d) Research projects
- e) How to make a poster

### **Introduction**

Leaders are people who can motivate others to achieve their potential to reach a common goal efficiently and smoothly. A leader does so by establishing a vision, sharing it and motivating others to follow it by utilizing individual talents and skills. Leadership is a role that requires specific skills. Individuals have different innate leadership skills. These innate skills can be enhanced and made more effective by training. Developing leadership is of particular importance in the field of mental health. Modern day psychiatrists need leadership skills in clinical settings as well as to influence policy makers and other stake holders as mental disorders are a major public health issue in the current era.

There are three skills that will make leadership more effective and easy:

1. Communication skills
2. Identifying suitable individuals who will share the vision
3. Timing of leader's action

Communication skills include the art of listening to others and understanding what they are saying or want to say. The skill of presenting one's plans in a way the others will want to participate in them or share them and the skill of summarizing and providing information to others in a comprehensible manner are also part of the ability to communicate effectively. Communication skills are important to most people and can be taught in a relatively short period of time.

The second group of skills concerns the identification of those who are likely to share the vision and wish to participate in the venture that the leader wishes to undertake.

The third group of skills concerns the timing of the leader's action. This is probably the most difficult proficiency to acquire as it requires several other skills that need to be acquired.

Despite the growing need for development of leadership skills in psychiatrists, this skill is not given priority in the postgraduate curriculum in Sri Lanka. Though the opportunities to develop leadership skills during training is scarce, a majority of them are expected to assume leadership roles early in their careers and are faced with unexpected challenges, without having skills to face them. As a result early career psychiatrists become vulnerable, frustrated and feel powerless. Through the workshop conducted by the Sri Lanka College of Psychiatrists, the importance of leadership skills was highlighted. It is hoped that this chapter will serve as a guide for early career psychiatrists to help improve some of their leadership skills.

## 1. How to Introduce One's Self

Introducing one's self is an essential and important skill. It is taken for granted that it comes naturally to one. Introductions are done almost daily. It might be a meeting, a workshop or even clinical encounters with your patients and families. Recall the number of people you remember after a brief introduction and the people you don't remember. What was it that stood out in them that you still remember? In an introduction you have to make sure that you stand out and will be remembered.

### ➤ Posture

When you introduce yourself you must stand up straight so that everyone is able to see you. Smile with the audience and the chairperson. Avoid having your hands in

your pockets. If you can't be seen from where you are, come to a place where you can be seen. Look at the chairperson and the audience when you talk.

➤ **How to talk**

When you speak make sure that you are heard by all. So, be loud and clear. If you have a long name tell them a way to remember it.

➤ **What to say**

• **What you do**

You may also like to tell the people what sort of work you do and where you work. Tell them what you do and if someone who has already introduced themselves has the same speciality, you may say “as the previous speaker, I too am a child psychiatrist”.

• **Where you are from**

You may like to tell them from where you are and then a way to remember it “I come from a beautiful area where mangoes are the best”.

• **Where you work**

If there are others who are also from the same place of work, say something that you do differently from others, eg. “I hope to do spatial psychiatry in the future” or the type of patients you look after.

*If you are gifted crack a joke!*

**Practice point**

INTRODUCE YOURSELF IN A WAY YOU WILL BE REMEMBERED.  
FOR YOU WILL MAKE A FIRST IMPRESSION ONLY ONCE!

**2. How to Make a Presentation**

➤ **General technique**

Find out the exact number of minutes you have and if using slides prepare them first. Try them out by yourself, saying everything you want to say and time it carefully. If you realise that it is taking far too long, check how many minutes long it is.

➤ **Shortening the lecture**

If you feel your presentation is too long decide which slides you want to cut out. Remove them, and try again. Remember, the audience does not need to know everything that you know!

What is the message you want to give? The title should relate to the AIM of a short lecture, and should command the audience's attention!

Keep repeating the lecture until it is slightly too short.

➤ **Preparing the slides: Guidelines for slides**

**DOs**

- ✓ Only show what you want the audience to see. Cut out everything else
- ✓ Those at the back of the hall must be able to read ALL of it
- ✓ Have only a few sentences
- ✓ Maximum 6 lines; max 40 letters per line
- ✓ Keep it simple – not too many colors
- ✓ Preferably only two colors
- ✓ Use legible fonts like – Arial, Tahoma, Comic Sans Serif
- ✓ Label all graphs, show clearly what the axes are
- ✓ Label all tables

**DON'Ts**

- × Do not use fonts such as Times Roman or Courier
- × Do not use distracting devices – animated cartoons, or complicated background
- × Do not use published formats for tables
- × Nothing fancy!

## An example of a good slide

**So, here is a good slide**

- Only a few sentences
- You can read them at the back of the lecture theatre
- Only two colors
- Nothing fancy!

### ➤ **Learn the beginning and the end by heart**

It is important that you learn the beginning and the end by heart. You will be much less nervous if you do! Decide how you will greet the audience and start by telling them the aim of your talk. It is very important that you DO NOT use notes for this part.

The lecture must end on a firm interesting note. Mention the implications of what you have said.

Learn this by heart.

### ➤ **Rehearsing**

Trying out the lecture before, is a must. This should preferably be done in front of your partner or a close friend. At the end of the talk they should be able to say if they understood what you were trying to say and if there were things they did not understand. The observer should also comment if you were stuck in your notes or whether there was adequate eye contact with the audience. Ask them for this information.

### ➤ **Days before the lecture**

It is important to find out from the organizers where exactly the lecture will be held. Once you know this, plan how you will get there. Ask them the type of audio visual equipment that is available at the lecture hall and find out the software available. Eg. Microsoft Office PowerPoint 2007 or 2010 or latest version.

If in doubt it is always easy to take the material in two different formats, eg. transparencies and power point presentation.

Remember to take TWO copies of your USB or disc.

➤ **Using notes**

It is best if you do not use notes. Use the slides to remind yourself of what you need to say. If you need to use notes use a small deck of 8 x 12 cm cards with the main points on them.

**DO NOT READ FROM THE NOTES**

➤ **The day of the presentation.**

It is important that you get to the lecture hall early. If there is an audio visual technician get to know him and ask him to show the audio-visual equipment that is being used. Review your presentation. Agree with him how you will be asking for the “next slide” by a gesture etc. or if you would be changing the slide yourself. Familiarize yourself with any controls, pointer, etc.

➤ **When delivering the talk**

• **How to stand**

Stand with your legs slightly apart with weight distributed on both legs. If you are using a computer make sure you are able to see it. Make sure the podium does not cover you and that you are seen by the audience! If not, stand away from the podium. Keep your hands visible, between shoulders and waist and movements of the hands are best if symmetrical. However, if you are nervous hold onto something.

• **How to speak**

Speak clearly, and not too fast or slow. Make sure that everyone can hear you and if you are not sure ask them, eg. “those at the back if you can hear me please raise your hands”. Make eye contact with your audience. This helps you to engage with the audience. If you do have to use notes, look up whenever you can and make eye contact with the audience.

• **How to use the pointer**

If you decide to use a pointer hold it in one hand and brace it with the other arm. This will hide your tremor if any. **DO NOT** turn round to look at the screen unless you are pointing something out with the pointer. Use the pointer on graphs and numbers and **DO NOT** point out text you are reading out.

• **If you exceed your time**

Despite rehearsing, occasionally you may run short of time. If so, do not panic - inform the Chairman you will finish in one minute. Then jump to your conclusion and end the lecture as you would have done. This is the importance of practising the start and the end.



### 3. Writing your Curriculum Vitae (CV)

#### When might you need a good CV?

You might need a good CV if you are moving to a better job, where you are not known. You will also need a good CV if you are up against stiff competition, if applying for research funding or applying for a promotion.

#### Good points in a CV to get shortlisted

- Striking, well set out, easy to read and without ANY spelling mistakes.
- Checked over, TWICE
- The lay-out and the font used should be attractive
- Printed on high quality paper
- Get your CV checked by someone who knows you well and ask how it might be further improved

#### Contents of the CV

**Title page**– Curriculum Vitae and name written

**Next page**

PERSONAL DETAILS (does not need own heading)

- Full name, maiden name if married woman
- Postal address
- Telephone, fax and e-mail numbers
- Nationality (if foreign, whether qualifications are recognized in the country you are applying to)
- Date and place of birth
- Medical Council Registration number
- (Temporary address at present)
- If appropriate: Visa status

#### **You should NOT tell them**

- × whether you are divorced or separated
- × how many children you have
- × or (if female) whether you intend to have any children

## DETAILS OF EDUCATION

(reverse order, starting from present)

- Give month and year of starting and stopping. Mention any outstanding achievement during basic schooling, but only highlights.
- Go right back to your secondary school (but few details here).
- Explain any gaps in your life - between courses or jobs.

## QUALIFICATIONS

- Give only public degrees, diplomas and so on
- Unless very poor, give grade awarded
- Special Awards & Prizes
- These go in now, with sub-heading

Eg.

**MBBS** (1992) Faculty of Medicine, University of Colombo

**M.Sc. 1st Class with Honours** in History of Medicine, Institute for the History of Medicine, University of London

**MD Psychiatry** Postgraduate Institute of Medicine, University of Colombo, Sri Lanka

**MRCPsych** Royal College of Psychiatrists, UK

## AWARDS & PRIZES

### DETAILS OF CLINICAL TRAINING – descriptive

Probably only necessary just after training is complete

But, if fairly junior, and unknown, here is an opportunity to give them important information

## TEACHING EXPERIENCE

If you've been to a course on "How to teach", start with this.

Mention any teaching you have done even informally for medical students, junior colleagues or nurses during ward rounds or otherwise.

## RESEARCH EXPERIENCE

### CAREER AIMS

### PUBLICATIONS

List full references to REFEREED journal articles, which have either appeared or are “in press”.

Do NOT describe papers that are “submitted”.

If you have other publications, list them separately. (chapters, books, other).

Ask whether they would like to see articles that are “in press”, and bring them with you to the interview if selected.

### OPTIONAL EXTRAS

- Research grants held
- Postgraduate courses attended
- 3 best publications
- Any special interests

### ADDITIONAL CLINICAL EXPERIENCE

- Psychotherapy
- Audit
- Committees
- Management activities

### ➤ **Adapt your CV to your seniority**

#### **If you are junior you may include the following**

Prizes at school & at the university and tell them as many good points as possible, about yourself.

#### **If you are senior you may include the following**

What you will achieve if appointed?

If you will obtain grants in competition?

## The Main Headings of a CV at a glance

- **Title Page**
- **Other pages**
- Personal details
- Details of education, with dates & grades
- Qualifications
- Details of professional training
- Special awards & prizes
- Teaching experience
- Research Activities
- Publications
- **Other good headings**
- Why you've applied for THIS job
- Career intentions
- Languages spoken, how fluently
- Computer literacy
- Any teaching experiences, and training
- Referees names, addresses and phone numbers, one of whom **MUST** be from your present employment. This is very important for prospective employers to know that you have not had any issues at your current work place.

## 4. Selecting a subject for research

The **FOUR** questions you should ask yourself when selecting a subject for research are :

1. Why am I doing research at this point in time?
2. How much time do I have?
3. How feasible is it?
4. What topic shall I choose?

### ***Question 1 : Reasons for doing research***

Before starting on a research project you should be clear about the reasons for doing it. Ask yourself ‘why am I doing this research project?’

Some of the reasons might be as follows:

- It will contribute to my career (eg. by a publication)
- It will open the door to a network of nice people
- It will open the door to a powerful team
- It will answer a question of interest
- It will help to learn the use of a technique
- It could be useful to patients, now
- It will contribute to image and reputation
- My supervisor requires that it be done
- It will open the door to new avenues of employment
- It will break my boredom

### ***Question 2 : Time factor***

Do I have enough time ?

- Will the study take much personal time ?
- Will I have to sacrifice a little, to do the study ?
- Will the study have to be completed before I leave this job and change position ?
- Would it be possible to decide when to work on this study (eg. during weekends, evenings) ?

### ***Question 3: Feasibility of the study***

How feasible is it to carry out the study ?

- Can the study use methods which can be learned quickly ?
- Can the study be completed even if some participants drop out ?
- Can the work on the study be incorporated into my normal work routine
- Is there a clear statement of roles and rights (eg. who decides on who will co-author the publication) ?

- Will the study involve personal expenses ?
- Will there be a faint chance that some money will become available for the study ?
- Will there be an agreement which makes it possible to have access to data for further publications ?
- Will the study present any danger (eg. of infection) during the investigation ?

***Question 4: The topic***

Why do I want to select this topic ?

- The topic is ‘in the wind’ ; fashionable
- The study could be continued later (eg. by a follow-up of the persons examined)
- The main question which the study aims to answer is clear and can be easily communicated to others
- The publication is likely to be easy
- The study will involve several (international) sites

***A helpful score when deciding on a research project***

(This score should be kept in mind when deciding to go ahead with a research project)

- Reasons for the study..... \_\_\_ out of 10
- Time for the study ..... \_\_\_ out of 4
- Feasibility..... \_\_\_ out of 8
- Topic..... \_\_\_ out of 5

A score of 17 would be ideal, but it is unlikely. Priority should be given to studies with a score higher than 12.

***Examples of studies with high scores***

Studies taking 2 – 8 weeks of time

- Pathways to care
- Surveys of captive populations

Studies taking 3 – 11 months of time

- Simple experimental studies
- Exploration of existing statistics

Studies taking longer should be left for later in one’s career

### **Other examples of studies**

- Studies of pathways to care (of men, women, different diseases etc)
- Studies of patients' satisfaction
- Studies of carers' satisfaction (or burden)
- Studies of mental illness in the physically ill
- Studies of physical illness in the mentally ill
- Studies of mental disorders in nursing homes  
(and in other settings with long stay populations)

### **Examples of studies**

- Studies of factors influencing length of treatment at in-patient facilities
- Census investigations in facilities (eg. of prescription patterns of medications or changes of patient populations over time)
- Studies of patients' or facilities' records
- Case studies (eg. of patients, treatment institutions)

## **5. How to make a poster**

### *What is the purpose of a poster?*

#### **The purpose of a poster is**

- To give a message
- It should ideally be one message but not more than three messages in one poster
- To convey information in a manner that makes it easy for the reader to get it.

### *Usual subjects*

- Report of a simple study or independent part of a larger study
- A message - humanitarian, political or other
- Description of a program or department

### *Unsuitable subjects*

The following are not suitable as posters

- × Full reports of studies
- × Discursive texts

- × Materials that do not gain by a visual presentation.
- × Materials that have not yet ripened in the authors' mind and carry no message.

### *Characteristics of posters*

- Posters are a visual tool.
- Posters draw attention to other matters - the author, a study, a department, an ideological position.
- Posters of good quality attract readers and make it possible for them to get the message quickly, in a minute or two at the most.

### *Maximum lengths for points*

- Introduction                      3 lines
- Goal                                    2 lines
- Method                                6 lines
- Results                                12 lines
- Discussion                            5 lines
- Conclusions                          3 lines
- References                            4 lines

### *Assets of posters*

- A well-known name, a logo, a familiar figure
- A striking photo or other picture
- Use of few harmonious, non-aggressive colors
- Decent print size easy to read from a distance of 2 meters

### *Essential accompaniments*

- Tools (scissors, tape, whitener, tacks)
- Copies of poster in A4 format with the authors' address, phones numbers, e-mail
- Notebook and pencil
- A foldable chair



## 3.2 LIVE YOUR LIFE IN FULL: A GUIDE FROM MINDFULNESS-BASED THERAPY AND COUNSELLING

### Learning outcomes

By reading this chapter you will learn:

- Mindfulness and its benefits for life
- Mindfulness-Based Therapy and Counselling (MBTC)
- Practical use of Mindfulness-Based Therapy and Counselling

### Introduction

Mindfulness (sati) and concentration meditation (samadhi) are not new concepts for Sri Lankans. They have been known for more than 2500 years due to religious influences and have brought peace and happiness to their lives.

Thomas Bien, states “mindfulness does not require one to be a Buddhist or to share Buddhist insights with the patient”. He further emphasizes that ‘mindfulness is also something that we can practice ourselves. Since mindfulness is ultimately the art of living happily, it is not a burden’. Today mindfulness is widely used for therapeutic and counselling purposes. It’s usefulness to the general public is beyond therapeutic value, as it helps to live life in full and to face problems in a positive manner.

Mindfulness-based therapy and counselling ( MBTC) is a training program developed by integrating mindfulness, concentration, meditation and some special life skills for therapists and counsellors to treat their clients with stress, anxiety, depression, addictions, bipolar disorder and panic disorders. The program was developed by an advisory group of the Department of Mental Health, Ministry of Public Health in Thailand. The content of this chapter is based on the training program conducted by Dr. Youngyud Wongpiromsarn, chief advisor to the group, and the “mindfulness-based therapy and counselling – MBTC-Manual for Therapists”.

### Mindfulness

Mindfulness has been defined by a number of scholars, researchers and religious leaders. According to Satipattana Sutta, “mindfulness is the only way to deliverance”. The Vietnamese Zen monk Thich Nhat Hanh explains,

“Our true home is not the past. Our true home is not the future. Our true home is here and now. Mindfulness is the energy that helps us to recognize the state of mind, that already exists in our lives.”

As Jeffrey S. Navid (2009) has explained, practicing mindfulness is an attempt to be here and now. Mindfulness is a process where, the mind is brought to focus on what is happening at the present moment while noticing the mind’s usual “interpretation” or “commentary”. It encourages letting go of the past, dreams for the future whilst fully embracing the present moment.

Jon Kabat-Zinn, the mindfulness based stress reduction pioneer, defines mindfulness as ‘paying attention in a particular way, on purpose, in the present moment and non-judgmentally’.

## **Mindfulness-Based Therapy and Counselling - MBTC**

MBTC provides an eight session guide to bring peace and happiness to human life.

1. Tranquil meditation practice
2. Mindfulness practice
3. Mindfulness and body sensation; learning to let go
4. Mindfulness and thoughts; learning to let go
5. Mindful relationships with others
6. Mindful communication with others
7. Self-compassion, compassion to others and forgiveness
8. How to apply mindfulness and meditation in everyday life

In considering the techniques used in mindfulness based therapy, the formal practices such as sitting meditation (attending to breathing, body sensations, sounds, thoughts, etc.), movement meditation (walking meditation), and guided discussion on experiences are used. In addition, informal practices such as doing day to day activities mindfully, and mini-meditation practices are also used.

### **1. Tranquil Meditation Practice**

Tranquil meditation practice provides an opportunity to be aware of the emotions and their consequences on mind and body. Emotions and stress can affect one’s mental processes such as love, compassion, sacrifice, patience, and forgiveness. Concentration meditation can help one to relax from distractions caused by emotions and stress. It can reduce intensity

of emotions and thoughts that predominate the subconscious mind and thus helps coping with upcoming stress. Practicing concentration meditation results in calmness of mind and improves performance.

During concentration meditation the mind is alert without interfering thoughts and feelings. Practicing concentration meditation will help to develop mindfulness without much difficulty.

### **Practice Point 1**

#### **3-step Meditation Practice**

##### **Step 1: Noticing your breath**

- Sit comfortably with your back upright, close your eyes, keep your feet on the floor and your hands on your lap. Relax and take long breaths in, and breathe out. Repeat 4 to 5 times.
- Keep the back of your hand near your nose. You will be able to notice the warmth of your breath, since the nerves at the back of your hand are more sensitive than the nerves in your nose. Put your hand down on your lap. Then try to notice your breath at the area between your nose and your upper lip. If you pay more attention, you will notice your breath better than before.
- Lengthen your breath and notice in which nostril you feel the breath better or you may feel your breath at the area between your nose and upper lip. When you know the area that you can feel your breath clearly, breathe naturally for 1 minute. You will begin to notice your breath at that area continuously. Continue breathing and noticing your breath for one more minute.
- Can you notice your breath? Notice where you feel your breath more clearly, at your left nostril, right nostril, or at the area between your nose and your upper lip. When you first practice noticing your breath, it may be hard for you to feel your breath at this area, but with practice, you will improve your awareness.

## **Practice Point 2**

### **3-step Meditation Practice**

#### **Step 2: Thought management**

- Close your eyes again, breathe naturally and try to notice your breath at one of your nostrils or at the area between your nose and your upper lip. Observe your breath for one minute.
- During this time, there will be some thoughts coming to your mind. Tell yourself to be aware of your thoughts but try not to follow them. Let go your thoughts and come back to observe your breath again.
- When your thoughts come back, be aware of them, but do not follow them. Let them go. Concentrate on your breath again.
- Do not try to stop your thoughts even if you feel uncomfortable. It will distract you.
- Let your thoughts go. Return to observe your breath.
- If many thoughts come to your mind, take one or two long breaths and come back to observe your breath again. Try to observe your breath as long as you can.
- Are you aware of thoughts in your mind? Can you let go of your thoughts? Can you come back to observe your breath again? How long can you stay with your breath without getting thoughts?
- If you cannot stay with your breath because thoughts arise in your mind, allow yourself to take one or two long breaths, then begin to observe your normal breath again. Try to focus on your breath as long as you can. When thoughts arise, remind yourself to let go of them and observe your breath again.

### **Practice Point 3**

#### **3-step Meditation Practice**

##### **Step 3: Sleepiness management**

- Close your eyes. Focus on your breath.
- Though many thoughts arise in your mind, let them go, take long breaths once or twice and observe your breath again. Try to stay with your breath as long as you can.
- During your practice, you may feel sleepy and may fall asleep. When you wake up, try to sit with your back upright, take five to six long breaths to allow your brain to get more oxygen that will help you feel fresh, or you may visualize a strong light in your brain to wake you up. When you are awake, continue to be aware of your breath again.
- Try to observe your breath continuously, manage your thoughts and your sleepiness by the methods that have been suggested and come back to observe your breath again. (continue for 2 minutes)
- Open your eyes and look downward at the floor near your feet, continue to observe your breath with your eyes open for 1 minute. This is called open-eye meditation.
- How are you? How do you feel? Do you feel calm? Do you feel relaxed? Can you manage your thoughts and your sleepiness?
- Try to practice this twice a day, in the morning and in the evening, each time for 10 minutes.

## **2. Mindfulness Practice**

Mindfulness helps us to live a peaceful life with our daily activities, while managing our inner thoughts and feelings. Everybody has learnt to be at least partially mindful. We can improve mindfulness by partly noticing our present breath while continuing with tasks at hand. It will help us focus better on what we are doing at present. Practicing mindfulness can help us to focus more on our work and will not interfere with emotions and stress, and will develop an inner-wisdom or the ability to let go. The concentration meditation helps to prepare the foundation for mindfulness. The technique used to practice mindfulness is to practice concentration meditation, close-eyes meditation and open-eyes meditation followed by the

‘open-eyes with partial awareness of breaths and focusing on doing the activity’. We can initiate practicing mindfulness with selected activities such as mindful walking and listening. After sufficient practice with selected activities, it could be extended to all activities and being mindful throughout the day.

### **Mindful Practice**

Close-eyes meditation (1 Minute)

Open-eyes meditation (1 Minute)

Open-eyes with partial awareness of breaths and focus on doing the activity

We can walk a distance in our usual way and experience tiredness and other related feelings with that exercise. Then we can walk the same distance mindfully, by partly noticing our present breath and paying attention to walking. We will be able to experience that mindful walking is associated with less tiredness and stress.

Mindful listening is another exercise that we can practice. We can listen to a selected song in our usual way. Then, we can listen to the same song mindfully, observing our breath while listening.

When we listen mindfully, we will be able to control our thoughts and emotions better than before, not be overwhelmed with the strong emotions emerging from the story.

At the beginning of the practice, you may not feel familiar with the new experience; later on with more practice, you will realize that you are paying more attention to what you do, notice more details, feel less emotions, be more rational and more mindful.

### **3. Mindfulness and Body Sensation; Learning to let go**

When we have strong emotions, the balance of the autonomic nervous system in our body will change and sensations will be felt. If we observe our emotions mindfully, we will notice the changes that take place. This is called letting go. Though we do not have strong emotions, we can still use mindfulness to notice our feelings or our body sensations; we can notice when they are arising and changing and can let go as well. The activities of the session are mentioned below.

We can start with conducting concentration meditation, practice mindfulness while standing, walking or listening. Practice noticing body sensations in more detail by practicing body scan.

## **Practice Point 4**

### **Body Scan Practice**

- Spend around 10 minutes to practice body scan.
- Sit comfortably, with your back upright, breathe naturally. Do not try to control your breath, do not count the numbers, do not say any mantra words, just focus on your natural breath quietly.
- Begin to observe all the feelings in each part of your body from the top of the head to the tip of the toes. We will observe each part step by step by dividing into 3 small parts as follows:
- We will begin with the top of the head or the skull where our hair grows; observe your breath while noticing the feelings of the area of your skull. The feelings you may find are: cold, hot, moist, soft, hard, heavy, light, itch, pain, tickling, cramp, tingling, tightness, etc.
- If the feelings are not strong, then proceed to your face, but if the feelings are very strong and make you feel bad or want to react, allow yourself to observe them patiently for 1 minute without doing anything, only observe your breath. Observe these feelings and their changes. If the feelings are very strong and make you feel painful, focus most on your breath for a minute.
- Then move your attention to your face. Observe the feelings that occur on your face such as hot, cold, sweat, itching, painful, etc. also observe the changing of these feelings as well.
- Move your attention to your neck, observe your breath and notice your feelings at your neck and the changes in these feelings.
- Move your attention to your right shoulder, right arm, and right hand. Observe the feelings that occur such as hot, cold, sweat, hard, soft, itch, pain, tightness, etc. If the feelings are very strong, don't react to them, only observe them and their changing nature until they disappear.
- Move your attention to your left shoulder, left arm, and left hand. Do the same for the right hand side.
- When you have finished observing the feelings from head to toe, begin to observe from toe to head. (*spend 10 minutes*)
- After 10 minutes, observe your breath for a while and then do open-eye meditation for 1 minute.

### **Practice Point 5**

#### **Focusing and Labeling Practice**

- After finishing practicing the body scan, close your eyes again, breathing deeply (3 times).
- Remind yourself of a situation that occurred in the past week that made you feel upset or unhappy. Try to review the details of the situation as much as you can, for example, where the situation occurred? who got involved in that situation? what that person said, did or express, which emotion? etc.
- Return to observe your breath and observe your body sensations such as feeling hot at your face, tightness in your chest, your heart beating very fast, sweat on your palms, difficulty in breathing, dry mouth and throat, etc. (spend around 3 minutes).
- Focus on the part of the body that you have a very strong feeling, observe the feeling of that part for 1 minute or you can let them go.
- You will find that the strong feeling has changed and has gone by that time.
- Being mindful of your breath and your body sensations will help you to stay with all the feelings without reacting, being upset or unhappy with them. In case you cannot feel any sensation in your body, you can identify your emotion instead or the feeling that occurs in your mind, for example, anger, fear, sadness, frustration, worry etc. and when you observe these feelings for a while you will see that they fade away (spend around 3 minutes).
- Do open-eye meditation for 1 minute.
- You will learn that every feeling or emotion that occurs, will change on their own and fade away at the end, you don't have to react to them at all. So you don't have to be troubled by them again in the future.
- You will be able to let go and have a peaceful mind as well.

#### **4. Mindfulness with Thoughts and Letting Go**

Negative thoughts often occur automatically and make us believe in them. However, mindfulness can help us identify thoughts from real situations more clearly. Observing negative thoughts will make us observe how they are arising, changing, and passing away. It will help us to let them go and no longer to feel distressed by those thoughts.



### **Practice Point 6**

#### **Mindful of Thoughts and Let Go Practice**

- Practice by meditating for 3 – 4 minutes.
- Sit comfortably, with your back upright, put your feet on the floor, place your hands on your lap, take 5 – 6 deep breaths and then breathe naturally. Observe your breath at the area where you can feel your breath better, such as the left nostril, right nostril, or the area between your nose and your upper lip.
- If thoughts arise in your mind, acknowledge them, but do not follow them. Return to observing your breath and continue to observe your breath as long as you can.
- Do this every time thoughts arise in your mind.
- Go on meditating for 3 minutes.
- Then practice mindfulness with thoughts.
- Be aware of your breath while focusing on your thoughts for 5 minutes. Try to observe the thoughts that arise in your mind, don't stop thinking, but focus on them continuously. You will notice that when your thought arises, it will change and fade away.
- When another thought arises, observe it, until it changes and fades away.
- Be mindful of your thoughts for 5 minutes.
- (After 5 minutes) Be aware of your breath and then visualize one of your daily activities that made you feel tired or exhausted. Recall it vividly, such as the time, place, person, gesture, conversation in that situation.
- While you visualize the activity, continue to be aware of your breath. Then observe your thought upon that activity, observe how your thought changes and how it fades away without any reaction, let it go. Be mindful of your thoughts on that situation for 5 minutes.
- (After 5 minutes) Open your eyes and do open-eye meditation for 1 minute, then take notes of your experiences.

## **5. Mindful Relationships**

### ***Mindful relationship practice***

Learning to review existing relationships and developing better relationships adds value to life. Mindful relationship practice helps to understand the influence of thoughts on our

relationships, and their consequences on our relationships with others. This helps us to be able to let go the negative thoughts and look at the relationships in a new dimension.

A long term relationship with someone who is close to us can accumulate a lot of negative automatic thoughts and make the relationship worse. Mindfulness and letting go of negative thoughts, considering the relationship in a new dimension, helps improve the relationship.

### **Practice Point 7**

#### **Reviewing Your Relationship**

- Start by meditating for 3 – 4 minutes.
- Sit comfortably, with your back upright, put your feet on the floor and hands on your lap. Take 5-6 deep breaths and then breathe as usual. Observe your breath at the area where you can feel your breath better, such as the left nostril, right nostril, or the area between your nose and your upper lip.
- If thoughts arise in your mind, acknowledge them, but do not follow them, return to observe your breath and continue to observe your breath as long as you can.
- Do this every time you have thoughts in your mind.
- Meditate for 3 minutes.
- (*After 3 minutes*) Slowly open your eyes. Practice open-eye meditation for a minute.
- Be aware of your breath and review your relationship with a person who is very close to you in 2 aspects.
- The first topic is the good things that he/she has done for you no matter what the issues are, whether big or small. Sometimes we may overlook these qualities, try to recall them once again.
- Separate the time into 2 periods. The first period is the period when you had many problems with him/her about six months prior to starting therapy. The second period about 2 years back.

#### **Continue... Reviewing Your Relationship**

- Think of the good things he/she has done for you 6 months before you came for therapy. While you are thinking and observing your breath you should be more mindful of your thoughts.
- (*Spend around 5 minutes*)

- *(After 5 minutes)* Now think of the good things he/she had done for you 2 years back. Spend 5 minutes on this and observe your breath at the same time. You will be more mindful with your thoughts.
- *(After 5 minutes)* Then do an exercise on the Activity form.
- Now think of the bad things you had done to him/her intentionally or unintentionally in the 6 months prior to therapy. Think of the bad things you had done to him/her 2 years ago. Think carefully.
- Begin by thinking of the bad things you had done to him/her 6 months before starting therapy; take 5 minutes to recall them. Observe your breath while thinking, so you will be more mindful of your thoughts.
- *(After 5 minutes)* Now think of the bad things you had done to him/her in the last 2 years. Spend 5 minutes. Observe your breath while thinking so you will become more mindful with your thoughts.
- *(After 5 minutes)* Then continue to do the exercise on the Activity form.

### Activity Form

#### Review Your Relationship

Please fill in the space below:

- The person who is very close to you and often annoyed you most is  
.....
- Think of the situations and the thoughts that often happen to you when you think of this person and identify your thoughts into 2 categories as follows;

<b>Bad things that he/she has done to me</b>	<b>Good things that I tried to do to him/her but haven't succeeded</b>

- How do these thoughts affect your relationship with this person?  
.....  
.....  
.....  
.....

### Activity Form

#### Continue.... Review Your Relationship

Then notice your breath, and review your relationship with him/her. Think of the good side of **him/her that you may have overlooked and the bad things that you did to him/her though you did it unintentionally.**

Write on the chart below, begin with the left side then the right side; separate the time period into 2 periods; the period you had the problem and before. eg. 1 month back and 2 years back. Time can be flexible according to the problems.

<b>His/her good side that I overlooked</b>	<b>Bad things that I did to him/her unintentionally</b>

- What have you learned after reviewing your relationship with this person?  
.....
- What you expect to happen to your relationship with this person?  
.....

## 6. Mindful Communication

Communication plays a vital role in maintaining human relationships. Unhealthy communication causes many of the psycho-social issues linked with human life. Therefore, identifying common communication problems and their consequences is important to maintain productive human relationships. The ability to use mindfulness in both verbal and non-verbal communication, is vital in building and maintaining healthy and fruitful relationships.

Negative verbal and non-verbal communication will enhance bad emotions and cause problems in relationships. Being mindful in our conversations helps us in our verbal and non-verbal communication, leading to better acceptance of our communiqué by others and helping in resolving conflicts.

### Practice Point 8

#### Improving Communication Skills

- Start by meditating for 3 – 4 minutes.
- Sit comfortably, with your back upright, have your feet on the floor and hands on your lap. Take 5-6 deep breaths and then breathe as usual. Observe your breath at the area where you can feel your breath better, such as the left nostril, right nostril, or the area between your nose and your upper lip.
- If there are thoughts arising in your mind, acknowledge them, but do not follow them, come back to observe your breath and continue to observe your breath as long as you can.
- Do this every time you have thoughts in your mind.
- Meditate for 3 minutes.
- (After 3 minutes) Slowly open your eyes and do open-eye meditation for 1 minute.
- Now you will be mindful reviewing your communication with the one who is most important to you. Observe your breath while you think of your communication with him/her. Think of the situation that often causes a problem between you and that person. If you are more mindful by observing your breath while you are thinking and noticing your feelings, you will develop better verbal and non verbal communication with him/her. You may also know how to use “I message” and can expect a better outcome.

## 7. Self-Compassion, Compassion to others and Forgiveness

While mindfulness is the way to acknowledge emotions, especially the bad emotions that are distressful, be aware of their change and let go. Self-compassion is the state that the mind is above mindfulness and can enhance better self-esteem and self-acceptance. With mindfulness, we can convey our compassion to a special person and all other living things. It can get rid of our anger and open up our mind.

### Practice Point 9

#### Self-Compassion Practice

- Start by doing meditating for 3 – 4 minutes.
- Sit comfortably, with your back upright, put your feet on the floor and hands on your lap. Take 5-6 deep breaths, and breathe naturally. Observe your breath at the area where you can feel your breath better, such as left nostril, right nostril, or the area between your nose and your upper lip.
- If there are thoughts occurring in your mind, acknowledge them, but do not follow them, come back to observe your breath and continue to observe your breath as long as you can.
- Do this every time you have thoughts in your mind.
- Meditate for 3 minutes.
- (*After 3 minutes*) Place both hands on your chest over the area of your heart. Feel the love and compassion you have for yourself, the warmth of your hands, and observe your breath. Breathe slowly 5 times, then place both hands on your lap.
- Notice sensations on your body starting from your head to your toes, while you observe your feelings at each part of your body. If you have a strong feeling at any part, stop there for 1 minute, and observe how the feeling changes and fades away. No matter what you feel on any part of your body, before moving to another part, thank that part. Thank each part that is very useful for you.
- When moving from one part of your body to another part try to observe the feeling of that part and thank that part that has been very helpful to you and convey your compassion to that part too. For example, thank your skull that protects your brain, eyes and ears that help you to see, to hear good things, neck that supports your head, arms and hands

### Continue ...Self-Compassion Practice

that work hard all day, heart that works 24 hours every day, thank your digestive system that changes the food into nutrients and energy, spine that supports your body and legs and feet that take you everywhere.

- If you have strong feelings on any part of your body, stop there for 1 minute to see how they change and fade away. You may realize that there is both happiness and misery. When they happen, they will fade away on their own, so you just let them go. They are not important to you at all (*Spend around 10 minutes*).
- (*After 10 minutes*) Take both hands and hug yourself, gently hold onto yourself to remind you to love and have compassion on yourself. Acknowledge the warm feeling from your hug, and then put your hands back on your lap.
- Next tell yourself:
  - May I be happy
  - May I be peaceful
  - May I be in harmony
  - May I be free from all the miseries
- If you have any thoughts occurring in your mind, let them go. Come back to observe your breath.
- Now tell yourself again:
  - May I be happy
  - May I be peaceful
  - May I be in harmony
  - May I be free from all the miseries
- (Pause for 30 seconds) Slowly open your eyes, do open-eye meditation for 1 minute.
- Note the experience in the Activity form.



## Practice Point 10

### Compassion and Forgiving Others

- Meditate for 3 – 4 minutes.
- Sit comfortably, with your back upright, place your feet on the floor and your hands on your lap, take 5-6 deep breaths and then breathe naturally. Observe your breath at the area where you can feel your breath better, such as left nostril, right nostril, or the area between your nose and your upper lip.
- If there are thoughts arising in your mind, acknowledge them, but do not follow them, come back to observe your breath and continue to observe your breath as long as you can.
- Do this every time thoughts come to your mind.
- Meditate for 3 minutes.
- (*After 3 minutes*) Think of a situation that was not serious and the person that made you feel upset and unhappy. Then observe the feelings of your body or the thoughts that occur with a calm mind and let go (spend around 3 minutes).
- (*After 3 minutes*) Both you and that person who troubled you are feeling miserable. Both of you are upset and unhappy. So it is better to forgive and convey compassion to each other.
- Observe your breath and tell yourself with calm and let go:
  - May you and I be happy
  - May you and I be peaceful
  - May you and I be in harmony
  - May you and I be free from all the miseries.
- Please put both hands on your chest over the area of your heart. Feel the love and compassion you have for yourself, the warmth of your hands, and observe your breath. Breathe slowly 5 times, then place the hands on your lap.

### Compassion and Forgiving Others

- Now think of the special person or living thing that brings happiness to you. Feel the peace and happiness that occurs in your mind. Now you can feel the happiness along with that person or living thing.
- Think of that person, living thing and yourself are at risk to all the misery. All have to face misery such as, sickness, ageing, death, fear, disappointment and sadness. That person and the living things always desire happiness and being free from all misery as well as you do.
- Tell yourself repeatedly, softly, and gently, feel the meaning of each word:
  - May that person (*identify his/ her name*) or that living thing be happy
  - May that person (*identify his/ her name*) or that living thing be at peace
  - May that person (*identify his/ her name*) or that living thing be in harmony
  - May that person (*identify his/ her name*) or that living thing be free from all misery
- Place both hands on your chest over the area of your heart. Feel the love and compassion you have for yourself, the warmth of your hands, and observe your breath. Breathe slowly 5 times, then place the hands on your lap.
- Now think of the special person or living thing that brings happiness to you. Observe peace and happiness that occurs in your mind. Now you can feel happiness along with that person or living thing.
- Think that the person or these living things are at risk of all the misery as well as you are. All of you have to face all misery such as, sickness, ageing, death, fear, disappointment and sadness. That person and that living thing always desires happiness and the need to be free from all misery as much as you do.
- Tell yourself repeatedly, softly, and gently, feel the meaning of each word:
  - May that person (*identify his/ her name*) or that living thing be happy
  - May that person (*identify his/ her name*) or that living thing be at peace
  - May that person (*identify his/ her name*) or that living thing be in harmony
  - May that person (*identify his/ her name*) or that living thing be free from all the misery

### **Compassion and Forgiving Others**

- If you have any thoughts in your mind, let them go. Come back to observe your breath again.
- Visualize in your mind that person and living thing. Feel the happiness in your heart.
- Now include yourself in your compassion.
- Put both hands on your chest over your heart, feel the warmth of your hands, be mindful with your breath and tell yourself:
  - o May you and I be happy
  - o May you and I be at peace
  - o May you and I be in harmony
  - o May you and I be free from all the misery
- Then convey your compassion to all the living things in the world who you do not even know, they are in misery as much as you are. Observe your breath while telling yourself:
  - o May all living things be happy
  - o May all living things be at peace
  - o May all living things be in harmony
  - o May all living things be free from all the misery
- Take time to savor with your compassion to others, the compassion that come from your heart naturally. You may use these words again at anytime you want.
- Slowly open your eyes, do open-eye meditation for 1 minute.

### **8. How to apply Mindfulness and Meditation in everyday life**

When we encounter difficulties, our mind may respond with many symptoms. However, if we can understand and accept it, see it with mindfulness and let it go, we will be able to protect our mind from being sick in the future. To enhance the best immunity for our mind, it is best to live a careful life by practicing concentration meditation and being mindful in our daily life until it becomes our way of life. To achieve this, we have to have the ability to connect mind development, concentration meditation, and mindfulness in our daily lives.

## Preparing Yourself for Tomorrow

Experience has shown that stress, anxiety, and depression are our miseries that happen due to many causes, both external and internal situations, the past and the present. It will be possible for us to get all these miseries again in the future. It is necessary for us to learn to recognize all these miseries, without being afraid of them or trying to avoid them. Instead, we should be mindful of them, observe how they arise, continue and pass away with our equanimous mind. When we can let go of all the misery, do not get attached to the bad emotions, we will be free, calmer, and happier than before.

If we can live a mindful life, we will be strong, stable, and able to encounter all difficulties with a balanced mind. Mindfulness will prevent us from severe misery. It can be done by practicing concentration meditation daily for 10 minutes, practicing body scan and being mindful with our thoughts for another 10 minutes. Conclude with practicing compassion to our self, others and all living things. We should practice mindfulness during the day by partially observing our breath whilst doing our job. Whenever we encounter difficulties or problems, we should return to observe our breath and also observe our emotion or thought and continue till it passes away. Then we are able to let go of our bad emotions or thoughts without resisting, denying, or avoiding them as before.

### Summary

Mindfulness, “the only way to deliverance” is a Buddhist practice used for therapeutic purposes. Mindfulness-Based Therapy and Counselling is a training program of this nature, developed by integrating mindfulness, concentration, meditation and some special life skills to be used by therapists and counselors to treat their clients who present with stress, anxiety, depression, addictive behavior, bipolar disorder, and panic disorder. The program was developed by an advisory group of the Department of Mental Health, Ministry of Public Health in Thailand. The content of this chapter is based on a training program conducted by the chief advisor to the group Prof. Youngyud Wongpiromsarn. It consists of tranquil meditation practice, mindfulness practice and mindful-based practice. Feelings, thoughts and mindfulness are linked with life skills such as communication, building relationships, forgiveness etc. Finally, it guides people to live life in full, using mindfulness as a way of life. This chapter encourages Sri Lankan mental health practitioners and the general public to use these mindfulness-based practices for the well being of themselves and of others.

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# CHAPTER 4

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# Change in Attitude and Behavior

This chapter is compiled based on the workshops conducted by Prof. Malcolm Hopwood, President, Royal Australian and New Zealand College of Psychiatrists (RANZCP), Ms. Elaine Halley, General Manager, Education and Training, RANZCP and Dr. Ramani Jayasundere, PhD, Senior Technical Advisor (Law and Gender), The Asia Foundation, on May 30th, 2016 in Colombo Sri Lanka.

## 4.1 POST TRAUMATIC STRESS DISORDER (PTSD): ASSESSMENT, MANAGEMENT AND CURRENT DEVELOPMENTS

### Learning Outcomes

- Describe the clinical presentations of different types of trauma and stress or related psychiatric disorders encountered in clinical practice.
- To be aware of the historical context and the evolution of Post Traumatic Stress Disorder (PTSD) as a diagnostic entity over the years.
- To expand the understanding on epidemiology, risk factors and common co-morbidities associated with PTSD.
- To gain knowledge on current developments in pharmacological and psychological treatment strategies of PTSD and associated co-morbidities.
- To evaluate the ways in which the current treatment techniques can be pragmatically applied in clinical practice.

### Introduction

Exposure to trauma in some form is inevitable in human life. Serious forms of trauma involves experiencing, witnessing or being confronted with an event/s that is/are exceptionally threatening and catastrophic in nature. Exposure to such exceptionally hazardous and distressing experiences evoke strong negative emotional reactions, the extent of which may differ in individuals. These different psychological responses are influenced by the actual nature of the event, the affected individual's involvement in it and the individual's perception and appraisal of the event. The key trauma variables that predict the responses includes severity of life threat, predictability and controllability of the event, duration, frequency and complexity of the trauma and the moral conflict posed by the trauma.

## Trauma Related Psychological Consequences

Psychological consequences are very common during the first few days / weeks following exposure to a major disaster, affecting about 80% of the individuals who are exposed. However, a majority of the symptoms will subside gradually and up to about 20% of the individuals are found to suffer from long term consequences around 1 month after a traumatic event. Symptoms persisting after a month are usually disabling, dysfunctional and potentially chronic; and hence require appropriate clinical interventions.

## Trauma Related Psychiatric Disorders

Psychopathologies encountered following exposure to trauma may take different forms as follows;

- Acute Stress Reaction/ Disorders
- Adjustment Disorders
- Post Traumatic Stress Disorder (PTSD)

The above disorders are classified as “Reactions to severe stress and adjustment disorders (F 43)” in ICD -10 and as “Trauma and stress related disorders” according to DSM 5 classification system.

Apart from developing the above mentioned disorders, the traumatic experience may act as a precipitating factor for development of or relapsing of a pre-existing psychiatric disorder. Frequent or prolonged exposure to catastrophic events is also known to be associated with development of depression, substance use disorders and enduring personality changes.

## Acute Stress Reactions / Disorders

This involves immediate and short lasting psychological responses to sudden intense stressors. The stressor may involve an actual or threatened physical injury or a psychologically stressful event. The core symptoms include narrowed attention span, sense of numbness, detachment, depersonalization, derealisation and social withdrawal. Physical symptoms such as palpitations, sweating and tremors also may be accompanied. Individual personality factors, previous experiences and available support may modify the clinical picture. The symptoms usually start within about 1 hour of exposure to trauma and diminish within about 2 days as defined by ICD – 10, while the DSM system describes a more prolonged response which may last up to 4 weeks. The two classification systems encompass two different phases of the anxiety response following trauma.

## Adjustment Disorder

Adjustment disorder is characterized by a more gradual and prolonged response to stressful changes in a person's life. Usually these psychological reactions arise in the face of adaptation to new circumstances in personal, occupational or social lives. Symptoms of adjustment disorder include depressive and anxiety symptoms, persistent worry, irritability, poor concentration and autonomic arousal. Substance misuse, deliberate self harm acts and functional impairment are observed in some cases, however adjustment disorder is not a valid diagnostic entity if the person fulfils criteria for another psychiatric diagnosis such as depression. Once the stressful circumstances are resolved, the disorder usually settles within about 6 months.

## Post Traumatic Stress Disorder

### Clinical Picture

Post Traumatic Stress Disorder (PTSD) denotes an intense and prolonged psychological response to an exceptionally stressful event, characterized by three core symptom clusters;

- Re-experiencing phenomena – flashbacks, imagery, nightmares
- Hyper arousal – persistent anxiety, poor concentration, irritability, autonomic arousal
- Avoidance behaviors – detachment / avoidance of reminders of event, inability to recall important aspects of the trauma

The events which may lead to the development of such symptoms include natural disasters (earth quakes, floods, tsunami etc) as well as man-made disastrous activities which include armed conflicts, violent crimes and road traffic accidents. Up to about 40% of people in the Western world are exposed to some kind of a traumatic event of this nature each year. The bush fires in Victoria and cyclones in Queensland are such incidents in which a large number of people were affected in Australia. This is no less different from the situation in developing countries like Sri Lanka. The twin tragedies of massive flooding and the landslides which took place in 2016 in Sri Lanka led to thousands of men, women and children losing their loved ones, accommodation and valuables, which caused immense distress and possible long term negative psychological outcomes.

### Historical Context

War related PTSD was commonly encountered among military veterans who were directly involved in the armed conflicts. It was first described during the American Civil War era (1861 – 1865) as “soldier's heart” / “cardiac neurosis” by the American Physician Jacob Mendes Da Costa. During World War 1, similar symptoms were given the name “shell

shock” / “gas neurosis” to describe the emotional plight of the soldiers who were directly exposed to the deleterious effects of war. The terms “chronic war neurosis” and “traumatic war neurosis” were used to imply similar symptoms during World War 2. The term Post Traumatic Stress Disorder (PTSD) originated during the Vietnam War (1954 – 1975) to describe the symptoms observed in Vietnam War veterans returning to America.

## Development of PTSD as a Diagnostic Entity

The evolution of the diagnostic entity currently recognized as PTSD has taken place in several stages. In DSM – I (1952) and DSM – II (1968), the terms “gross stress reaction” and “adjustment reaction of adult life” were used respectively to describe the abnormal psychological responses following trauma. The term “post traumatic stress disorder” was first introduced in DSM – III (1980), and has been in use until the present day. In both DSM – III and DSM – IV, the diagnostic criteria of PTSD consisted of the same basic elements described above. However, DSM 5 criteria presents a more specific elaboration with expansion of symptoms. Other than the 3 core symptom clusters of re-experiencing phenomena, hyper arousal and avoidance of reminders of the event, it has introduced a 4th symptom cluster encompassing persistent negative emotions and distorted cognitions following a stressful event.

## The DSM 5 Criteria for the Diagnosis of PTSD

- The person was exposed to the following event(s): death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation, in one or more of the following ways:
  1. Experiencing the event(s) him/herself
  2. Witnessing the event(s) as they occurred to others
  3. Learning that the event(s) occurred to a close relative or a close friend
  4. Experiencing repeated or extreme exposure to aversive details of the event(s) (eg. first responders collecting body parts; police officers repeatedly exposed to details of child abuse)
- Intrusion symptoms that are associated with the traumatic event(s) (that began after the traumatic event(s), as evidenced by 1 or more of the following:
  1. Spontaneous or cued recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

2. Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s). Note: In children, there may be frightening dreams without recognizable content.
  3. Dissociative reactions (eg, flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
  4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
  5. Marked physiological reactions to reminders of the traumatic event(s).
- Persistent avoidance of stimuli associated with the traumatic event(s) (that began after the traumatic event(s), as evidenced by efforts to avoid 1 or more of the following:
    1. Thoughts, feelings, or physical sensations that arouse recollections of the traumatic event(s).
    2. Activities, places, physical reminders, or times (eg, anniversary reactions) that arouse recollections of the traumatic event(s).
    3. People, conversations, or interpersonal situations that arouse recollections of the traumatic event(s).
  - Negative alterations in cognitions and mood that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s), as evidenced by 3 or more of the following:

Note: In children, as evidenced by 2 or more of the following;

1. Inability to remember an important aspect of the traumatic event(s) (typically dissociative amnesia; not due to head injury, alcohol, or drugs).
2. Persistent and exaggerated negative expectations about one's self, others, or the world
3. Persistent distorted blame of self or others about the cause or consequences of the traumatic event(s).
4. Pervasive negative emotional state -- for example: fear, horror, anger, guilt, or shame.

5. Markedly diminished interest or participation in significant activities.
  6. Feeling of detachment or estrangement from others.
  7. Persistent inability to experience positive emotions (eg. unable to have loving feelings, psychic numbing).
- Alterations in arousal and reactivity that are associated with the traumatic event(s) (that began or worsened after the traumatic event(s), as evidenced by 3 or more of the following:

Note: In children, as evidenced by 2 or more of the following;

1. Irritable, angry, or aggressive behavior
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance -- for example, difficulty falling or staying asleep, or restless sleep.

## Epidemiology

Life time prevalence estimates of PTSD in civilian samples range from 1% - 9%. The National Co-Morbidity Survey conducted in 1995 using DSM III R criteria has revealed an estimated life time prevalence of 7.8% in the general population. Australian Bureau of Statistics (ABS) has revealed that 12 month prevalence of PTSD is around 3.3%. Females who are exposed to stressful events are twice as likely to develop PTSD compared to males. Intentional acts of interpersonal violence, in particular combat and sexual assault are more likely to lead to PTSD than natural disasters or accidental injuries. Studies have revealed that up to 50% of victims of rape, and 25% of victims of non sexual assault develop PTSD during their life time while approximately 10% of people subjected to accidental trauma and 4 -5% of those who experienced natural disasters develop similar symptoms.

The occurrence of PTSD in military personnel involved in armed conflicts is much higher compared to civilians exposed to traumatic events. Up to 15% of United States veterans and 12% of Australian veterans who were involved in Vietnam War are currently experiencing symptoms of PTSD. The life time prevalence of PTSD in the same groups was as high as 30% and 22% respectively.

## Co-morbidities

PTSD is commonly associated with many other psychological and medical co-morbidity. Alcohol use disorders, major depression, dysthymia, generalized anxiety and panic attacks are commonly encountered amongst sufferers of PTSD. Frequent medical co-morbidities in this group include hypercholesterolemia, hypertension and obesity.

## Aetiology and Risk Factors

Neurobiology of PTSD has been extensively studied and some of the aetio-pathological routes implicated include endogenous steroid changes, hippocampal atrophy and dysregulation of frontal control of amygdala activity. Functional brain imaging studies have revealed alterations in these brain regions. Twin studies suggest that the susceptibility to PTSD is in part genetically determined. The risk of PTSD is increased in people who have a family history of psychiatric disorder, which may in turn reflect genetic factors, however, the specific genes implicated are not identified yet.

Risk factors for the development of PTSD following trauma may be related to diverse factors.

- Pre-trauma factors:
  - Tendency towards anxiety & depression
  - Prior psychiatric history
  - Prior trauma history
- Peri-trauma factors:
  - Level of exposure to trauma (both real and perceived)
  - Degree of life threat, exposure to others' suffering, etc.
  - Predictability and controllability of the trauma
  - Peri-traumatic dissociation and arousal
- Post-trauma factors:
  - Level of social support
  - Validation of the experience
  - Opportunities to “process” the trauma

These factors define individual vulnerabilities for the development and maintenance of PTSD symptoms and can be utilized as important therapeutic targets in optimal management.

Management of PTSD, its co-morbidities and associated debility and dysfunction in psychological, occupational and social spheres poses specific challenges to the psychiatry team.

## Management

The initial management of victims of a traumatic event should include provision of a safe and secure shelter, food, other amenities and means of reconciling with their loved ones. Practical support and provision of accurate information is helpful, but specific psychotherapies in the initial phase are not indicated.

Communities and governments should be well armed with disaster management plans to be implemented immediately in the face of a massive disaster in order to provide assistance for the individuals affected. Service delivery should be done in an organized manner to be optimally effective. This involves recognizing the impacts of trauma, appropriate planning, service provision and rapid crisis response. Health services should be ready with medical personnel having necessary expertise to deal with physical and psychological disabilities. Addressing the physical and psychological needs of the victims in the initial stages facilitates the natural recovery process in a considerable number of individuals.

People, whose distressing symptoms are persistent, should be offered specific management strategies which include pharmacological, psychological and social interventions, which can be laid down as follows;

1. Engagement
2. Comprehensive assessment
3. Psycho-education
4. Active treatment of co-morbid conditions (substance abuse, depression, etc.)
5. Psychotropic medications
6. Management strategies for PTSD symptoms (anxiety, anger, etc.)
7. Trauma focused work
8. Partner and family support
9. Social reintegration
10. Relapse prevention and maintenance

## Engagement

Engagement of patients with PTSD for therapy is a challenging task for clinicians as the therapy itself may re-evoke unpleasant memories of the event, leading to avoidance behaviors. Provision of a calm and friendly atmosphere ensuring privacy and confidentiality



is the key component in effective engagement of such individuals to therapy. Their queries about the nature of the disaster, extent of damage and the possibility of recurrence should also be dealt with, in the initial stages.

## **Comprehensive Assessment**

Assessment includes empathetic enquiries about the nature of the traumatic event, nature and duration of the symptoms and associated disabilities. Patients should be provided with adequate time to explore their concerns and worries such as anger, fear, grief, guilt, and thoughts of self harm at their own pace. Pre morbid anxious personality traits which may predispose to development of some symptoms, past history of psychiatric illnesses and secondary complications such as substance use and depressive symptoms should also be elicited in a comprehensive history and mental state examination. If trauma has involved head injury, a neurological examination with detailed assessment of cognitive functions is mandatory.

## **Psycho-education**

Patient and carers should be educated about the nature of a normal psychological response to a traumatic event, the basis of symptoms in physiological, cognitive & behavioral domains and explanation on how some symptoms they might be experiencing may cause disability and dysfunction. Information should also be provided about how ongoing stressors and individual personality characteristics may modify the clinical presentation. Providing accurate information, reassurance and emotional support is mandatory, as the affected individuals are in immense distress. At the same time, they might find it difficult to process new information, therefore using simple language and delivering information in small chunks is necessary.

## **Management of Co-morbidities**

If the patient is suffering from secondary complications such as depression or substance use disorders, appropriate pharmacological and psychological therapies should be offered for the co-morbidities as they add up to the disability and worsen the prognosis.

## **Psychological Approaches**

### **Trauma Focused Cognitive Behavior Therapy**

When considering specific psychotherapeutic approaches for the management of PTSD, trauma focused cognitive behavior therapy is considered as the most appropriate treatment. It consists of behavioral and cognitive strategies to overcome avoidance behaviors and

maladaptive cognitions. The behavioral component of treatment involves exposing the individual to the situations that are being actively avoided such as places, people and objects which creates reminders about the event. In the initial therapy sessions, imaginary exposure techniques such as imaginary reliving and writing a trauma narrative which helps to recall and rearrange the fragmented memories of the event are useful, but in vivo exposure to the avoided stimuli should be offered whenever possible. The exposure sessions should be arranged in a graded hierarchical manner from the least anxiety provoking stimulus to the most anxiety provoking one. Each task should be repeated until the individual integrates the experience to his or her life.

The cognitive restructuring involves identifying maladaptive assumptions and beliefs about the self and the world, re-evaluating them on the basis of evidence, challenging and replacing maladaptive automatic thoughts and beliefs with healthier ones. Cognitive errors involving over estimation of danger, excessive precautions and self depreciating negative thoughts are identified and challenged through discussions of evidence for and against them. Studies have revealed that a 50% reduction in PTSD symptoms can be achieved in 32% - 53% of patients receiving 10 sessions of CBT. The NICE guidelines suggest 8 -12 sessions of trauma focused CBT for affected individuals, but if it can be started as early as the first month after the event, as few as 5 sessions would be sufficient.

## Eye Movement Desensitization and Reprocessing

Eye movement desensitization and reprocessing (EMDR) is also used as a therapy technique in some centres. It involves induction of rapid rhythmic eye movements by asking the patient to track the therapist's finger while focusing on trauma related images and negative emotions, and repeated until the distress is lessened. It is suggested that the eye movements induce a rapid eye movements (REM) like stage, which helps in processing the fragmented memories and integration to semantic networks. However, the evidence base for EMDR is not large and some clinicians argue that the induction of memories of trauma independent of eye movement may serve the purpose as it is similar to exposure therapy.

## Pharmacological Agents

Several antidepressant drugs have shown efficacy in the management of PTSD. Placebo controlled evidence is available for

- Tricyclic antidepressants (imipramine, amitriptyline)
- SSRIs (fluoxetine, sertraline, paroxetine)
- Venlafaxine
- Mirtazapine

Other agents which are trialled and used off the label include;

- Antipsychotics esp. atypicals (quetiapine, olanzapine, risperidone, aripiprazole)
- Mood stabilizers (valproate, topiramate, carbamazepine)
- Short term benzodiazepines (lorazepam)
- Propranolol
- Prazocin – improvement in night mares noted in several studies

Though there is existing evidence for the above mentioned drug treatments, it has a lower effect size than structured psychotherapy, according to a meta-analysis conducted by the National Institute for Health and Clinical Excellence (NICE). Hence, trauma focused cognitive behavior therapy and anxiety reducing psychological interventions should be offered for all individuals with PTSD before considering pharmacotherapy unless the patient has significant depressive symptoms.

## Relapse Prevention and Maintenance

Managing ongoing stressors, personal empowerment and strengthening the social support network are some useful strategies in overcoming relapses.

### Summary

- Exposure to trauma involves experiencing, witnessing or being confronted with events of exceptionally threatening or catastrophic nature.
- Psychopathologies encountered following exposure to trauma include acute stress reaction/ disorders, adjustment disorders and post traumatic stress disorder (PTSD).
- Post traumatic stress disorder (PTSD) is characterized by three core symptom clusters consisting of re-experiencing phenomena, hyper arousal and avoidance behaviors.
- Life time prevalence estimates of PTSD in civilian samples range from 1% - 9%, and is much higher in military personnel.
- Several pre trauma, peri - trauma and post trauma factors have been implicated in the development and maintenance of PTSD symptoms.
- PTSD is commonly associated with many other co-morbidities which include alcohol use disorders, major depression, generalized anxiety and panic attacks.

- Management of PTSD consists of engagement, comprehensive assessment, psycho-education, pharmacological / psycho therapeutic interventions and relapse prevention programs.
- Trauma focused cognitive behavior therapy is considered as the most appropriate psycho therapeutic intervention in the management of PTSD. It consists of behavioral and cognitive strategies to overcome avoidance behaviors and maladaptive cognitions.
- Several antidepressant, anti psychotic and mood stabilizer medications have shown efficacy in management of PTSD, however the effect size is smaller than for structured psychotherapy.

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## 4.2 GENDER SENSITIVITY IN SERVICE PROVISION

### *Ensuring equal treatment of women and men seeking services*

#### A Brief Introduction

The importance of gender sensitivity in any type of professional service provision is a subject that is periodically discussed, yet only marginally researched. Discourse surrounding gender sensitivity includes understanding what gender means in a conceptual as well as practical manner, of exploring, identifying and understanding gender issues in the societies that professionals work in, and providing gender sensitive services to maximize the benefits of such services to those in need. In providing psychiatric care, it becomes essential to understand gender issues that surround and impact on the lives of those seeking care, and to integrate gender sensitivity and promotion of gender equality in all aspects of service provision.

This chapter is based on a presentation on “Gender Issues and Trauma Affected Populations” at the 2016 Annual Academic Sessions of the Sri Lanka College of Psychiatrists and the International Congress of the Asian Federation of Psychiatric Associations. It aims to provide a brief introduction to the importance of gender sensitivity, and the need to integrate responses to gender issues in the services provided by psychiatrists. The chapter aims to provide introductory information and knowledge.

#### Gender

Gender describes a collection of identities and interpretations constructed by society to identify and categorize males and females. It is not the biological distinction that makes a person male or female - which is the sex difference in people where biological factors demarcate them as men or women. Gender is the definition given by society and held by men, women as well as the third sex, on the characteristics of men and women. Thus the interpretation of who a female is and who a male is can differ from society to society, culture to culture, place to place and even from person to person.

“Gender” is not only about women. It is not about women’s equality or discrimination against women. It is about women and men, the identities created about women and men through the interactions that men and women have in society. Erroneously “Gender” is often used synonymously with “women”. Thus the reason is, when one looks at gender based discrimination, especially gender based violence, women are more often disadvantaged and

victimized than men, and thus discussion around gender equality often focusses more on women's equality.

- Being gender sensitive refers to gender awareness and consideration of gender issues within the profession, during service provision and other activities.
- Gender equality refers to the commitment to treat both sexes equally.
- Gender equality is not just about women; it is about men and women, how they interact and live in society and about treating all equally.
- Gender issues play a large role in our personal life as well as in society. All gender differences are not problems. Only if a gender difference is a problem do we have to address this issue.
- Attitudes about gender can lead to discrimination and sometimes violence, for instance, domestic violence. When dealing with issues such as domestic violence, understanding and addressing any underlying gender issues or gender role conflict is crucial to achieve a long-lasting resolution to the problem.
- It is important to be aware and sensitive of gender issues when providing services to the community, to ensure the best quality of care.

## Gender Equality

Gender equality is when every woman and man receives equal treatment and is not discriminated against based on their sex. Sometimes, in order to treat men and women equally, one sex must be given special treatment because the other sex is at an advantageous position.

*Eg.: There is less than 5% of women represented in politics in Sri Lanka. To bring about gender equality, the government has brought in a law that says there must be at least 25% women represented in political positions in local government institutions. This is special treatment.*

This special treatment is called affirmative action or positive discrimination. This is done to bring about equality where the playing field is biased and favours one sex.

*Gender equality is achieved when women and men enjoy the same rights and opportunities across all sectors of society, including in the family, in economic participation and decision-making, and when the different behaviors, aspirations and needs of women and men are equally valued and favored.*

## “Gender” in Service Provision

Understanding how gender plays out in people’s lives is important to ensure that women and men are served equally and no one is marginalized or left out of service provision. Focusing on gender involves several steps.

1. **Awareness** of gender issues. This involves being aware of expectations placed on women and men, how men and women perceive their roles, and identities in life and how gender differences can cause conflicts and problems for women and men.
2. **Gender sensitivity.** This involves being sensitive to issues that come up when one is aware of gender differences. Looking at problems, disputes and conflicts men and women face from a gender sensitive lens, will make the process of helping them more sensitive, bring about remedies and answers that help women and men, and ensure equality between men and women.
3. **Promoting gender equality.** When providing services to people, it is important to provide specific services to women and men responding to their different needs, wants and situations. That way, one can promote equality between men and women which is essential to ensure user friendly service delivery.
4. **Mainstreaming gender equality.** This is about integrating gender sensitivity and responding to the different situations and needs of women and men within any profession and in service provision. Mainstreaming gender within professions would include looking at equal numbers of women and men in decision making positions, equal participation of women and men in the profession and special mechanisms to prevent gender based discrimination such as policies to promote equal participation, and prevention of sexual harassment which often marginalizes and victimizes women. Mainstreaming gender in service provision would include understanding the different position, status, needs and expectations of women and men and responding to such when providing services instead of providing services to all people irrespective of gender differences.

Writing on understanding mental disorder *The American Journal of Psychiatry* highlights the importance of “understanding how and why our patients develop the particular illnesses that they do and how we can predict and affect the future course of their illnesses. Specifically, we seek to understand how illness develops as a consequence of a complex matrix of factors that impinge on each individual patient.” The author identifies gender as one of those complex factors.

The Journal mentions that “Gender is an interesting example of a complex factor that may influence the development or course of mental illnesses. A person’s sex is genetically

determined at the time of conception and is not a matter of choice. However, the way a man or woman lives within his or her assigned sex can play out in many different directions. Gender identity is influenced by many things, such as socialization styles suggested by parents or schools or peers, location and quality of housing, the availability of education and the type provided, the kinds of toys that are given to the child, and perhaps even the kind of clothing that a child is allowed to wear. All these factors—and no doubt many others—help shape identity, and perhaps also ego strength and resilience. In turn, they may also affect differential vulnerability to mental illnesses.”

Kendler et al. quoted in the same article “examine the inter-relationship between social supports and vulnerability to depression, they find that women are more sensitive to the depressogenic effects of having low levels of social support than men. For the men the association between social supports and risk for depression is modest and not significant. Paradoxically, having a lower rate of social support does not account for the higher rate of depression in the women; controlling for social supports actually augments the higher rate of depression in women. That is, women still have higher rates of depression even when the influence of social supports is taken into account. These results suggest that there may be gender differences in the mechanisms of depression, and that lack of social supports may be an important part of the causal pathway in women but not in men.”

Kennedy et al. in the same Journal “examines gender differences in incidence and age at onset for bipolar disorder and mania. Men are found to have a slightly higher rate of bipolar disorder during their early years (ages 16–25), but women have a higher rate overall and a generally later age at onset. Women are also more likely to begin their bipolar life course with an episode of depression.” The study further finds that “there are gender differences in vulnerability to mental illnesses. Men have higher rates of schizophrenia, antisocial personality, ADHD, and learning disabilities. Women are more vulnerable to mood disorders and borderline personality disorder. Understanding why these patterns of predisposition occur will ultimately improve our knowledge of the pathophysiology and etiology of these various mental illnesses.”

## The Broader Purpose of Gender Equality

Gender equality promotes respect for diversity. Understanding that men and women are different, understanding what makes each sex different and integrating this understanding into all the work you do ensures respect for difference and diversity and makes work including service provision more effective.

Gender sensitivity and commitment to gender equality is about  
**RESPECT FOR DIVERSITY**  
**(Women and Men)**



Ultimately gender sensitive work promotes equality between men and women, bringing about satisfaction of the services.

There are several essential requirements to being gender sensitive. These involve the following:

1. Awareness about gender and the difference gender makes in the day to day lives of men and women which can give rise to problems and issues.
2. Sensitivity to these differences that gender makes.
3. Understanding the causes of these differences and the impact these difference create.
4. A rights approach that accepts unconditional equality between the sexes. This means that one accepts unconditionally that women and men are equal and that they should be treated equally despite what culture and convention says to make them different which justifies treating men and women differently in an unfair manner making them unequal.

Gender sensitivity includes gender based attitudes. Gender based attitudes are built around acceptance of the way society treats women and men differently. These attitudes can often cause different treatment outcomes that marginalizes and victimizes women as well as men. Therefore, it is important to explore, analyse and change these attitudes that treat people differently in order to change unfavorable attitudes.

Therefore, gender based attitudes are a collection of ideas, perceptions, norms and even values that are associated with socially defined identities of women and men. For example society expects women to take the primary role in keeping the family together, in bringing up children, in care giving and home making while expecting men to always be the primary income earner and protector of the family. These expectations cannot be met always by all people. There are times where a woman has to take on the role of income earner and protector of the family and the man to take a bigger responsibility in home making. These reversals of socially constructed roles can cause problems.

Gender attitudes and identities impact on people's personal lives as well as the public. These attitudes and identities force men and women to behave in a particular way. They impact on the roles that men and women are expected to play in life, the responsibilities they take on, their expression of needs and wants as well as interests, expectations and what makes them happy. Being confined to stereotyped attitudes and identities assigned to men and women by society as well as breaking away from them due to personal choice or necessity can cause problems for both women and men. In such situations, those who are helping professionals need to understand how gender attitudes and identities impact on people's lives, if they are, to offer solutions and remedies or support people to help themselves.

The statement that "One is not born, but rather becomes, a woman" by Simone de Beauvoir aptly explains the difference between sex and gender. Butlet (1986) write that " Simone de Beauvoirs' formulation distinguishes sex from gender and suggests that gender is an aspect of identity gradually acquired. The distinction between sex and gender has been crucial to the long-standing feminist effort to debunk the claim that anatomy is destiny; sex is understood to be the invariant, anatomically distinct, and factic aspect of the female body, whereas gender is the cultural meaning and form that body acquires, the variable modes of that body's acculturation."

Gender identities are characteristics, qualities and behaviors we identify women and men with. Society has different ways in which they describe women and how they describe men. These identities are acquired by women and men from childhood through adulthood to old age and are taught to us by various social institutions i.e. the family, the school, religious institutions, workplace and society at large. A woman or man is not born with these characteristics or qualities but they are placed upon them by society. These characteristics can thus change from place to place, community to community and society to society in the way each defines what a woman should be and what a man should be. Problems arise when a woman or man does not keep to or conform to these popular and firmly held identities.

Gender identities that are made up of attitudes, beliefs, norms and even values that are different for men and different for women are not constant. They change with time and are different in different places. But they often discriminate against women and men and can cause violence which is known as gender based violence. The link between gender attitudes and gender based discrimination or gender based violence can sometimes be vague and hard to pin point. But when one deconstructs the causes of problems, discrimination and violence, one can clearly see that gender differences are often the reason for such discrimination or violence. Understanding gender attitudes can provide one with an understanding of the tensions and pressure experienced by women and men merely because they are women or men and give an insight into what causes exploitation, discrimination and abuse. Understanding gender attitudes and the difference they make can lead one to understand the different treatment, discrimination, marginalization and vulnerability experienced by women or men in given situations.

Any issue of discrimination or violence due to gender differences between men and women is caused because one sex feels more powerful over the other. This power is derived from the position and status society places women and men in, where one sex is favored and made more powerful over the other. Often it is men that society places in more powerful positions but this is not always so. Due to this power difference or power imbalance based on

gender identities created by society, one sex can and does discriminate against and is violent towards the other. Understanding this power imbalance and finding ways of balancing the power between parties can result in effective solutions to problems.

In the discourse on gender and psychiatric service provision, discussion must essentially be had on gender based violence. Gender based violence is violence that results from gender differences and the power these differences place on one sex over the other where persons of one sex (often men, but not always) feel more power over the other due to the different status given by society to men and women. For example, situations of domestic violence by men against their wives is a result of the man feeling more powerful as the head of the household or the income earner over his wife who appears to adopt a secondary role in the family.

Gender based violence is a manifestation of the overt or sometimes subtle acceptance of gender attitudes, norms and values that discriminate against women and men placing one sex as inferior to the other and thus is a less powerful situation in a relationship.

Gender based violence stems from society's identity of what a woman should be and what a man should be; what a woman should and should not do and what a man should and should not do. When one does not conform to these stereotyped identities or abuses or manipulates these identities, conflicts arise and the one with more power over the other will victimize the vulnerable.

The acceptance of these unfair and unequal gendered power relations leads to, reinforces and perpetuates a greater acceptance and tolerance of acts of violence especially by men against women.

People commit acts of gender based violence because they can and because they feel power over the victim to commit such acts. It is a mere fact of feeling entitled to commit such acts of violence that makes these acts possible. They are acts of violence by the more powerful in a relationship over the less powerful, made less powerful by what society accepts as the rightful place of that person.

Often causes of gender based violence are cited as alcoholism, poverty, stress, loss of family values, exposure to violence, lack of self-control or social acceptance of certain forms of violence etc. There are many explanations used by men and women to explain and justify gender based violence. But these are not causes of violence. They are mere excuses used by those who have the power over another to be violent. These causes do not push men (and sometimes women) to be violent against another. They are violent because they feel they have the right to be violent. Explaining violence with such causes creates a myth surrounding why gender based violence takes place. Such views lead to a perception that gender based violence is rare or exceptional, and/or that it is caused by factors outside of

people's control. They place the onus on victims to ensure that they minimize the chances of their behavior instigating violence.

The root cause of gender based discrimination, especially gender based violence is always power. It is the power imbalance between the perpetrator and the victim that causes one to be violent towards the other. Power can be derived from a relationship, from circumstances, from socialization – all these are based on gendered attitudes.

Jayasundere (2009) has written on gender based violence and power that “The concept of ‘gender’ in itself sets out to clarify the ways in which patriarchal socialization processes plays a critical function in creating socially ‘acceptable’ norms of behavior and rights for women and for men. These socialization processes in effect give more power to men over women and demarcate lines of conduct where women and men have differential and often unequal access to and control over resources, whether it is in terms of food, healthcare, skills training, credit, property, income or, in the arena of decision-making. Lack of access to such resources can also result in those with less ‘power’ being subjected to violence and intimidation, which could take the form of acts of verbal, physical and sexual violations, whether in the privacy of their own homes or in the public sphere. It is acknowledged that the issue of who or which group in society has more power than others and who can exert acts of gender based violence is not restricted to economic power but is very much rooted in notions of social power and hierarchies in access to exercising such power.”

To ensure the removal of power imbalances that cause discrimination or violence between men and women, it is essential that one believes in equality between the sexes and works towards gender equality.

## **The Importance of Gender Sensitivity in Service Provision**

Any form of equality does not exist in a vacuum. Similarly, neither does gender equality. To address gender based discrimination from the unconditional stand point of accepting and committing to gender equality necessarily means addressing gender attitudes that can and do give rise to expressions of discrimination and violence.

While gender attitudes are often subjective, they are also fluid and changeable. But the commitment to gender equality is not subjective. Neither can it be fluid or in varying degrees or vary over time.

There is little written on the importance of gender sensitivity in the services that Psychiatrists provide. However commenting on the importance of understanding gender differences, the *American Journal of Psychiatry* states that “being a good psychiatrist makes a difference too. Psychiatry is the only medical specialty that treats the whole person. We must see each patient as a unique person and understand and treat that person not only in terms of

presenting symptoms and diagnosis but also as a human being who lives within a complex psychosocial matrix.”

Thus, in providing services, gender sensitivity makes the difference to changing lives. Internalising gender equality is important in service provision as well as in professional behavior. Taking a moment to understand gendered perceptions makes gender sensitivity easy.

### **An example of the importance of gender**

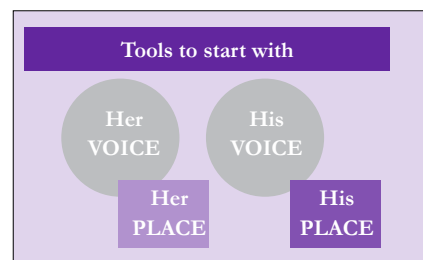
The Hojat et.al. in the *American Journal of Psychiatry* writes on gender in services provision and makes a comment on ‘empathy’.

“Several explanations can be offered for gender differences in empathy. For example, it has been suggested that women are more receptive than men to emotional signals, a quality that can contribute to a better understanding and, hence, to a better empathetic relationship. Also, on the basis of the evolutionary theory of parental investment, women are believed to develop more caregiving attitudes toward their offspring than men. The findings on gender differences in empathy are in agreement with the reports that female physicians spend more time with their patients, have fewer patients, and render more preventive and patient-oriented care.”

## **Some Steps to Start Being Gender Sensitive in Service Provision**

When faced with a client or clients, take a moment to understand how gender plays in their lives.

Ask questions to understand differences that gender makes in the synthesis or analysis of the problem. Are they due to pressures of being expected to conform to gender identities and gender roles, the pressures of not conforming to accepted gender identities and gender roles or whether it is the unfair use of power in a relationship that is not equal.



## **Summary of Gender Sensitivity in Service Provision**

- Explore how the services you provide can balance the power imbalances.
- Offer services that accept difference and diversity without conforming to socially and culturally accepted unfair treatment.

- Let women speak about what is important to her.
- Create space for women to speak about what is important to her.
- Let men speak about what is important to him.
- Create space for men to speak about what is important to him.
- Question internalized gendered attitudes, perceptions and identities.
- Approach everything from an understanding and acceptance of the right to equality.

That will be an effective start to providing gender sensitive services.

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# CHAPTER 5

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# Knowledge Development

This chapter is compiled based on the psychopharmacology workshop conducted by Dr. Udena Attygalle, Consultant, Child and Adolescent Psychiatrist, Teaching Hospital, Karapitiya, Dr. Rasitha Perera, Child and Adolescent Psychiatrist, Sirimavo Bandaranaike Specialized Children's Hospital and Dr. Kapila Ranasinghe, Consultant Psychiatrist, National Institute of Mental Health on June 28th, 2016 in Colombo, Sri Lanka.

## 5.1 PSYCHIATRIC CO-MORBIDITY IN OLD AGE

### Intended Learning Outcomes

1. To enhance the knowledge on common psychiatric co-morbidity in old age and treatment considerations.
2. To maintain the highest standard in patient care and service delivery through an update on new developments in old age psychiatry.

### Introduction

The recent population projections have shown that Sri Lanka has an ageing population. The decline of population growth is expected to increase the proportion of elders further. By 2051, the population over 60 years will be 25% and elders over 80 years will be 5%. This population shift not only puts increasing stress on public finances and reduces the effective labor force but it also increases pressure on national health system from medical and psychiatric morbidity.

### Co-morbidity in Old Age Psychiatry

#### Dementia and Mild Cognitive Impairment

Dementia describes a wide range of symptoms associated with decline in memory and other higher cognitive processes severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease (AD) accounts for 60 to 80 percent of dementia cases.

The over 80-year-old population has a marked increase in the prevalence of dementia. Over the age of 75 years, the annual incidence of AD is about 1%, increasing to approximately 10% at the age of 85. Reported prevalence rates of AD are between 5 and 7% in those over the age of 65 years. In the population aged 85- 90, the prevalence of AD is 12%.

These increases have major implications for the provision of healthcare for population generally and for dementia care in particular. When dementia cases increase, there will be more people exhibiting behavioral and psychological symptoms of dementia (BPSD). This constitutes the greatest burden to caregivers. This module describes these important aspects of dementia, as well as their frequency and impact.

BPSD have been identified as integral parts of dementing disorders from the earliest descriptions of these conditions. For example, in defining the ‘dementia senile’ in 1838, Esquirol noted that it is a condition, which may be accompanied by emotional disturbances. Alois Alzheimer, in his classic early twentieth century case description of the disease, now universally associated with his name, noted behavioral symptoms as prominent manifestations in his brief case description

The symptoms included:

- Paranoia
- Delusions
- Hallucinations
- Screaming

Vascular dementia (previously called multi-infarct dementia) also has emotional instability and BPSD as prominent features. BPSD, including aggressive behavior and visual hallucinations, are seen in Lewy body dementia.

Behavioral symptoms: Usually identified on the basis of observation of the patient, including physical aggression, screaming, restlessness, agitation, wandering, culturally inappropriate behaviors, sexual disinhibition, hoarding, cursing and shadowing

Psychological symptoms: Usually and mainly assessed on the basis of interviews with patients and relatives; these symptoms include anxiety, depressive moods, hallucinations and delusions. A psychosis of Alzheimer’s disease has been accepted since 1999.

BPSD can result in suffering, premature institutionalization, increased costs of care, and significant loss of quality of life for the patient and his or her family and caregivers

A number of studies looking at the occurrence of BPSD in nursing home populations have found these symptoms to occur in up to 90% of patients.

## Prevalence of BPSD

Signs or symptoms	Reported frequency (%)
Psychotic symptoms	
1. Delusions	20 – 73%
2. Hallucinations	15 – 49%
Affective symptoms	
1. Depressive	20 – 27%
2. Apathy	15 – 19%
3. Manic	3 – 12%
Personality	
1. Personality change	Up to 90%
2. Behavioral symptoms	Up to 50%

All patients included in a study carried out in the National Institute of Mental Health (NIMH), Angoda and National Hospital of Sri Lanka (NHSL) demonstrated behavioral and psychological symptoms irrespective of the dementia severity.

## Prevalence rates in Sri Lanka

Sign or symptom	Reported frequency (%)
Delusion	53.4%
Irritability	50.7%
Agitation	41.1%
Depression	37%

## Management of BPSD

Priority	Example
Physical care needs	Delirium, pain, constipation, unmet needs
Behavioral management strategies	Optimal communication, reduce noise, distraction, ABC behavioral modification, other psychological strategies, music, sleep hygiene
Psychological	Boredom, frustration, bereavement, anxiety and distress, social isolation
Psychotropic medication	Important but limited role, restrict to short duration of 12 weeks
Care for the carer	Provide support, respite care

Medication has a modest effect on BPSD. First generation antipsychotics widely used for decades for BPSD in dementia, is less well tolerated due to extra pyramidal and anticholinergic side effects. Significant morbidity and mortality is associated with antipsychotic treatment. Small effect size, poor tolerability and potential increase in mortality has reduced the wide prescription once associated with second generation antipsychotics (SGA). Initial warnings regarding increased mortality in patients treated with SGA have been extended to all SGAs as well as conventional antipsychotics in view of recent findings (FDA Alert 2008). Product labeling for all First Generation Antipsychotics (FGA) and Second Generation Antipsychotics (SGA) are compelled to carry a warning about the possible risk of cerebrovascular accidents.

Both FGA and SGA are associated with a considerable risk of cerebrovascular accidents and extra pyramidal side effects (EPSE), postural hypotension, tardive dyskinesia and metabolic syndrome limiting antipsychotic use in treatment of BPSD.

Risperidone is the only medication licensed in the UK for the management of aggression and psychosis. However, very minor effectiveness advantages for olanzapine and risperidone over placebo, exists in time to discontinuation.

Some efficacy for cautious use of; Quetiapine, Olanzapine, Aripiprazole and Clozapine (treatment resistant agitation) have being described.

Evidence shows Acetyl cholinesterase inhibitors and N-Methyl D-Aspartate receptor antagonists to improve BPSD. Rivastigmine has shown positive results for behavioral and psychological symptoms associated with vascular and Lewy body dementia.

**Management of BPSD**

Acetylcholine esterase inhibitors eg. Donapezil, galantamine, rivastigmine	Improves Cognition / Behavioral disturbances
NMDA receptor antagonists- Memantine	

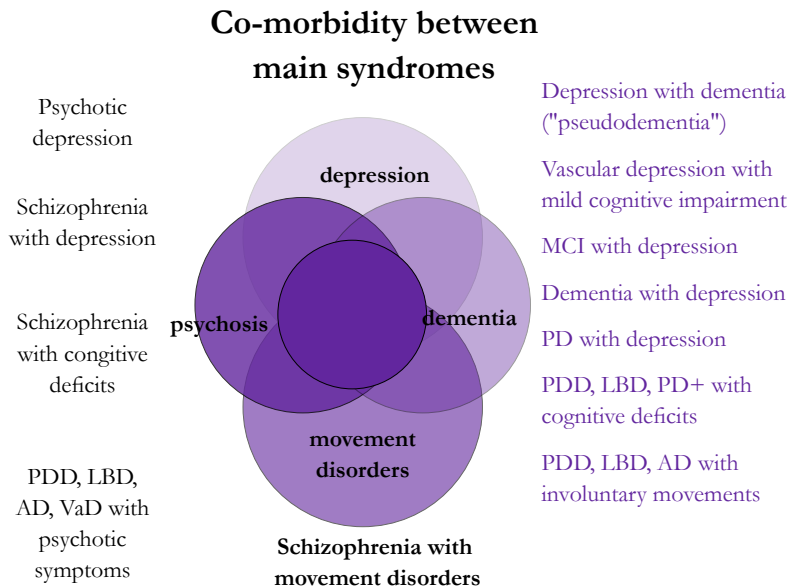
**Antidepressants in Behavioral and Psychological Symptoms in Dementia**

The relationship between dementia and depression is complex. Depression is a risk factor, which may occur as a consequence or maybe confused with each other. Prevalence of depression is around 30- 50% in dementia with 10% experiencing major depressive episodes.

The best evidence exists for Sertraline and Citalopram.

Fluoxetine and Paroxetine are best avoided due to medication interactions and side effects.

Tricyclic antidepressants are best avoided due to greater anticholinergic side effects burden and higher risk of QT prolongation.



(Lewy bodies dementia (LBD), Parkinson's disease dementia (PDD), Parkinson's disease (PD), Alzheimer's disease (AD), Vascular dementia (VaD), Mild cognitive impairment (MIC))

## Late Life Depression

Medical conditions such as cardiovascular disease, chronic pain, diabetes and Parkinson's disease are associated with high risk of depressive disorder.

By 2041, one out of every four persons is expected to be an elderly person, making Sri Lankans the oldest population in South Asia.

In the elderly, depression associated morbidity and mortality are increased due to physical frailty and comorbid medical conditions. Elderly persons have a higher risk of self-neglect and detrimental consequences of immobility (eg. deep vein thrombosis), and completed suicides in nearly 20%.

Prevalence of depression varies from 5% - 50% in various studies, and the USA prevalence rate is 9.1% according to the National Health and Nutrition Examination Survey, 2006 (NHANES).

- In the UK 8.6% - 14.1%.
- In Sri Lanka more than 60% among geriatric patients in a tertiary care unit, 27.8% in a community survey.

Medical co-morbidities that are often associated with elderly depression can be divided into three parts:

- medical illness leading to depression,
- depression leading to medical illness,
- Independent co morbidities.

### **Depression in cardiovascular disorder**

More than half of patients with cardiovascular disease report some symptoms of depression. Only 25% of patients are diagnosed as having depression, and out of those only about half receive treatment.

## **Treatment of Depression in Elderly**

Medications

- Tricyclics - Avoid in patients with cardio-vascular disease.
- Selective Serotonin Reuptake Inhibitors SSRIs – generally recommended, but beware of drug interactions.

Sertraline – Drug of choice, safe in post myocardial infarction (MI) and in heart failure

SADHART (Sertraline Anti-Depressant Heart Attack Trial) found that death and non-fatal MI 20% lower with Sertraline and lowers death and non-fatal MI by 42%.

### **Practice point**

Dosage - Sertraline 50-150mg

Continuation phase 6-9 months

Then slowly taper the medication

Citalopram / Escitalopram – may increase QTc interval

Torsade de pointes / sudden cardiac deaths reported in overdose

Mirtazapine – Evidence of safety in post MI

Avoid Venlafaxine (Possible QTc prolongation / high BP)

## Stroke and Depression

Most patients with post stroke depression are diagnosed within 1-2 months and only a few develop symptoms after 1 year. Around 25% to 50% post stroke survivors develop depressive symptoms and 50% of those have major depressive disorder. However, 10-20% are not diagnosed until 6-12 months after the stroke.

Depression in post stroke survivors is identifiable in various settings such as rehabilitation hospital, outpatient clinic and community setting. Depression is known to slow the functional rehabilitation and significantly affect global cognitive functioning and motor recovery in this patient group. Patients who receive treatment, experience significant recovery than those who remained untreated. Depression reduces the ability to participate in post stroke therapy sessions due to loss of/ less interest, less effort and frustration interfering with rehabilitation programs.

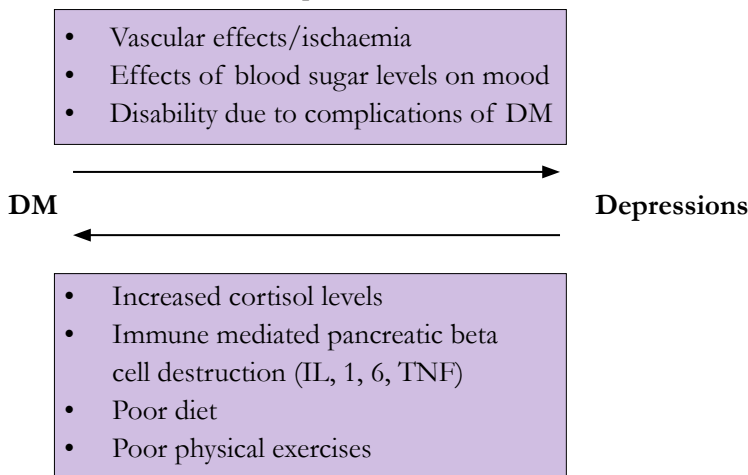
## Treatment of Post Stroke Depression

The high prevalence of medical co-morbidity and potential for interaction with co-prescribed medications complicate the treatment.

- Nortriptyline, SSRIs, mirtazapine – most studied, effective and safe
- SSRIs – Citalopram / escitalopram if patient is on warfarin,
- Nortriptyline, fluoxetine, escitalopram, sertraline, mirtazapine are used for prophylaxis in stroke patients to prevent depression.

## Depression and Diabetes Mellitus (DM)

Bi - directional relationship:



The prevalence rates of depression in diabetes is between 9% - 60%. Diabetes doubles the odds of co-morbid depression. Depression has a negative impact on glycaemic control and likewise poor metabolic control may worsen depression.

### **Practice point**

#### **Management of depression in diabetes mellitus**

- All patients with a diagnosis of depression should be screened for DM
- Antidepressants are effective and moderately improve glycaemic control.
- SSRIs recommended first line treatment – fluoxetine preferred
  - Improves HbA1C levels
  - Reduced insulin requirements
  - Enhanced insulin sensitivity
  - Enhanced weight loss
- SNRI – minimal effects on glycaemic control and weight
- Duloxetine – in diabetic neuropathy
- Antidepressants + cognitive behavior therapy (CBT) improves mood but not glycaemic control
- Psychotherapy – helps with mood, not necessarily glycaemic control

#### **Psychiatric co-morbidity in Chronic Obstructive Pulmonary Disease (COPD)**

- Depressive symptoms – 57%
- Panic / other anxiety disorders – 50%
- Long term high dose steroids can induce depressive / anxiety symptoms
- SSRIs well tolerated
- Nortriptyline / imipramine also has established efficacy.

#### **Psychiatric co-morbidities in movement disorders**

Prevalence of comorbid psychiatric disorders high in Parkinson's disease

Major depression – 25%  
Anxiety disorders – 25%  
Psychosis – 25%  
Dementia – up to 80%



Depression in Parkinson's disease predicts, greater cognitive decline, deterioration in functioning, progression of motor symptoms, widespread neuro-degeneration. Depression may also occur with withdrawal of dopamine agonists.

## Management of Depression in Parkinson's Disease

Both SSRIs (paroxetine) and SNRIs (venlafaxine) are effective compared to placebo and not associated with worsening of motor symptoms.

## Factors Associated with Reduced Response to Antidepressants

- Older age (>75years)
- Lesser severity
- Late onset (>60years)
- First episode
- Anxious depression
- Executive dysfunction

## Psychosis in Parkinson's Disease

Anticholinergics and dopamine agonists are known to induce psychosis and consideration should be given to reducing / stopping them. Atypical antipsychotics with lesser propensity to cause extra pyramidal side effects (EPSE) are preferred in the management of psychotic symptoms (eg. quetiapine / low dose clozapine).

## Prescribing in the Elderly Patients with Renal Impairment

The elderly (> 65 years) are assumed to have mild renal impairment hence it is prudent to avoid nephrotoxic medications (eg. lithium). In addition medications with extensive renal clearance should be used with caution (eg. sulpiride, amisulpride, lithium).

- Start medications at low dose and increase gradually
- Avoid long acting depots
- Cautious use of anticholinergics due to urinary retention
- Avoid medications known to increase QTc as electrolyte disturbances in established renal failure can increase cardiac risk
- Monitor renal functions

## Prescribing in the Elderly with Hepatic Impairment

- Lower starting doses
- Simple regimen with few medications
- Be cautious with medications with extensive hepatic metabolism
- Longer intervals between dose increments
- Avoid sedatives / medications causing constipation (risk of hepatic encephalopathy)
- Monitor LFT

## Schizophrenia in the Elderly

Cautious use of anti-psychotics is advised due to its:

- propensity to cause metabolic syndrome (eg. olanzapine)
- anticholinergic side effects (eg. chlorpromazine)
- cardiac side effects (eg. haloperidol)
- effect on postural drop and falls (eg. chlorpromazine / quetiapine)
- sedation (eg. olanzapine)
- extra pyramidal side effects (eg. typical anti-psychotics)
- may need to reduce antipsychotic dosage

## Summary

As the proportion of elderly in the population increases, psychiatric illnesses also proportionately increase. Prescribing in dementia, depression and co morbidities with medical illnesses need special attention.

Dementia is often compounded by behavioral and psychological symptoms (BPSD), a major management challenge. Symptoms are best treated with psychological therapies and when medications are indicated, acetylcholine esterase inhibitors, NMDA receptor antagonists, second generation antipsychotics and SSRIs are used. Use of medication for BPSD should be time limited.

Late life depression could be treated with SSRI medications. In general, low doses of psychotropic medications and regular monitoring are required when prescribing for the elderly.

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## 5.2 TREATMENT OF DEPRESSION IN CHILDREN AND ADOLESCENTS

### Objectives

1. Describe the differences between paediatric and adult depression.
2. Identify evidence-based pharmacological and non-pharmacological treatments for pediatric depression.
3. Make rational treatment recommendations for children and adolescents with depression.

### Introduction

Paediatric depression is a relatively common psychiatric condition with considerable disability including academic failure. It is often untreated or undertreated.

### Background

- Case reports on childhood depression date back to the early 17th century.
- Melancholia in children was first reported in the mid 19th century.
- Existence of depression in children was seriously doubted prior to 1960 it was felt that child's immature super ego would not permit the development of depression.
- Research from Europe and NIMH funded American studies in the 1970's increased the awareness and acceptance of childhood depression.

### Epidemiology

Depression is infrequent before mid-childhood and is associated with dysfunctional families.

- Varying rates of depression have been reported
- Generally, the accepted annual incidence is as follows.
  - Pre-school age - 1%
  - School age - 2%
  - Adolescent age – 4% - 8%
- Gender ratio of female : male is 1:1 in childhood and 2:1 by adolescence
- Lifetime prevalence of Major Depressive Disorder (MDD) among adolescents is 15% – 20% (similar to adults)

## Clinical Picture

Depression in childhood and adolescence clinically appear similar to adulthood depression in most ways. Children rarely express depressive cognitions as adults and instead of depressed mood they may present with unexplained medical symptoms. The common developmental projections of depression in children and adolescents can be categorized as,

Children	Adolescents
More anxiety symptoms (e.g., phobias, separation anxiety), somatic complaints, and auditory hallucinations	More cognitive component compared to children
Present as temper tantrums and behavioral problems	Depressive cognitions become apparent
Fewer psychotic symptoms or serious suicidal attempts	More sleep & appetite disturbances, delusions, suicidal ideation & attempts
Preoccupation with death, low self-esteem, social withdrawal and poor school performance appear in middle childhood	Compared to adults, still more behavior problems and fewer neuro-vegetative difficulties

## Co-morbidities

- Most children with MDD have a co-morbid psychiatric diagnosis:
  - \* 40% – 90% has a second psychiatric disorder
  - \* 20% – 50% has two or more comorbid disorders
- Dysthymia and anxiety disorders (30% – 80%)
- Disruptive disorders (10% – 80%)
- Substance use disorders (20% – 30%)
- Conduct problems may develop secondary to depression and persist after the depression is effectively treated
- Separation anxiety is more common in children, whereas substance use, conduct disorder, social phobia, and generalized anxiety disorder are more common in adolescents

## Treatment

### Tricyclic antidepressants (TCA)

Tricyclic antidepressants (TCA) while being effective in adult depression have shown little utility in the treatment of pediatric depression. While open label trials have shown a positive response in 60% – 80% children and 44% -75% adolescents with depression the double blind placebo controlled trials failed to demonstrate a significant difference between the placebo and the active TCA treatment and a meta-analysis found no difference. Many limitations have been associated with the tricyclic antidepressant studies including small sample sizes, diagnostic heterogeneity, limited study duration and use of lower doses.

TCAs are being used in children and adolescents for the management of depression, anxiety disorders (particularly serotonergic TCAs), ADHD, analgesia (migraine headache prevention and neuropathic pain) and enuresis.

### Selective serotonin reuptake inhibitors (SSRIs)

- Numerous open label studies report a 70% – 90% response rate to SSRIs in adolescents.
- One historical case-control study found fluoxetine to be superior to imipramine in a severely ill inpatient adolescent population
- Two randomized double blind placebo controlled studies by Emslie et.al. demonstrated the superiority of fluoxetine over placebo, leading to FDA approval of fluoxetine for the treatment of paediatric depression (ages 7 – 17).

Current FDA approved antidepressants in children and adolescents include;

Major depressive disorder		Anxiety spectrum disorders
Fluoxetine : age 8- 17	Escitalopram : age 12 -17	Fluoxetine : Age 7 – 17 Sertraline : Age 6 – 17 Fluvoxamine : Age 8 – 17 Clomipramine : Age 11 – 17

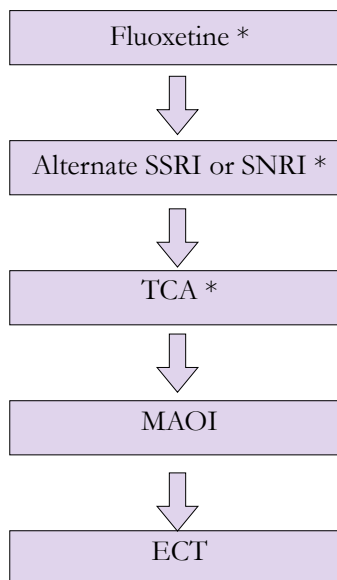
### Antidepressant augmentation

Studies have shown mild beneficial effects of lithium carbonate augmentation of imipramine and venlafaxine in the treatment of refractory depression in adolescents.

### Electroconvulsive therapy(ECT)

- Case reports in children and adolescents date back to 1942. Most cases suffer from lack of diagnostic clarity, small sample size, and heterogeneous diagnoses.

- Since 1990 numerous studies (all retrospective) have reported success with ECT in adolescents with a variety of psychiatric disorders which were primarily unipolar or bipolar mood disorders.
- Severe depression that is life threatening or refractory depression may respond to electroconvulsive therapy.
- Significant improvements were noted among those who received ECT with response rates varying from 51% – 100% in these studies, while higher response rates noted among those with mood disorders.
- **Algorithm of treatment of depression in children and adolescents**



#### Augmentation

*\*May augment with: lithium, T3, stimulant, buspirone, pindolol, antipsychotics, 2nd antidepressant or benzodiazepine.*

#### Psychotherapy for depression in children and adolescents

- 7 of 9 studies indicate that CBT is more efficacious than a wait-list condition or than a non-CBT alternative psychotherapy.
- Systematic review of CBT in depressed children and adolescents indicated a beneficial effect in 62% of treated patients compared to 36% in placebo groups.



- CBT is associated with more rapid remission of symptoms than family therapy or supportive therapy.
- Long term follow-up indicates high rates of remission or recovery among adolescents with MDD but no superiority of CBT over other psychotherapies.
- No single type of CBT has been shown to be more efficacious than any other.
- IPT has been shown more efficacious than a wait-list condition or minimal clinical management in two acute treatment studies.

### **Combined treatment for depression**

Effectiveness of pharmacotherapy and psychotherapy for treatment of depression has been assessed in the multi site treatment of adolescent depression study (TADS). Participants were randomly assigned to fluoxetine alone (10 – 40 mg/d), CBT alone, fluoxetine with CBT or placebo.

1. Combined treatment (fluoxetine + CBT) was statistically superior to fluoxetine alone and CBT alone.
2. Fluoxetine alone was superior to CBT alone, which did not separate from placebo.
3. The response rates for each treatment group at 12 weeks were, Fluoxetine + CBT (71%), fluoxetine alone (61%), CBT alone (43%), and placebo (35%). Suicidal ideation decreased with treatment, but less so with fluoxetine therapy than with combination therapy or CBT.
4. By 36 week extension, CBT had “caught up” with fluoxetine and response rates were 69% for fluoxetine and 65% for CBT.
5. Combined CBT + fluoxetine reached maximum benefit at week 18 (85% response rate), 3 months earlier than CBT or fluoxetine alone (all treatment converged at week 36, with medication + CBT at 86%, medication and CBT alone each at 81%).

NIMH sponsored “Treatment of Resistant Depression in Adolescents” (TORDIA) is a multi center controlled clinical trial involving 12 – 17 year old adolescents with treatment resistant depression.

1. CBT + a switch to either medication regimen showed a higher response rate (55%) than medication switch alone (41%).
2. No difference in response rate between a second SSRI and venlafaxine was noted while more side effects reported with venlafaxine ( In addition to this an association with higher rates of suicidal events were reported in those who entered the study.

3. No differential effects on self-harm .
4. Combination of treatment was more evident among youths who had more comorbid disorders (especially ADHD and anxiety disorders), no abuse history, and less hopelessness.

## Suicide Risk in Antidepressant Treatment of Depression in Children and Adolescents

Findings across 36 weeks demonstrate that patients treated with fluoxetine alone (14.7%) were twice as likely as patients treated with combined fluoxetine + CBT (8.4%) or CBT alone (6.3%) to show both clinically significant suicidal intentions (on patient report) and to experience treatment emergent suicide events (on clinician report). Therefore:

- (1) There is no increased risk of a suicide event with CBT
- (2) There is a protective effect on suicidality from adding CBT to medication

## FDA Recommendations on Antidepressant Treatment

After starting an antidepressant a child should generally see his/her healthcare provider:

Once a week for the first 4 weeks

Every 2 weeks for the next 4 weeks

After taking the antidepressant for 12 weeks

After 12 weeks, on advice of health care provider, follow up arrangements are made

### Summary

Childhood depression is a common entity, particularly among adolescents, and is often associated with co-morbidities. There is strong evidence for effectiveness of SSRIs, CBT and combination of both, in treating paediatric depression. Treatment with SSRI could increase suicidality in childhood depression and regular monitoring and addition of CBT may be beneficial in this regard. TCAs, ECT and augmentation of antidepressants with other agents have shown some benefits in childhood depression.

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## 5.3 PSYCHOPHARMACOLOGY UPDATES IN ATTENTION DEFICIT HYPERKINETIC DISORDER (ADHD)

### Learning Objectives

1. Become familiar with medications used in the treatment of ADHD, its use and overuse.

### Background

The symptom domains of ADHD are;

- Sustained and prolonged motor activity (hyperactivity)
- Difficulty in maintaining attention (inattention)
- Impulsiveness and difficulty in withholding responses (impulsivity)

These symptoms are persistent and occur in many situations. The motor restlessness, over activity often starts before school age. They may have co-morbid learning difficulties and many develop minor forms of antisocial behavior. Depressive symptoms and low self-esteem commonly occur among these children. Some degree of executive dysfunction occurs in 70% of children with ADHD.

Depressive disorder, anxiety disorder and conduct disorder coexists in about 50% of ADHD children. Learning disability and language impairment are commonly present. Previous exclusion criteria for autism spectrum disorder has been removed in DSM 5 and no longer regarded as part of the syndrome of childhood autism.

### Epidemiology

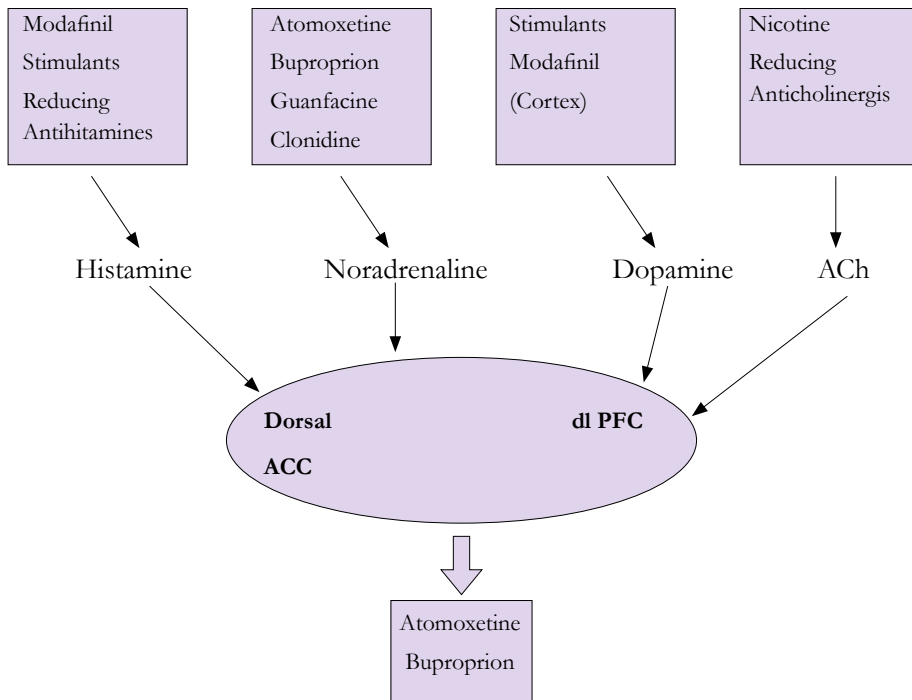
ADHD prevalence across studies varies according to the diagnostic criteria applied. Prevalence is about 5% according to DSM IV whereas ICD 10 rate is 1%. Male to female ratio is 3: 1. The disorder is more frequent among children brought up in socially disadvantaged environment and those raised in institutions.

### Aetiology

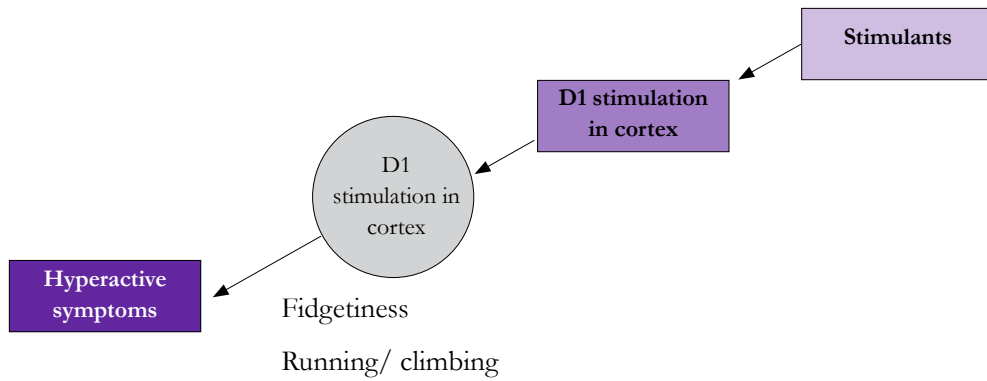
Known risk factors associated with ADHD are genetic, intrauterine tobacco exposure, prematurity and low birth weight.

Neurological findings	Motor clumsiness, language delay, abnormalities of speech
Neuroimaging studies	Functional and structural abnormalities in prefrontal and striatal regions, cerebellum, white matter disruption and disordered anatomical and functional connectivity between brain regions
Genetic studies	Twin studies, adoption studies Linkage and association studies implicated dopamine transmitter system, D4 receptor SNAP -25
Social factors	Disadvantaged social conditions
Other	Foetal exposure to tobacco, food additives, Zinc deficiency

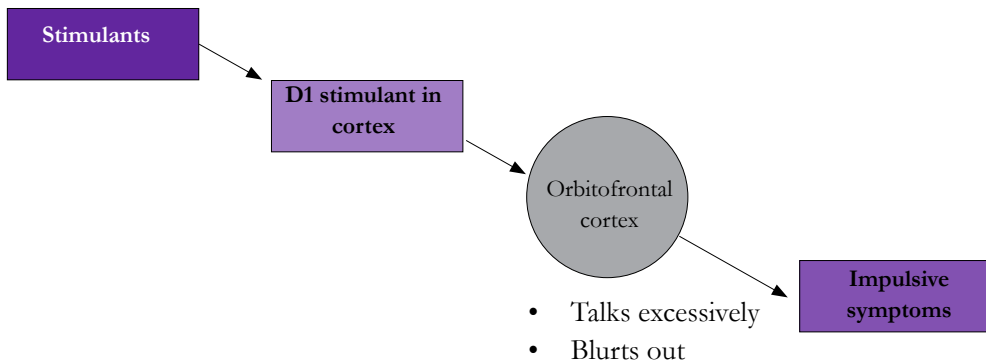
### Match Drugs with Neurotransmitters



## Match Neurotransmitters with Circuits and Drugs with Hyperactive Symptoms



## Match Neurotransmitter with Circuits and Drugs for Impulsive Symptoms



## Developing a Treatment Plan

1. Evaluation and planning
2. Parent support and guidance
3. Behavioral therapy can be recommended initially if,
  - ADHD symptoms are mild to moderate
  - In preschoolers
  - When pharmacotherapy is rejected

4. Practitioners role in an established treatment plan is to,
  - Coordinate with school or college student health services regarding ADHD treatment
  - Prepare patient and family for major transition

## Treatment of Attention Deficit Hyperactivity Disorder

The indication of treatment is the presence of impairment resulting from ADHD. Patients with mild to moderate ADHD are usually first treated with behavior therapy and education. Medication is the first line treatment for severe ADHD and second line treatment when psychological approaches fail within a reasonable time.

The multimodal treatment of attention deficit hyperactivity disorder study (MTA) is a multi site study designed to evaluate the leading treatments for ADHD, including behavior therapy, medications and the combination of the two. MTA concluded that combination treatment and medication management were both significantly superior to intensive behavior treatment alone and routine community care in reducing ADHD symptoms. In other areas of functioning, combination treatment was consistently superior to routine community care, whereas medication alone or behavior therapy was not. Studies also suggested stimulant drugs to decrease alterations in brain structure and function in subjects with ADHD relative to un-medicated patients and controls.

Despite the initial concern regarding weight and height decline in children treated with methylphenidate, a subsequent naturalistic 10 year prospective study found no evidence for this claim.

MTA 8 year follow-up revealed that,

- All patients improved over time
- Little difference among initial treatment arms for ADHD outcome at follow-up
- Initial weight/height declines were followed by rebound of both variables, but ultimate effects were uncertain.
- Inconsistent findings on substance use

The preschool ADHD treatment study (PATS) included preschool children in the range of 3 – 5 years and administered low doses of methylphenidate. The results showed that preschoolers may benefit from low doses of medication when it is closely monitored, however, positive effects are less evident and side effects greater than previous reports in older children.



PATS 6 year follow up revealed that ADHD in preschoolers is a relatively stable diagnosis and the course is generally chronic with high symptom severity and impairment in very young children with moderate to severe ADHD despite treatment with medication. Development of more effective ADHD intervention strategies is needed in this age group.

## Methylphenidate

- First choice when medication is indicated.
- Treatment should be initiated at small dose and increased upto a maximum dose of 60 mg per day.
- Ritalin is not recommended in children below 6 years of age as the safety and efficacy in this age group have not been established.
- Careful history (assessment for a family history of sudden death or ventricular arrhythmia), physical examination for the presence of cardiac disease followed by further cardiac evaluation if initial assessment is suggestive of possible cardiac disease should be carried out in each potential patient for methylphenidate.
- Prompt cardiac evaluation is indicated in patients who develop following during treatment with methylphenidate.
  - Extensional chest pain
  - Unexplained syncope
  - Symptoms of cardiac diseases
- Adverse effects include insomnia, anorexia, increased blood pressure and growth deceleration.
- Studies show evidence for a positive impact on child growth with longer breaks from medication and shorter breaks could reduce insomnia and improve appetite.

## Atomoxetine

- Is a suitable first line alternative.
- Efficacy is higher in treatment naïve patients compared to those previously treated with methylphenidate.
- No sleep disturbances and can be used in patients with comorbid tic disorder
- Should be initiated at a total daily dose of 0.5 mg/ kg. The initial dose should be maintained for a minimum of 7 days prior to upward dose titration.
- Maintenance dose is 1.2 mg/kg/day.

- Patients weighting more than 70 kg initiated at a total dose of 40mg/day. The recommended maintenance dose is 80 mg/ day.
- Black box warning exists for increased suicidal intentions.

## Clonidine and Guanfacine

- Effect size is less than stimulant drugs
- Extended release formulations are available

## Indications for Behavioral Therapy for ADHD

- When family oppose the use of stimulant medication
- To reduce residual symptoms of ADHD
- To make pharmacological therapy more effective
- To reduce amount of medication
- High parental satisfaction

## Alternative Agents for ADH

- Meta-analysis of 10 studies showed mild to modest improvement in ADHD symptoms with good tolerability for Omega- 3 / Omega -6 fatty acids.
- Melatonin improves sleep and continued effectiveness in 3.8 year follow up study using developmentally disabled youth with ADHD.
- Some evidence supports the efficacy of carbamazepine and bupropion.
- Use of second generation antipsychotics are not supported, however risperidone may help in reducing a severe degree of aggression and agitation, especially with moderate learning disability.

## Summary

ADHD is a common psychiatric disorder in childhood and is associated with significant disability when untreated. Medications are the first line treatment for severe ADHD and second line treatment when psychological approaches fail in less severe forms. Methylphenidate is the medication of choice followed by atomoxetine.

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## 5.4 MANAGEMENT OF AUTISM SPECTRUM DISORDER

### Learning Objectives

1. Become proficient in early diagnosis of autism spectrum disorder
2. Describe varied treatment strategies of autism spectrum disorder

### Introduction

Autism is a neurodevelopmental disorder characterized by deficits in social interaction, verbal and non-verbal communication, and restricted and repetitive behavior. Early diagnosis and treatment of autism or autism spectrum disorder is associated with better prognosis.

### Historical Background

- The word "autism," comes from the Greek word "autos," meaning "self." The term describes conditions in which a person is removed from social interaction, hence, an isolated self.
- Eugene Bleuler used the term “autism” to describe a patient with schizophrenia who had withdrawn into his own world. He used the term in the research papers on dementia praecox referring to morbid self-admiration and withdrawal within self.
- Autism was first observed by Leo Kanner, a psychiatrist in 1943 when he was studying a group of infants; hence he coined the term “early infantile autism” in his paper published in 1943.
- Kanner witnessed children who were “socially aloof”, were mute or had abnormal speech and were resistant to change in routine. He noted how alert and intelligent these children appeared.
- In 1944 Hans Asperger, a German scientist working separately, studied a group of children. These children also resembled Kanner’s descriptions. The children he studied, however, did not have echolalia as a linguistic problem but spoke like grownups. He also mentioned that many of the children were clumsy and were different from normal children in terms of fine motor skills.
- The pioneering work of Lorna Wing gave rise to the concept of the triad of impairments on which the diagnostic criteria for autism developed. They are,
  - o Social impairment
  - o Verbal and non-verbal language impairment
  - o Repetitive/stereotyped activities.

## Diagnosis and Clinical Manifestation of Autism Spectrum Disorder (ASD)

### International Classification of Diseases, tenth revision (ICD-10)

- Presence of abnormal or impaired development that manifests before the age of three years
- The characteristic type of abnormal functioning in all three areas of psychopathology
  - Social impairment
  - Verbal and non-verbal language impairment
  - Repetitive/stereotyped activities.

### Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM 5)

Two clinical domains in DSM 5 (instead of the 3 in DMS-IV)

- A-Deficits in social communication and social interaction (blends social with communication)
- B-Restricted, repetitive patterns of behavior (includes insistence on sameness)

Symptoms must be present in early childhood and must impair functioning.

### Clinical manifestations

Social communication	Restricted and repetitive behaviors
<ul style="list-style-type: none"> <li>• Do not point at objects to show interest</li> <li>• Do not look at objects when another person points at them</li> <li>• Do not have trouble relating to others or not have an interest in other people at all</li> <li>• Appear to be “in their own world”</li> <li>• Avoid eye contact and want to be alone</li> <li>• Have trouble understanding other people’s feelings or talking about their own feelings</li> </ul>	<ul style="list-style-type: none"> <li>• Repeat actions over and over again</li> <li>• Play with toys or objects non-functionally</li> <li>• Have trouble adapting when a routine changes</li> <li>• Have unusual reactions to the way things smell, taste, look, feel, or sound</li> <li>• Have unusual motor movements</li> </ul>

Varied validated instruments are being used to gather information from parents and objective instruments are used for assessment of the individuals with ASD. Mental retardation, attention deficit hyperactivity disorder (ADHD), epilepsy, anxiety, obsessive compulsive and mood disorders complicate the clinical presentation of ASD which warrants the routine screening for comorbid medical and psychiatric disorders.

## Epidemiology of Autism Spectrum Disorder

Globally, autism is estimated to affect more than 20 million people as of 2013. It occurs four to five times more often in boys than in girls. The number of people diagnosed has been increasing dramatically over the last 2-3 decades, partly due to changes in diagnostic practice. It is unclear whether actual rates have increased.

Disorder	Prevalence
Autism	20/10,000
Asperger's syndrome	6/10,000
Rett's syndrome	1/10,000
Childhood disintegrative disorder	2/100,000

## Aetiology of Autism Spectrum Disorder

Most cases involve a complex and variable combination of genetic and environmental factors that influence early brain development.

The heritability of ASD is 80 - 90% and twin studies indicate a higher concordance between monozygotic than dizygotic twins. The siblings of autism probands experience mild impairment in language and social interaction compared to the general population. Susceptibility loci on chromosomes 2, 7, 17 and gene variants including NRXN1, NLGN3 and CNV 15q11-13 have been identified to be involved in ASD.

## Early Detection and Intervention of ASD in Children

- Interventions should commence in infants with risk signs despite not reaching a definitive diagnosis. There is growing interest for the development of markers which identify autism at an early age, before the behavioral manifestations occur.
- Infants with risk signs should be offered interventions for symptoms without waiting for definitive diagnosis.
- It is also important to screen for signs and symptoms of autism on multiple occasions as some children develop the signs at a later stage.

## Approaches to Treatment

1. Family support and training
2. Medical management
  - a. Routine well child care
  - b. Treat co-morbid conditions
    - Seizure disorders
    - Sleep disturbances
    - Gastrointestinal problems
    - Challenging behaviors
3. Complementary therapies

## Clinical Approaches to Challenging Behavior

Careful assessments of target behavior include timing, nature, intensity and triggers of such behaviors and response to interventions. Information should be gathered from multiple sources. Behavioral assessment scales can be used to get objective results. Medical factors may cause or exacerbate symptoms and such causes should be carefully looked for. It is important to be knowledgeable on existing and available support services such as educational programs and family support services.

Once the assessment is complete, treatment strategies, behavioral strategies and / or medication could be considered. Medication is used when symptoms cause significant impairment or if there is suboptimal response to behavioral modifications. When choosing medication its efficacy for target symptoms, potential adverse effects and practical considerations (dosing, monitoring & cost) should be borne in mind. Before commencement of medication, it is important to identify desired outcomes and assessment measures.

Advice to parents and monitoring child for effects of treatment should be done carefully after commencement of treatment. This include discussing time course of expected effects, arranging follow-up visits, outlining plan for alternative options if medication is not effective and obtaining baseline laboratory data. Consideration should be given to withdraw medication after 6 months of treatment.

Pharmacotherapies are currently used in adjunct to psychological interventions in individuals with ASD. Risperidone, methylphenidate and SSRIs hold the bulk of the evidence in treatment of challenging behaviors and comorbid disorders in ASD. New evidence is emerging for alpha 2 agonists, cholinergic agents, glutamatergic agents and oxytocin.

Psychotropic medications were used to reduce challenging behaviors and improve response to behavioral and educational interventions. Rosenberg et al (2010) reported that 35% of children with ASD were prescribed at least 1 psychotropic medication. They found the use of psychotropic medications increased with older age, intellectual disability or psychiatric co-morbidity and stimulants, anti-psychotics, and SSRIs are the most commonly prescribed medications.

### **Clinical use of Stimulants in ASD**

Studies have shown that methylphenidate treatment may show benefit in some patients with ASD and ADHD-like symptoms. The rate and magnitude of response is lower and the rate of adverse effects is higher than seen in children with ADHD alone. There is preliminary evidence for atomoxetine in the treatment of milder forms of ASD.

### **Clinical use of Antipsychotics in ASD**

Aggression towards self and others is a common problem in ASD. Even though behavioral and environmental approaches are the first line recommendation, severe behavioral problems may require pharmacological interventions. Treatment is usually recommended for 6 months to one year. First line pharmacological treatment for irritability in children and adolescents with ASD are the second generation antipsychotics. Risperidone was the first medication to obtain the FDA approval for the treatment of irritability in children aged 5-16 with ASD.

The research Unit on Paediatric Psychopharmacology (RUPP) trial on risperidone reported that risperidone was safe and effective for short-term treatment of tantrums, aggression, and self-injurious behavior in children with ASD. Improvements were also seen in hyperactivity and stereotypic behavior. The short period of study limits inferences about long-term efficacy and side effects. Aripiprazole has been approved for the same indication in children aged 6-17 and is associated with a significant reduction in irritability. Aripiprazole is beneficial in reducing hyperactivity and stereotypes.

### **Clinical use of SSRIs in ASD**

It should be noted that there is a similarity between repetitive behaviors of ASD and symptoms of obsessive compulsive disorder (OCD). There is evidence of serotonin system abnormalities in ASD. Small, open-label studies with various SSRIs have shown some benefits, while placebo controlled studies and larger studies failed to show improvement of repetitive behaviors in ASD. Side effects due to SSRI are more common in ASD.



## Other Medications used in ASD

- Alpha-2 adrenergic agonists (clonidine, guanfacine)
  - Hyperactivity, inattention
  - Sedation, dry mouth, decreased BP, dizziness, constipation, irritability
- Anti-epileptics (topiramate, valproate)
- Donepezil
- Memantine

## Complementary and Alternative Therapies

Biological treatments	Non biological treatments
Dietary modifications	Auditory integration therapy
Vitamins/ supplements	Behavioral optometry
Chelation therapy	Cranio-sacral manipulation
Melatonin	Music therapy
Antibiotics/ antifungals	Yoga
Immunoglobulins	Snouzelan
Hyperbaric oxygen	

## Gluten and Casein Free Diet

It has been speculated that gluten (protein found in wheat, rye, barley) and casein (protein found in dairy products) break down into opioid-like peptides which diffuse across abnormally permeable GI lining (“leaky gut theory”) and excess opiate activity in central nervous system results in symptoms of autism. However, the Cochrane review in 2009 concluded that there is insufficient evidence at this time to support the use of gluten/casein free diets and that a further study was needed with well-designed trials.

## Vitamins and Supplements

There is some evidence that omega 3 fatty acids, Alpha Lipoic Acid (ALA), Eicosapentaenoic Acid (EPA) and Docosahexaenoic Acid (DHA) can have positive effects on hyperactivity and stereotypy. These supplements can cause gastro-intestinal disturbances.

## Chelation Therapy in ASD

Based on the hypothesis that children with ASD have mercury toxicity, chelation therapy has been proposed as a treatment for ASD. However, there is no firm evidence to support a link between thimerosal, a mercury-based preservative that has been used in multi-dose

vials of medicines and vaccines, and ASD. No controlled studies have been conducted to examine the effectiveness of chelation. Chelation agents can be associated with severe side effects such as arrhythmia, kidney failure, bone marrow suppression and death.

## Melatonin

Sleep problems are highly prevalent in ASD (44%-83%) and has been linked to abnormal melatonin regulation in ASD. A few studies have shown some benefits such as increased sleep duration and reduced sleep latency. Melatonin shows good tolerability. It has been recommended to give 1-3mg of melatonin 30 minutes prior to bedtime.

## Psychotherapeutic Approaches

Floor time	Form of non-invasive play therapy. The emphasis is on human connection. Emphasis is not on the duration but the appropriate manner in which a skill is achieved.
Son rise	Special play room, free of distractions. Join the child to create connections and provide unconditional love and acceptance
ABA (Applied Behavioral Analysis)	Most scientifically valid treatment in ASD, effectiveness depends on prompt application during a problem behavior
Sensory integration therapy	Assessed and carried out by occupational therapists
Auditory integration therapy	Spending prescribed amount of time listening to a record of particular combination of sound waves to retrain the ear mechanisms
Music therapy	Is conducted by trained therapists

## Summary

Interventions should commence in infants with risk signs such as impairment in social communication and interaction despite not reaching a definitive diagnosis. Treatment of ASD includes family support, parental training, complementary therapies and medical management of routine child care and co-morbid conditions. Pharmacotherapies are currently used in adjunct to psychological interventions in individuals with ASD. Risperidone, methylphenidate and SSRIs hold the bulk of the evidence in treatment of challenging behaviors and co-morbid disorders in ASD. Evidence for gluten and casein free diet, nutritional supplements, chelation therapy in the treatment of ASD is equivocal.

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# CHAPTER 6

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## 6.1 COUPLES THERAPY

### Learning Outcomes

- To be aware of the professional conduct of couples therapists
- Describe the assessment for couples therapy assessment
- To be able to conceptualize and thereby set treatment goals for couples therapy
- To expand the knowledge on specific treatment techniques for couples therapy
- To improve knowledge on treatment strategies of couples therapy in special situations such as in extra dyadic relationships, substance misuse, depression and sexual dysfunction

### Section 1

#### Introduction to Couples Therapy

##### Professional conduct of couples therapist

A therapist doing couples therapy, like any other therapist is bound by professional ethics. The success of the therapy is based on a sound professional relationship with both partners. The therapist should not appear biased or partial towards one of the partners. The professional nature of the relationship and avoidance of boundary transgression are very important in couples therapy considering the nature of this treatment. At times one of the partners may be emotionally vulnerable and the therapist should be mindful of that and always emphasise his/her role and the limits of the relationship. Consequently, phone calls or contacts with partners out of the sessions should be avoided as much as possible, especially if this is done without the knowledge of the other partner. Occasional brief contacts are acceptable, particularly if the caller needs a reminder about how to enact new behaviors that the couple had agreed on during the previous therapy session. If the caller begins to complain about

the partner or raise other issues that are appropriate for treatment, the therapist should suggest that these concerns be voiced early in the next combined session.

## **Assessment**

### ***Assessment and Treatment Planning***

A comprehensive and structured assessment process provides the foundation for all future interventions. Unless couples enter therapy in a state of acute crisis, the first two sessions are devoted to assessment and evaluation. Couples are informed that the purpose of the initial evaluation is to identify their concerns about the relationship and the factors that influence their difficulties, as well as to determine whether therapy is the best course of action for them at the present time.

### **Goals of the assessment -**

- (1) To determine the appropriateness of couple therapy.
- (2) To identify the concerns and potential areas of enrichment/growth for which a couple has sought assistance.
- (3) To clarify the factors associated with the two individuals, the couple as a dyad, and the couple's environment, that contribute to their presenting concerns.

If the couple and therapist decide that therapy is not the optimal plan, they determine some alternative course of action (eg. individual therapy for one or both partners to address factors that do not appear to be caused by conditions within the couple relationship).

Overall six primary questions guide the assessment phase and ensure that the therapist gathers information central to the development of the formulation:

1. How distressed is this couple?
2. How committed is this couple to the relationship?
3. What issues divide the partners?
4. Why are these issues such a problem for them?
5. What are the strengths holding them together?
6. What can treatment do to help them?

## **Assessment Methods**

The initial assessment phase typically involves multiple strategies for information gathering;

1. Clinical interviews with the couple
2. Clinical interview with the individual partners
3. Direct observation of the couple's interaction patterns



Questionnaires are used in assessment of couples therapy in other countries [Dyadic Adjustment Scale and the Marital Satisfaction Inventory]. However, there are no validated questionnaires for that purpose in Sri Lanka.

### **Areas assessed in the initial joint interviews**

- How they met
- What attracted them to each other
- How they developed a deeper involvement and commitment
- What life events had significant positive or negative influences on their relationship
- Any prior experiences in couple or individual therapy
- Influences of ethnicity and religion
- Current relationship concerns as well as individual, dyadic, and environmental factors that contribute to the couple's presenting issues

Finally, the initial interview provides the therapist's first opportunity to establish a balanced and collaborative working relationship with both partners.

To inquire about relationship strengths, the therapist inquires about strengths present in the early phases of the relationship and asks what happens when things are going well. For instance, the therapist could ask,

“What parts of your relationship worked well when you were first together?”

“What parts of your relationship were you proud of?”

“How is the relationship different now during times that you are getting along?”

In addition, the therapist may want to focus on the couple's possible strengths and hopes for the future. It may be helpful to ask the partners how their relationship might be different if their current problems no longer existed.

Evidence of significant psychopathology in an individual client leads the therapist to pursue a more in-depth assessment of the individual's functioning and perhaps to make a referral for individual therapy.

At the beginning, it is important for the therapist to socialize the couple to the treatment model, establish trust, and instill hope. To socialize couples, therapists should explain the structure of the therapy, focusing in particular on the distinction between the assessment and treatment phases of the model. It is important to help couples anticipate the sequence of the upcoming sessions and remind them that treatment goals and an overall agreement regarding therapy will be the focus of the feedback session. Often, carefully explaining the

separation of the assessment and treatment phases of couples therapy is helpful for couples who have some hesitation about beginning treatment; therefore, the very structure of couples therapy helps to honour and respect what is often the very natural ambivalence that couples experience.

During this conversation the therapist explains to the couple about the assessment and ways of assessment. The therapist also makes a distinction between assessment and treatment and informs the possibility of further treatment by someone else. The therapist also sets the tone by encouraging input from both partners.

### **Areas of concern**

Experience in working with couples in Sri Lanka underscores the importance of routine screening for common individual factors, as many partners will not spontaneously divulge such information to the therapist. These are

- Morbid jealousy
- Substance misuse
- Domestic violence
- Depression
- Influence of extended family
- Extra marital relationships

### **Morbid Jealousy**

Many partners don't want admit to this behavior or to the other person discussing about it. Therefore, it should be screened in a sensitive manner. Alcohol misuse, depression and sexual disorders may co-occur with morbid jealousy.

### **Substance Misuse**

Alcohol is a commonly used psychoactive substance in Sri Lanka and excessive use of it can have devastating impact on their marriage or relationship. Use of other substances such as cannabis, though relatively less frequent can have same negative consequences. Many partners who use substances are unable or unwilling to consider it as a problem.

### **Domestic Violence**

Domestic violence is aggressive or abusive behavior towards the partner. This may include physical, verbal, emotional, sexual or economic abuse. In any culture, particularly in the Sri Lankan culture this will not be discussed openly. Therefore, the screening about domestic violence should be done thoughtfully. Some of the questions the therapist could ask are

Does your partner...

- *Use intimidation or threats to gain compliance?*
- *Treat you roughly - grab, push, pinch, shove or bite you?*
- *Embarrass or make fun of you unjustifiably in front of your friends or family?*
- *Pressure you sexually for things you don't want to do?*
- *Prevent you from doing things you want - like spending time with your friends or family?*
- *Make you feel like there "is no way out" of the relationship?*

Do you...

- *Try not to do anything that would cause conflict or make your partner angry?*
- *Always do what your partner wants you to do instead of what you want?*
- *Sometimes feel scared of how your partner will act?*
- *Constantly make excuses to other people for your partner's behavior?*
- *Believe that you can help your partner change if only you changed something about yourself?*

Alcohol misuse, depression, anger management issues or morbid jealousy may be associated with domestic violence.

## **Depression**

Depression is frequently associated with relationship issues. It may be a cause or result of relationship problem. Whether depression is a cause or result, it may perpetuate the relationship problem.

Considering the frequent co- occurrence of individual psychopathology and relationship problems, it is common for one or both members of a couple to have individual treatment while having couples therapy. However, it is very important that the use of medication and/ or individual therapy will not result in that member of the couple being defined as the sole source of problems in the relationship. At times, treating individual problems such as substance misuse or depression may resolve the relationship issues without couples therapy.

## **Section 2**

### **Conceptualization**

#### **Goal Setting**

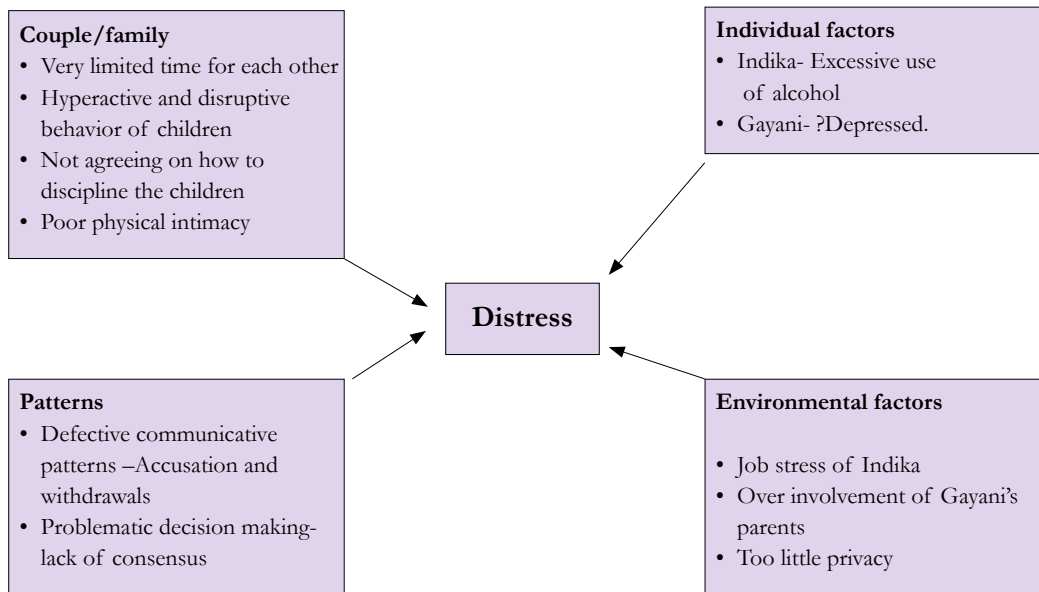
After completing the initial assessment, the therapist meets with the couple to provide treatment recommendations. The therapist will discuss with the couple about his conceptualization of their distress including factors impacting on their relationship. These

factors may be related to the couple such as too little time with each other, family, such as difficult behavior of children or intrusions of in-laws, individual, such as substance misuse of husband and environmental factors, such as financial problems. The therapist will also discuss repetitive negative interactional, behavioral, cognitive, and affective response patterns which may maintain the relationship difficulties. This conceptualization should be non-biased, realistic and should lead to treatment.

## Conceptualization

### Example

Indika, a 38 year old garment factory manager and Gayani, a 35 year old teacher has been married for 11 years. They have 4 year old twin sons and the four of them live at Gayani's parents' house with her parents and unmarried brother. They present with relationship difficulties over the last 2 years.



Previous or childhood experience may explain why some couples have their current problems. It is important for the therapist inquire about childhood experience and how it colors current problems.

## Translating problems into treatment goals

It is very important that the therapist checks with the couple whether his conceptualization resonates with the couple's understanding of their problem. The therapist then works

together with the couple in identifying modifiable problems and translating those into treatment goals.

This would be based on the conceptualization.

- Limited time together - Increasing intimacy in the relationship by increasing time together.
- Defective communication - Re-establishing better communication between two partners.
- Problematic decision making - Better liaison and consensus in decision making.
- Hyperactive behavior of children - Consider further assessment and treatment for their behavioral issues.
- Possible depression in Gayani - Have in depth assessment for depression.
- Excessive Alcohol use in Indika - Open discussion on how to reduce alcohol intake.

It is important to have a firm agreement on goals as the success of the therapy depends on the couple's commitment to achieving these goals. If both partners are unable to agree on a certain goal it should be discussed further. These goals should be realistic, practical and achievable during therapy. For example, living with Gayani's parents may be problematic for their relationship, living in a separate place poses various problems including affordability and child care arrangements making it an almost impractical solution. Individual problems and goals should be seen in the context of the relationship, such as what can be done to address Gayani's depression and Indika's alcohol problem as a couple.

The therapist will then describe specific appropriate intervention techniques to achieve these goals. Therapist will get the fullest cooperation of both partners in treatment planning so they will be able to have ownership in treatment and will create hope.

## Section 3

### Specific Treatment Strategies

#### Communication Skills

Poor communication has been identified as a major problem for relationship problems. The therapist should assess for such problems and help the couple to develop better communication skills.

#### Teaching Communication Skills

The therapist generally begins the treatment with training in communication skills by defining effective communication as “message intended (by speaker) equals message

received (by listener)” and emphasizing the need to learn both “listening” and “speaking” skills. The therapist can expand this definition further including factors in each person that can impede communication.

Teaching couples communication skills of listening and speaking and how to use planned communication sessions are essential prerequisites for negotiating desired behavior changes.

The therapist could start this training with non-problem areas that are positive or neutral and move to problem areas and emotionally charged issues only after each skill has been practiced on easier topics.

### **Listening Skills**

Good listening helps each spouse to feel understood and supported and to slow down couple interactions to prevent quick escalation of aversive exchanges. Instruct couples when listening to the partner repeat words and/or feelings of the speaker’s message and to check whether the message received was the intended message. (“What I heard you say was .... Is that right?”). When the listener has understood the speaker’s message, roles change and the first listener then speaks. Teaching a partner to communicate and understand by summarizing the spouse’s message and checking the accuracy of the received message before stating his or her own position is often a major accomplishment. Failure to understand the meaning of the message and the position of the speaker will lead to picking on the words by the listener instead of understanding the real meaning of the message.

### **Skills for Listening to the Partner.**

Ways to respond while the partner is speaking

- Show that the partner understands the other partner’s statements and accepts his or her right to have those thoughts and feelings. Demonstrate this acceptance through the tone of voice, facial expressions, and posture.
- Try to put themselves in the other partner’s place and look at the situation from his or her perspective to determine how the partner feels and thinks about the issue.

### **Expressing Feelings Directly**

Expressing both positive and negative feelings directly is an alternative to blaming, hostile and indirect communication. Avoidance of responsibility and communication characterize many distressed relationships.

The speaker takes responsibility for his or her own feelings and words and does not blame the other person for how he or she feels. Clear ‘I’ statements should be encouraged, and blaming the partner for the speaker’s feelings and positions should be discouraged.

For eg. “I feel sad because (of your action)” is a better way of communicating than “you made me sad” which is blaming the partner for the speaker's feelings. This reduces listener defensiveness and makes it easier for the listener to receive the intended message. Present ample examples of differences between direct expressions of feelings and indirect and ineffective or hurtful expressions. After presenting the rationale and instructions, show correct and incorrect ways of expressing feelings and elicit the couple's reactions to these different scenes. Then have the couple role-play a communication session in which spouses take turns being speaker and listener, with the speaker expressing feelings directly and the listener using the listening response. During this role-play, coach the couple to practice reflecting on the direct expressions of feelings. Assign similar communication sessions as homework, with each session being for 0 to 15 minutes, three to four times weekly. Subsequent therapy sessions involve more practice with role-play, both during the sessions and as homework. Gradually increase the difficulty of the topics practised by the couple every week.

#### Advice to couples on sharing thoughts and emotions

- State their views subjectively, as their own feelings and thoughts, not as absolute truths. Also, speak for themselves, what they think and feel, not what their partner thinks and feels.
- Express his/her emotions or feelings; not just his/her ideas.
- When talking about the partner, state their feelings about the partner, not just about an event or a situation.
- When expressing negative emotions or concerns, also include any positive feelings they have about the person or situation.
- Make the statement as specific as possible, both in terms of specific emotions and thoughts.
- Speak in “paragraphs”; that is, express one main idea with some elaboration, then allow the partner to respond. Speaking for a long time period without a break makes it hard for the partner to listen.
- Express feelings and thoughts with tact and timing, so that the partner can listen to what they are saying without becoming defensive.

#### Advise on how to respond after your partner finishes speaking

- Reflection - After your partner finishes speaking, summarize and restate his or her most important feelings, desires, conflicts and thoughts.

- While in the listener role, do not
  - o ask questions, except for clarification
  - o express own viewpoint or opinion
  - o interpret or change the meaning of the partner's statements
  - o offer solutions or attempt to solve a problem, if one exists
  - o make judgments or evaluate what the partner has said

### **Expressing in a Positive Manner**

“What matters the most is not what you say but how you say it”.

The same information can be expressed in different ways. It can be positive, negative, productive or counterproductive. When negative and counterproductive communication strategies are used repeatedly it causes significant damage to a relationship. The therapist should encourage the couple to use positive communication styles.

### **Negotiating for Requests**

Learning to make positive specific requests, and being open to negotiate and compromise, leads to agreements and helps resolve issues amicably. Positive specific requests are an alternative to the all-too-frequent practice of couples complaining in vague and unclear terms and trying to coerce, browbeat, and force the other partner to change. For homework, each partner lists at least five requests. Negotiation and compromise comes next. Spouses share their lists of requests, starting with the most specific and positive items. The therapist gives feedback on the requests presented and help rewrite items as needed. Then explain that negotiating and compromising can help couples reach an agreement in which each partner will agree to comply with one specific request of the other. After giving instructions and examples, coach the couple during a communication session in which requests are made in a positive specific form, heard by each partner, and translated into a mutually satisfactory, realistic agreement for the upcoming week. Finally, record the agreement on a homework sheet that the couple knows you will review with them during the next session. Such agreements can be a major focus of a number of couples therapy sessions.

### **Communication Sessions**

These are planned, structured discussions in which spouses talk privately, face-to-face, without distractions, and with each spouse taking turns expressing his or her point of view without interruptions. Communication sessions can be introduced for 2-5 minutes daily when couples first practice acknowledging caring behaviors. In later weeks when the couple



discusses current relationship problems or concerns, communication sessions typically are assigned for 10 to 15 minutes three to four times a week. Discuss with the couple the time and place that they plan to have their assigned communication practice sessions. Assess the success of this plan at the next session, and suggest any needed changes. Establishing a communication session as a method for discussing feelings, events, and problems is very helpful for many couples.

### **Guided Behavior Change**

Guided behavior change is a form of behavioral therapy where no new skills are required to be learned, but the couples are merely guided to think of what interactions in their relationship they can change to make their interactions more positively meaningful to each other and society. It includes changes such as an increase in the frequency of their current positive behaviors and a decrease in the frequency and intensity of negative interactions. To strengthen this further, the therapist can use a focused, guided behavior change exercise. Each partner is encouraged to write down positive behaviors they have observed in each other in between sessions and bring them to the following session. These would include even trivial matters such as how well the wife packed his lunch or how the husband responded when the child started crying. The task is not only a strategy to help the couple to understand how they are valued by each other but also to identify significance of the partner as an individual.

### **Change in their own Behaviors**

“Be the change that you wish to see in the world.” – Mahathma Gandhi

In a distressed couple, each partner may promptly point out the problematic behaviors of the other person and how the other partner should change such behaviors. This may lead to further arguments. Therefore, the therapist needs to show the importance of each person committing to constructive behavior changes regardless of the other person’s behavior.

### **Behavior Changes**

The therapist should encourage the couple to take concrete and practical steps to reduce the rate and magnitude of interactions and behaviors detrimental to the relationship and to increase the frequency and magnitude of positive behaviors. These interventions involve each partner engaging in various positive behaviors to make the other person happier.

These may include small, day-to-day efforts such as helping the partner with cooking or washing dishes, ironing clothes, giving a phone call while at work to find out how the other partner is doing and bringing in something the partner likes. The above interventions are useful when the therapist observes that the partners have stopped making much effort to

be caring and loving towards each other, have allowed themselves to become preoccupied with other demands, and have treated their relationship as a low priority.

At times more explicit interventions going beyond above efforts including “love days” and “caring days” where the couple would dedicate an entire day without other interruptions to re-build their relationship may be required

### **Improving Quality Time Spent with Each Other**

Proximity and spending enjoyable and fulfilling time with each other are essential ingredients of a good relationship. Many distressed couples do not spend quality time with each other like they did when they had a better relationship. While the therapist empathizes with partners’ difficulty in finding time to spend with each other, therapist should help the couple to find a practical solution. The partners need to agree on a concrete plan such as specific time and date and how to arrange that time.

### **Problem Solving**

#### **Guidelines for Decision-making**

Discuss possible solutions.

- Propose concrete, specific solutions that take your own and your partner’s needs and preferences into account. Do not focus on solutions that meet only your individual needs.
- Focus on solutions for the present and the future. Do not dwell on the past or attempt to attribute blame for past difficulties.
- If you tend to focus on a single or a limited number of alternatives, consider “brainstorming” (generating a variety of possible solutions in a creative way).
- Decide on a solution that is feasible and agreeable to both of you.
  - o If you cannot find a solution that pleases you both, suggest a compromise solution. If a compromise is not possible, agree to follow one person’s preferences.
  - o State your solution in clear, specific, behavioral terms.
  - o After agreeing on a solution, have one partner restate the solution.
  - o Do not accept a solution if you do not intend to follow through with it.
  - o Do not accept a solution that will make you angry or resentful.

- Decide on a trial period to implement the solution if it is a situation that will occur more than once.
  - Allow for several attempts of the new solution.
  - Review the solution at the end of the trial period.
  - Revise the solution if needed, taking into account what you have learned thus far.

## Cognitive Interventions

Behaviors in relationship are important. Yet the interpretation of such behaviors are coloured by cognitive factors. For example, a husband might buy a valuable present for his wife, but whether she construes this as a positive or negative behavior is likely to be influenced by her explanation for the behavior. If she believes he is trying to be thoughtful and loving, she might experience buying a present as positive. However, if she concludes that he is attempting to bribe her by buying a present because he is planning to buy something expensive for him, she might feel manipulated and experience the same behavior as negative.

- Selective attention—what each person notices about the partner and the relationship.
- Attributions— causal and responsibility inferences about marital events.
- Expectancies— predictions of what will occur in the relationship in the future.
- Assumptions—what each partner believes people and relationships actually are like.
- Standards—what each believes people and relationships should be like.

## Emotional Focused Solutions in Couples Therapy

Sepalika is married to Anura. Anura works at a bank and Sepalika stopped working after they had kids. They have two kids who are now 3 and 5. Anura believes Sepalika should go back to work now for better financial stability and Sepalika wants to wait till both kids are going to school. They have arguments about that, but otherwise they are loving.

One day, Anura came to the kitchen after work while Sepalika was cooking dinner, having put the children to sleep. She is making Malu Ambulthiyal, one of Anura's favourite curries and Anura started discussing about how much he had to spend on daily groceries and how little they can save. Sepalika got increasingly impatient about what Anura said and knew it will end up with the fight on when she should start working.

Sepalika – *“We are getting into one of those dead-end fights. You are tired after work, I am tired after running behind our kids. Are we going to fight it out? You will tell me why I should go to work and how much we can save then. I will cry and withdraw. Both feel bad and hurt afterwards. Do we need to do it? Or can we discuss about something else?”*

Anura in a soft voice “*No fights, no crying*” and then, “*Maluambultbiyal smells really good.*”

He stroked Sepalika’s head and left the kitchen saying “*I will go and see whether children are asleep*”

In the above incident between Sepalika and Anura, they negotiated moments of emotional disconnection, steered away from dangerous escalation and towards safety and security. In that moment of conflict and disconnection, they were able to recognize a negative repetitive pattern, stop fighting and re-establish an emotional connection. However, this is not easy for many couples and they go on to fight and feel more and more emotionally distant as a result. To stop this cycle, partners have to be able to take a step back, reflect on the pattern, de-escalate the conflict, be responsible for their part in that pattern or conflict and create a basic emotional safety. They are required to work together to limit damaging interactions and dialogues and to resolve their basic insecurities. Emotionally Focused Couples therapy will help the couples who are stuck in this situation.

### **Theoretical Perspective of Emotionally Focused Solutions of Couples Therapy**

Along with Behavioral Couples Therapy, Emotionally Focused Couples therapy (EFCT) has been empirically tested for relationship problems. EFCT is a brief systematic therapy that aims at modifying distressed couples’ negative interaction patterns and emotional responses in order to secure a emotional bond. EFCT believes that the main factors in relationship problems are the continuing negative emotional states and resultant damaging interactional patterns which in turn maintain this emotional state. EFCT uses combinations of psychodynamic approach to gain insights into intrapsychic inner experience and interpersonal systemic perspective with a focus on cyclical, self-reinforcing interactional responses. EFCT relies heavily on attachment theory which explains adult intimate relationship and love and views couple’s distress in terms of separation distress, insecure bond, schemas concerned with the dependability of others and the worth or lovableness of self.

In EFCT, the therapist will make couples identify the negative patterns in their interactions, demonstrate to them how to address those moments more constructively and encourage them to apply what they have learned during therapy in daily life. The therapist could ask them to revisit contentious or turbulent moments and have the dialogue again during the therapy session. The therapist could interrupt the interaction asking partners questions such as “What just happened here?” thereby demonstrating to them how it spirals out of control, how to de-escalate the situation and what could be done to steer it on a more positive direction.

EFCT comprises of 3 phases and 9 steps.

## **The nine steps of EFCT are as follows**

### **Cycle De-escalation**

- Step 1. Assessment - building a trusting alliance and clarifying the key issues in the couple's distress using an attachment perspective.
- Step 2. Recognizing the negative interactional cycle which perpetuates attachment insecurity and relationship distress.
- Step 3. Identifying the unrecognized emotions which drive the interactional positions.
- Step 4. Reframe the problem in terms of the cycle, the underlying emotions, and attachment needs.

### **Changing Interactional Positions.**

- Step 5. Encouraging identification of unacknowledged needs and aspects of self and integrating these into relationship interactions.
- Step 6. Encouraging acceptance of the partner's new construction of experience in the relationship and new responses.
- Step 7. Promoting the expression of specific needs and wants and creating emotional engagement.

### **Consolidation/Integration.**

- Step 8. Facilitating the emergence of new solutions to old problematic relationship issues.
- Step 9. Consolidating new positions and new cycles of attachment behavior.

## **Some Specific Techniques of EFCT**

### **Changing the direction**

During their conflict, partners get totally trapped in the cycle of finding who is right and who is wrong or who is the perpetrator and who is the victim. They become rivals accusing each other of wrong doing and mistakes and accusing each other. At that point if the partners can see the futility of the interaction and use “we” for exclusive use of “I” and “you” it will change the direction of the interaction for better. The therapist should get them to look at how to stop fighting and change the direction. The therapist can give suggestions initially. One of the main points is to view them as dyad rather focusing on their individual interests.

### **Identifying their Own Patterns**

The therapist will encourage each partner to identify their own negative patterns in the

interactions and they should do so together. The therapist could help them to identify the patterns if they are unable to do so.

*“We discussed about the repetitive patterns in your interactions during fights. Can each of you claim your own pattern? Don’t comment about the other person, it is about you. “*

### **Identifying Their Own Feelings.**

It is clear that certain emotions drive the negative interactional style. Most of the time these emotions or affective states are not very clear cut, they are ambiguous. Some are very easy to identify and others are not so easy to access. For example when partners feel angry, they may also feel vulnerable. The feeling of vulnerability is not apparent and it is difficult for the partners to acknowledge those feelings as they are not comfortable with it. But identifying them and communicating their true feeling to the other person will go a long way in establishing emotional connection.

The therapist has to play an active role in this as partners may not be able to identify deeper emotions easily. The therapist needs to explain to them emotions are ambiguous and all of us may have two polarising emotions at the same time. The therapist can introduce the concept of “part of me feels this and I guess the other part feels that” will help them to contextualize it.

### **Recognizing their Impact on Partner’s Emotions**

It is obvious when two people are in an intimate relationship each other has immense impact on each other’s emotions. But sometimes when partners are in heated conflicts they may lose sight of the impact they have on partner’s emotions. The therapist should promote Recognizing and acknowledging impact of their behavior on partner’s emotions.

Due to antagonism or ignorance partners may fail to see their influence on each other. Even when they see it they would be reluctant to admit it as it is uncomfortable. The therapist needs to tell them it is understandable, they can have negative emotional influence on each other and it is important talk about it.

### **Renewing the Relationship**

Stop fighting, changing direction, identifying repetitive negative patterns. Identifying their own and each other’s emotions and the influence they have on other person’s emotion will help to renew the relationship. Partners will see them as allies rather than rivals. They will not let fights and arguments get out of hand which will widen the relationship rift.

The success of the therapy remains in their application in day to day life. Partners will not always be able to apply this knowledge, skills and the specific steps every time they disconnect

or have a conflict. Practicing these skills by going over disturbing past interactions again and again until they learn from each other will be extremely important. The therapist should promote them to practice these skills during sessions as much as possible. Once they have become proficient at that, they can begin to integrate these steps into the everyday rhythm of their relationship. When they have a conflict or feel distanced from each other, they can take a step back and ask, “What’s happening here?”

## Section 4

### Couples Therapy and the Treatment of Affairs

Extra-marital affair or extra-dyadic relationship is one of the most challenging yet rather common experiences a couple may have to deal with. Although there are no Sri Lankan data, studies conducted in Western countries suggested almost a quarter of males and one sixth of females have had extra-marital relationships. Considering the prevalence and significance of extra-dyadic relationships it is not surprising that infidelity is the one of most common reason for couples therapy and the most difficult situation to handle in the therapy.

Extra-marital affairs could be understood as a form of interpersonal trauma that may explain the aftermath of infidelity including emotional, cognitive and behavioral responses. Trauma for the injured partner may occur in the context of violation of their beliefs and assumptions regarding other people and the world regarding being faithful to each other all the time and looking out for each other’s wellbeing. Emotional security of the injured partner may be threatened as they may feel they do not know their partner anymore and they can not trust anyone anymore. Not only the injured partner is traumatised, the participating partner too may feel traumatised due to violation of values and principles which they thought would have been defined such as faithfulness and honesty.

Severed trust and unpredictability make it difficult for the injured partner to move forward with the relationship, even when the affair has ended. One of the major obstacles in moving forward is not knowing why the affair occurred. The injured partner may feel that they cannot trust their partners not to hurt them again.

Such trauma occurring in the context of interpersonal betrayal may benefit from trauma focused therapy based on forgiveness. They not only focus on forgiveness but also focus on assisting partners understand why the extra-marital affair took place by exploring the factors surrounding the relationship. This therapy may involve;

- Improving the relationship between partners by increasing the compassion towards participating partners and reducing negative emotions towards that partner

- Moving forward from the episode by giving up the right to chastise the participating partner
- Developing a more sensible perspective of the affair, improved balanced understanding about their own and their partners' behaviors, at present
- Better insight into themselves and their partners
- Improved relationship skills and more positive interactions
- Instilling hope for recovery

### **Assessment**

It is important during the initial assessment to address several questions regarding extra-dyadic relationship. The therapist should determine

- When the affair started?
- What was the nature of the affair (primarily emotional, primarily sexual, or both)?
- What factors have contributed to the affair?
- What were the things the participating partner hoped to achieve through the affair?
- What is the current status of the extra marital affair?
- If the affair has ended, is it temporary or permanent?
- Has either partner had any dealings with the third party since ending of the affair?
- Have the partners discussed what form of contact is acceptable or how to ensure no further contact will take place, if that is what has been agreed?
- What does the third party want?
- Is the other person married or in a committed relationship? If so, does the third party's partner know?
- Who else knows about the affair?
- Are there any financial, work related or legal consequences or health implications such as sexual transmitted diseases or pregnancies?
- Is there violence in the relationship? particularly, after extra-marital relationship came to light?
- Is there a threat from the third party or related people towards the couple?
- Have there been previous extra-marital affairs in either partner?
- What the partners plan to do with their relationship? Continue it, end it or ambivalent about it?



A degree of uncertainty about the future of the relationship is not uncommon at least initially in one of the partners. The therapist should explain to the partners that it may be difficult to make a decision about the future of their relationship during the aftermath of the extramarital relationship coming to light and suggest to them to not to take irreversible decision prematurely.

## **Stages of the Therapy**

Once the assessment and goal setting are complete, the therapist can focus on the other elements of the therapy which could be divided in 3 broad stages.

### **Stage 1: Dealing with the Impact of the Affair**

This stage will focus on containing the damage caused by the affair and helping the couple to explore the impact of the affair. During this process the injured partner will be provided with the opportunity to communicate the impact of the affair effectively to the other partner, while the participating partner will have a chance to empathize and apologize in a sincere manner.

#### *Damage control*

The therapist will help the partners to contain negative interaction considering possible frequent conflicts. The therapist will explain that these measures are temporary and designed primarily for “damage control.” While they may calm the situation and regain some trust and normalcy in the relationship, it could be counter productive in the long run. For example, the whereabouts of the participating partner can be checked frequently to reduce arguments when the partner returns home while the partner promptly lets the other know where they are. This may help to re-establish the trust and once it is achieved, this would be stopped.

#### *Discussing the impact of the affair using constructive communication*

Typically the injured partner wants to express to the participating partner how she or he has been hurt or angered by the affair. However, this should occur without destructive anger which will be counterproductive to the recovery. The therapist should encourage partners to use appropriate communication techniques such as listening and direct communication as described above. If necessary, the therapist may ask the injured partner to write a letter to the participating partner describing the feeling and thoughts. The therapist will assist them to highlight soft and positive feelings such as “You matter to me, and it hurts me that I might not matter to you”. The therapist will then ask the participating partner to respond in a constructive and truthful manner.

### *Time-outs*

The partners may need time-out to reduce the high level of negative affect in the aftermath. The partners are instructed on how to recognize when they need to call a time-out. They need to identify warning signs of getting angry or overly emotional, then should request for a time-out and come back and discuss the matter later.

### *Looking after themselves*

Extra marital affairs often lead to emotions such as shame, anger, anxiety, depression and poor self-esteem. The therapist should encourage basic self-care in including good diet, adequate sleep, physical exercise, going to the temple, having contacts with friends and relatives, not taking alcohol or substances and not disclosing matters to inappropriate people.

### *Coping with flashbacks*

Both partners are also likely to encounter occurrences that will remind them of the relationship after the affair. This will lead to flaring up of raw emotions. For example, a wife who comes across ‘a missed call’ may trigger a flashback about similar incidents during the affair. If the husband is not aware of this sequence of events, the wife’s reaction may be perplexing, which may in turn cast doubts on the recovery. By having their process explained and normalized, the partners may be less likely to misattribute these interactions to lack of progress.

## **Stage 2: Exploring why**

Once the aftermath of the affair has been contained, the therapist can address the fundamental concern many injured partners are preoccupied with: “why did my husband/wife do this?” It involves exploring factors that contributed to the affair including;

- Relationship factors - ie. poor communication, lack of time with each other
- Factors related to the participating partner - ie. beliefs about the relationships
- Factors related to the injured partner - ie. poor emotional closeness
- External factors - ie. in-laws, financial difficulties or job related issues

The therapist would highlight the important difference between contributing to the context of the affair and being responsible for engaging in the affair. The therapist will hold the participating partner responsible for his/her choice to have the affair, or selecting this “solution” to their relational or individual dilemmas. Yet the therapist will encourage the injured partner to explore how he/she or their relationship may have contributed to the affair.

### Stage 3: Moving on

In the final stage of this treatment which is based on principles of forgiveness the couple will be encouraged to address any remaining concerns or doubts about the relationship and thereby reconstruct previously held cherished beliefs about the marriage. It is not uncommon for injured partner to find this objectionable as they may take forgiveness for agreeing on what happened as acceptable. The therapist should highlight that the partner can forgive, yet appropriately hold partners responsible for their behaviors but not at the cost of moving on.

## Section 5

### Couples Therapy for Substance Misuse

Couples therapy works on the premise that family members can reward abstinence and a better relationship will help the individual with substance misuse to have a lower risk of relapse. Evidence suggests that couples therapy produces greater abstinence and better relationship functioning than typical individual therapy.

Most of the time, relationships of people who misuse substances suffer due to their substance use. At times, they start using substances or continue using them in the context of relationship strain. Therefore the main objective of the therapy would be

- Improve the quality of relationship
- Through improved relationship address the substance misuse problem more effectively

In couples therapy, the partner with substance abuse (referred to as husband as the partner with substance misuse in this section) would be seen with the wife to arrange and discuss a plan. In the therapy session the patient states his intent not to drink /use drugs and the wife expresses support for the patient's efforts to stay abstinent. Couples therapy also increases positive activities and teaches communication skills. The wife records the days of abstinence (or reduced use). Both partners agree not to discuss past drinking or fears about future drinking at home to prevent arguments and conflicts related to substance use which in turn can trigger relapse. Such discussion would be kept for the therapy sessions.

Relapse of drinking or drug use may happen during couples therapy. Therefore, crisis intervention for substance use is an important part of the therapy. It works best if intervened early before the substance use goes on for a long period. Therapy would involve discussing a contingency management early in the treatment. The plan would discuss what partners should do if substance use occurs or if they fear it is imminent and what to do once substance use

has occurred. While steps should be taken to stop substance use and the therapist should encourage the couple to view relapse as a learning experience. Discuss about how their behavior should change from what they learnt to ensure chance of relapse would be minimal. It is equally important for the couple to identify what trigger led up to the relapse and generate alternative solutions other than substance use for similar future situations.

### **Shared Rewarding Activities**

Many families of individuals with a substance abuser ceased to engage in shared recreational and leisure activities due to their lack of availability for family activities due to substance misuse and strained familial relationships due to the same reason. Participation by partners in shared activities is shown to improve the treatment outcomes of substance use. Planning of shared rewarding activities can be started by simply having each spouse make a separate list of possible activities. Each activity must involve both spouses, either by themselves or with their children / other adults. They should identify common problems that prevent the couple from engaging in such activities and plan to overcome such problems. It is important to advise the partners not to discuss problems or conflicts during their planned activity.

### **Communication Skills**

As mentioned above, listening skills and expressing feelings directly and practicing such skills during communication sessions are very important in improving treatment outcomes of substance misuse problems.

## **Section 6**

### **Couples Therapy for Depression**

#### **Depression and Relationship Issues**

When a partner is depressed it is not unusual to feel loss or reduced love /positive emotions they once experienced toward their partner. This will have a serious negative effect on the marriage considering love is a vital part of many marital relationships. While marital problems may be a consequence of depression, such relationship issues may make one or both partners depressed. Even if depression occurred secondarily to marital issues it will work as a perpetuating factor for problems in the marriage. Therefore the therapist should look for depression in any of the partners who present with relationship problems at the outset.

The therapist should directly address those concerns and reassure partners that loss or reduced love is a normal part of depression and is often accompanied by loss of other positive motivations and feelings rather than specific dislike towards the partner. A depressed partner may express negative emotions about not only self but also their partner. Depressed

couples are significantly unhappy with their marriages than are non-depressed couples due to the restrictive effect of depression on expression of affect and intimacy.

### **Couples Therapy and Depression**

When a partner is depressed, treatment for depression is often necessary but may not be adequate if there are marital problems associated with depression. Therefore, in such instances couples therapy for depression should be recommended for many couples in conjunction with treatment for depression. If they present first for couples, the depressed partner should be encouraged to seek treatment for depression. However, if the partner is either unable or unwilling to take treatment the therapist should consider continuing with couples therapy. If the risk of suicide or suicidal behavior is relatively higher, depression is complicated with psychotic symptoms couples therapy may be postponed.

### **Treatment**

The main objectives of couples therapy for depression are to improve the relationship while reducing depressive symptoms. The therapy involves several strategies.

#### **Increased Couple and Individual Activities**

Studies have shown that engaging in behaviors expressing love and caring improve not only the quality of the relationship but depressive symptoms too. As described above, the therapist will encourage the couple to increase a range of small caring gestures which was there earlier but underused after depression started. However, when one partner expects all of his or her satisfaction to derive from activities involving the partner, it can be particularly stressful to the relationship. Therefore, the partner with depression is encouraged to pursue individual interests more actively, while concurrently engaging in increased joint activities.

#### **Increasing Self-esteem**

Reduced self-esteem is a core symptom and perpetuating factor in depression. Interactions with the partner can increase the self-esteem which will improve both depression and quality of the relationship. This could be achieved through positive communication in which one partner appreciates the positive qualities or behaviors of the other.

#### **Reducing or Eliminating Stressors**

Depression is often maintained in the context of perpetual stressors including relationship strains. Reduction in such problems results in improvement in depression. Negative communication styles such as blaming or devaluing a partner through excessive and unreasonable criticism is a significant stressor in the relationship, which will maintain depression. Such behaviors should be identified and addressed effectively.

## **Monitoring for Physical and Verbal Abuse**

When one partner is depressed it is more likely that domestic violence happens in the couple. The therapist should be mindful and watchful about this and should address this promptly if this occurs, as it will be detrimental to depression and relationship.

## **Section 7**

### **Treatment of Sexual Dysfunction in Couples Therapy**

#### **Sexuality in Relationships**

Sexuality is an integral part of marriage. When sexual functioning is good, it is a positive and important component but not an essential factor of a relationship. Sexual functioning typically contributes about 20% to a relationship which serves as a shared pleasure, enhancer of positive feelings, tension reducer and reinforcer of intimacy. However, when sexuality is dysfunctional or non-existent, it plays an exceedingly powerful negative role, affecting intimacy at times up to 75%. Therefore it is not surprising that sexual dysfunction is one of the most common reasons for initial separation of couples.

#### **Sexual Dysfunction**

Sexual function comprises of the ability to experience desire (positive anticipation and feel deserving of sexual pleasure), arousal (receptivity and responsivity to erotic touch, resulting in subjective arousal and lubrication for the woman and erection for the man), orgasm (a voluntary response that is a natural culmination of high arousal), and satisfaction (feeling emotionally and sexually fulfilled and bonded).

Sexual dysfunction is more common among women than among men.

The most common female dysfunctions include hypoactive sexual desire disorder, non-orgasmic response during partner sex, painful intercourse (dyspareunia), female arousal dysfunction and primary nonorgasmic response. The most common male sexual dysfunctions include premature ejaculation, erectile dysfunction, hypoactive sexual desire disorder and ejaculatory inhibition.

#### **Sex Therapy**

The primary goal of sex therapy is to introduce or re-establish a comfortable, functional couple sexual style, which means that each person is capable of experiencing desire, arousal, orgasm, and emotional satisfaction.

## **Dysfunction of Sexual Desire and Arousal**

The essential keys to sexual desire are positive anticipation and feeling that the partner deserves sexual pleasure in this relationship. While each partner is responsible for his or her desire, the better relationship between partners improves desire. Blaming the other person for poor desire or exerting pressure on the other partner for better sexual functioning is counterproductive.

The average frequency of sexual intercourse varies from couple to couple. While the frequency for couples in their 20s is two to three times a week; for couples in their 50s, it may be once a week. Desire is facilitated by a regular rhythm of sexual activity rather than abstaining from it for a long period. When sex occurs less than fortnightly, couples become self-conscious and fall into a cycle of anticipatory and performance anxiety leading to further reduction or avoidance.

The essence of sexuality is giving and receiving pleasure oriented touching. Touching occurs both inside and outside the bedroom. Both male and female partners should be comfortable initiating and both partners feel free to say no. Touching should be valued for itself and should not necessarily lead to intercourse.

Couples who maintain a healthy sexuality may have five stages of touching. First stage is affectionate touching such as holding hands and hugging while clothes on. Second stage is non-genital, sensual touch including whole-body massage or cuddling in the bed which can be clothed, semiclothed, or nude. Third stage is playful touch with intermixed genital and nongenital touching, clothed or unclothed. Fourth stage is erotic touch (manual, oral, or rubbing) to heighten arousal and orgasm for one or both partners. Fifth and final stage integrates pleasurable and erotic touch that flows into intercourse.

Personal turn-ons such as sexual fantasies / erotic scenarios facilitate sexual anticipation and desire. Erotic scenarios and techniques are integral to female sexuality. When awareness of the scenarios and techniques improve, it enhances arousal. Partners should use that awareness to make requests and state preferences and guide the partner. Partners should feel free to state their preferences and request erotic techniques of their liking. Sex associated with special celebrations or anniversaries, sex when feeling caring and close, or even sex to soothe a personal disappointment or loss may improve the desire.

Foreplay, sexual stimulation prior to intercourse in order to get her ready for intercourse, increases arousal and desire. Eroticism and arousal can lead to intercourse and yet intercourse is not necessary for a satisfying sexual experience. The prescription for satisfying sexuality is to integrate intimacy, pleasuring, and eroticism.

## **Erectile Dysfunction**

It is important conceptualize erectile difficulty as a situational problem rather than viewing it as a failure and label the person as impotent. One of the commonly held misbeliefs is that if a man loses his initial erection, then it means he is sexually turned off. It is a natural for erections to wax and wane during prolonged pleasuring. Intercourse and orgasm with subsequent erection can be quite satisfying.

One does not need an erect penis to satisfy a woman. Orgasm can be achieved through manual, oral, or rubbing stimulation. Sexual encounter should not be stopped when one cannot maintain an erection. It is important to understand one cannot force an erection. The therapist should advise the patient not be a “passive spectator” who is distracted by the state of his penis but actively engaging in sex during the encounter. They should be comfortable saying that pressure to perform, makes sex ‘not good’ and request sex to be at a comfortable pace so it can be an enjoyable, playful and pleasurable thing.

One way to regain confidence is through masturbation. During masturbation, they can practice gaining and losing erections and focus on fantasies and stimulation that transfer to partner sex.

## **Section 8**

### **A Model of Couples Therapy for Sri Lanka**

Section 8 is written by Dr. Mahesh Rajasuriya based on his experience of working with couples who have relationship difficulties in Sri Lanka.

#### **1. Purpose of the Relationship**

The concept of relationship and reasons for getting married have different connotations for different people. The motives that drive people to start relationships are diverse and usually hidden from awareness of the very persons who harbour them. Over time, and during therapy sessions, these motives may become more visible and even changed.

#### **2. Bond Between the Two Partners**

The bond in relationship can be defined as the connection between two people. This goes beyond being attracted to each other and sharing common values and interests. Bond is the single most important factor in a relationship that makes it healthy. The degree of the bond is typically expressed through behavior. These expressions can be labelled as care or caring. Such common expressions include greetings, kind words, cuddling, smiles, kisses, gifts, small favours, mischievous pinching, small talk, being together and adjusting attire of the other.



Sometimes, despite a very low level of fondness, there might be a deep sense of bond, which they both want to revive and liven up. In certain instances, it is this deeper bond that drives them to see the therapist with a commitment to get better. However this deeper bond could be masked by conflicts and anger stemming out of deterioration of fondness between the couple.

The therapist needs to understand the development and milestones of the bond between the couple. In certain couples, bonding may not have happened at all. In such a situation the therapist should focus on creating the bond.

### **3. Learnt Interpersonal Responses(LIP)**

The bond described above between a couple is made up of elaborate learnt responses of each other, which are cognitive, emotional and behavioral. The patterns of emotions, behavior and cognitive processors could be healthy or damaging to the relationship. These patterns, with time become reinforced, ingrained and resistant to change. Sometimes some of these responses may include other members of the unit, for e.g. mother-in-law living with them. Learnt interpersonal responses, as defined here are not mere cognitive distortions described in conventional CBT.

LIP responses are crucial in forming and maintaining an intimate bond. Falling in love can be seen as an upward (positive) spiralling of LIP responses between two people, when conditions are right for the relationship to develop. In marital discord the single most important factor is negative LIP responses. All the other factors contribute to marital discord by shaping LIP responses.

### **4. Cohesion in the Couple**

The concept of group cohesion described in social psychology is the other factor of the three most critically important factors in a relationship, the other two being the bond and the LIP responses described above. For the cohesion to grow, the couple, a group of two, have to function as a group having common goals and challenges, with a united effort, which is largely free from outside influences. External influences in an Eastern culture mainly arise from in-laws and/or parents.

When the cohesion improves, the couple begins to feel as a single unit. When they spend money, they do so as a unit, than as individuals. The money they earn, the property they inherit, the expenses they have, the time they need to invest on children and constructing their house are seen with the point of view of a single unit. If the cohesion is low, these are viewed as if they are two units. A few examples are given in Box 1.

Box 1

Situation	View of a couple with high level of cohesion	View of a couple with a low level of cohesion
Husband is employed but not the wife.	Man's salary is the income of the family. Both have an equal say in deciding what to do with that money.	The money belongs to the man and woman has to plead for money for her expenses, even to buy groceries.
Wife inherited a car, which is the only vehicle the couple has now.	The car is seen as the family vehicle and both use it with each other's consent.	The woman has to give permission for the man to use the car, even to transport a child.
Both husband and wife are employed.	Both salaries come to a joint account, or they manage all income as a single source of income.	Man or woman is not fully aware what the specific income of the other party is.
One partner is reading for a higher education qualification.	The other partner is delighted about the educational excellence of the two as a unit.	The other partner is unhappy that one is going to be superior in educational level.

## 5. Individual Personal Attributes

Contrary to common belief that personal incompatibility is the core problem in a problematic relationship, it generally contributes as a part of the problem. Most couples in therapy have had a good relationship at a time in the past, most likely with the same personal attributes that they have now.

However, any personal attribute that affects the relationship in a significant manner, needs to be identified and if relevant, addressed. A common list of personal attributes that affect the relationship is given below.

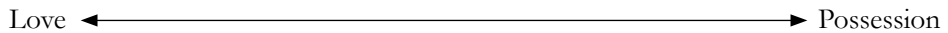
### 1. Interpersonal interaction style

If the partners are not assertive, it is difficult to improve and maintain the bond, cohesiveness and good sexual life. The passive man is too conforming, then the woman might feel unaroused in bed; the aggressive man imposes his rules constantly hurting the woman, who accumulates negative emotions in her; the passive-aggressive woman may make the life of her man so difficult and unpredictable with her apparently inexplicable mood swings.

It may be common to find that one or both partners lack assertiveness. It is essential to address this issue in order to resolve issues such as poor cohesion. For example, to overcome the influences of parents/ in-laws in their decision making, the couple has to have a high level of assertiveness.

## 2. Possession

Love is the foundation of any healthy personal relationship which is selfless, whereas possession is a completely self-centred/ serving attribute. Everyone is possessive to a certain degree. As possessiveness grows, the relationship begins to perish. We may need to move, as much as possible, towards the love end of the spectrum given in figure 1.



**Figure 1**

Extreme form of possessiveness is pathological, known as delusional or morbid jealousy. While treatment is helpful, possessiveness may persist after successful treatment of their psychopathology.

## 3. Values/ life philosophy

A life philosophy is important in making relationships work or perish. A person's life philosophy based on money, makes it really difficult to live with that person. So, will a one based on total selfless dedication to others. One person may consider having children to impede the advancement of their careers shaping the decision on having children or not; in another couple one partner may want to cancel their long anticipated trip to Bangkok since he feels that making such a trip might earn an unwanted recognition that they are rich.

## 4. Maladaptive beliefs

Beliefs of the partners are important in relationships. A few examples of maladaptive beliefs relevant to the health of an intimate relationship are highlighted in Box 2.

**Box 2:**

- I should marry the most beautiful woman
- Men are more honest/ brave/ ethical/ stronger than women
- When our children grow up we have to sleep in separate rooms
- As we grow old, we should have less interest/ desire/ need of sex
- Relationships are normally on a downward trajectory after inception
- Household chores are gender specific/ men should never scrape coconut
- Mothers are solely responsible for the outcome of the children's education/ up-bringing/ character development
- Women should heed men/ Women should not go above a man
- Personal happiness should be completely or almost completely sacrificed for the sake of children
- A relationship is a game; I need to score the same or more points as he did/ If the woman hurts the man (with words etc), then the man has to get back at her and make it even
- Children take sides with one parent from a very early age. / If he hurts me, I will hurt his daughter.
- We can do whatever we want to our children; it's nobody's business
- The main purpose of having children is to use them as an insurance in old age
- I am a member of two families/ units: my family and my parents
- If our relationship is good, none of us should be attracted to another person

### **Content of Therapy**

Similar to the study of psychopathology, the form and content demarcation is useful in the study of therapy as well. What has been discussed up to now is mostly the content of the therapy.

### **Form of Therapy**

Steps in applying the theoretical model with couples in real life is described below.

## General Steps

The therapist is strongly advised to dedicate a session or a day for psychotherapies including couples therapy. In a busy clinic, where ten minutes is allocated to a patient, trying to initiate psychotherapy for couples jeopardises not only the therapy, but the whole session. In a normal clinic setup, when patients exceed allocated time, other patients will show distress and might demand similar time allocation and attention causing discomfort to the therapist. The therapist may not be in a good and relaxed frame of mind to carry out psychotherapy. Therefore, a dedicated session for psychotherapy helps the therapist to devote his attention to patients needing psychotherapy.

Assessment of the couple is not easy but we generally forget that most important details are hidden in plain sight. The therapist has to be strong-armed only rarely to elicit important information. For example when the therapist asks for the last prescription or referral note, the way the two interact with each other in front of the therapist yields important information. For eg. if they have not brought the required document, one might blame the other for forgetting this vital sheet of paper. This observation renders information on the patterns of behavior of the couple.

Some matters are best assessed, discussed and addressed with both partners being present together, while others are best addressed individually. Matters where direct blame does not appear to be placed on one partner are to be discussed together; for example the meaning of cohesion. However, once the therapist learns that the woman's behavior frequently undermines the cohesion of the couple by daily updating her mother with details of the relationship and day's happening, it is wise to talk to her individually about this.

It is mandatory to inform both partners that what is discussed with an individual partner is confidential. Agreement needs to be reached not to request information on what the other partner divulged, without his consent. If the therapist requires that the matter discussed individually be shared with the other partner, consent from the first is necessary.

Box 3 contains some dos and don'ts.

## Box 3

Dos		
1	Try to change the relationship.	It is the relationship that needs to improve, not necessarily the two individuals.
2	Rule out psychopathology and psychological pathologies.	One or both partners may have illnesses (e.g. morbid jealousy) or psychological pathologies (e.g. extreme possessiveness). If so, they need to be addressed.
3	Your responsibility is to the couple.	Not the in-laws who pay you or the family member, doctor who referred them to you.
4	Doing psychotherapy consciously	Psychotherapy cannot be automatic. You may have started treating the woman for depression, later to realise that the marital relationship needs intervention. Then the couple and the therapist need to be aware of the fact that marital therapy begins.
5	Know the motives in undergoing therapy in each partner.	Find out the explicit motives, spending adequate amount of time, and do this from time to time to see if original motives have changed.
6	Initiate and develop the necessary logistical arrangements.	Develop a system of managing therapy session appointments, which is convenient to patients as well as to the therapist.
7	Keep notes.	This is to ensure the content of the therapy is recorded systematically to monitor progress during and in between sessions. Remember to note the plan for the next session.
8	Evaluate progress of therapy from time to time.	It is easy to miss improvements as well as deteriorations and lack of progress.
9	Be conscious of goals of therapy.	Have explicit goals, other than improvement of relationship. E.g. Reduction of possessiveness in wife. Therapy without clear goals could be counterproductive

Don'ts		
1	Do not try to make the two more compatible.	Contrary to the common misconception, it is not the incompatibility that undermines a relationship. The two genders are known as 'opposites'!
2	Do not try to ascertain who is right and who is wrong.	Therapy is not a hearing as in the courts of law. Partners often try to prove the faults of the other with you. Remind them that this is a therapy session, not a hearing in the court of law. Also be conscious of the counter-transference that may make you to take a side.
3	Do not let them treat you as if you are his/ her partner.	As in any form of psychotherapy, the therapist needs to pay great attention to transference in both clients.
4	Do not let them have negative interactions in therapy.	Try to minimize quarrels and arguments in therapy sessions except to have a brief insight into their LIPs.
5	Do not expect them to say 'good bye'.	Coming for therapy regularly is a serious commitment. When they get better they may conveniently forget to turn up for the potential last session.
6	Do not mix it up with your relationship.	Try to insulate your relationship from therapy. However, therapist may learn important lessons for a better relationship from patients.
7	Do not fall into traps.	Throughout therapy clients will try to have their own agenda (e.g. prove that the other party is at fault). Encourage clients to be aware of traps laid by other people, including own partner in life.

### Specific steps

Practical specific steps of therapy using this model are described below.

1. Assessment of the two partners as two individual patients

This is to rule out or recognize, if present, psychiatric and medical conditions. The method of doing this is essentially similar to a routine interaction between a clinician and a patient.

## 2. Assessment of the relationship

It is essentially a sincere attempt at understanding the relationship between the couple in a holistic manner. The theoretical framework described previously in this chapter provides basis for this assessment. While consideration of all the factors are necessary in every couple, one or a few factors stand out from others in any given couple in contributing to the issues within the relationship. Bond, LIP responses, cohesion and sexual life are the common factors encountered.

A tool is a convenient way to assess many aspects of a relationship. It may cover the items listed under 'Conceptualizing couples therapy' above.

### a. Cultural substrate of basic psychology of each partner

It is useful to assess cultural differences in the two individuals in certain couples. Eg. the two partners come from two different ethnic groups/ religions/ countries.

### b. Purpose of the relationship

It is unwise to believe the purpose given by the clients to be the real one. During initial assessment, and in subsequent sessions, the therapist will get to know the two of them more deeply, and their overt and covert expectations of their relationship.

### c. Bond between the two partners

The Tool to Assess Nimbleness of the Unit may shed light on the depth and breadth of the bond. However, empathy can be used to unmask the real bond between the two. In other words the therapist feels the level of bond, which is the most emotional component of the relationship, with his or her own emotional capacity. Repeated empathic assessment of the bond is quite useful in evaluation of the progress of therapy.

### d. Learnt interpersonal responses

This is a more technical assessment, resembling standard assessments in CBT. Rarely do partners need to maintain thought diaries in order to assess LIP responses, but paying astute attention to every quantum of interaction that happens in a session, can reveal much of information. Again, the Tool to Assess Nimbleness of the Unit may help directly, as well as to guide the therapist in what questions need to be asked.



The therapist needs to be aware, explicitly and persistently, that LIP responses are the core substance of the bond, which is the foundation of the relationship. However, trying to teach the couple on numerous negative LIP responses between them is not fruitful, as this awareness cannot be taught. As the LIP responses become more positive, and the bond become more intimate and the relationship healthier, the therapist may attempt bringing their attention to the critical importance of LIP responses.

e. Cohesion in the couple

Although the couple agrees that the cohesion of the couple should be high for a successful relationship, many couples do not see this point at the beginning of the therapy. Therefore it is highly recommended that they are first given a non-personal teaching session on cohesion and factors that affect cohesion of a couple.

f. Individual personal attributes

Presence of psychopathology is convenient to address. The therapist may decide to treat psychopathology himself or refer to a colleague. However, the personal attributes that need to be addressed, for example, extreme possessiveness, is best handled by the therapist. Sometimes it may warrant a few individual sessions with the particular partner.

### **Assessment of the perceived objectives of the therapy by the partners**

The objective of each partner in seeking help from a therapist/ psychiatrist may differ. Sometimes they are quite the opposite of what the therapist initially guessed. These objectives are the foundation for the motivation to continue therapy. Therefore, objectives unknown to the therapist greatly jeopardize the continuation of therapy.

The objective could be a need to create mere façade to trick the world to believe that they are madly in love, so she can continue to post nice pictures of them together on social media and get more friends to react to them. Sometimes, the objective is to continue the status quo of commercial dependency on each other, as in the case of the businessman with a private hospital needing his consultant physician wife to run the patient care services. More often than not, they really want to love each other and have a great time, but they just cannot. It is not surprising to find a mixture of many objectives described above in one or both partners.

Sometimes, the objective goes against the indications of marital therapy. For example the man of a particular couple wants your help to placate his wife and

continue his affair without her knowledge. Obviously, no therapy can make this relationship better. A woman, who wants to demonstrate to her righteous Victorian mother that everything possible was done before getting divorced, is going to make sure that therapy flunks. A husband who wants to prove that women after forty are sexually dead, will never want to have a better bond and sex life with his wife, who is approaching her menopause, despite the sincere efforts of the therapist.

However, unmasking such contraindications to couples therapy is not the beginning of a disaster. It is the beginning of an alternative practical solution, such as divorce or legal measures. If the motives are unclear, or oscillate between ending the relationship and making it better, a temporary suspension of the relationship, in the form of geographical separation, might prove useful.

### 3. Making a treatment plan

The core of treatment plan is to improve the bond. For this, other aspects of the relationship have to be addressed as well. For all these to happen, the couple has to be explicitly and steadfastly committed to achieve a better relationship, as they have to put in a sustained high calibre effort in the name of couples therapy. That is why getting to know the role of therapy is so vital.

Once the stage is set to continue the therapy with the goal of improving the relationship, the therapist has to see the couple weekly or fortnightly for a varying number of sessions, usually between four and ten, sometimes more. The plan for these sessions would be to address issues recognized in the assessment.

#### **LIP responses**

The issues are mostly related to the bond and the LIP responses. While each recognized negative LIP response may be addressed in psychotherapy sessions, simple advice sometimes achieves significant changes in LIP responses and the bond. Eg. During individual sessions with partners, suggesting one partner to give a gift for no reason to the other before the next session while suggesting the other partner to appreciate a gift.

A few examples of possible ways of addressing recognized LIP responses are given below in Box 5.

## Box 5

LIP response	Possible intervention
Wife having to ask money frequently for daily expenses which irritates husband, giving rise to arguments.	Couple finding a new way to handle daily expenses, such as giving a set amount of money each month/ week by the husband, agreed by both parties, which has to be managed by the wife.
Husband admiring his father's ability to make money even in old age, while making wife feel bad about her father who acts in an irresponsible way.	A complete voluntary ban on discussion of such matters OR both agreeing that they are the primary unit, and their fathers are now no longer members of this primary unit.
Man taking his partner to parties and spending considerable time with his male friends irritating the partner.	Both agreeing to go to parties and to sit with friends together, and to avoid parties where that is not possible. The man may go to such men-only parties on his own once in a while.

In addition to bond and LIP responses, the cohesion is very important to address.

### *Sexual life*

If specific therapy for sexual dysfunctions are needed, they are to be seamlessly integrated into the therapy sessions. Usually the therapist and the couple have to wait for a few weeks for the bond to improve before starting to address sex life. During that limbo period it is desirable to have a ban on sex if current sex life seems to be making the bond worse. Once the bond is fairly intimate, sex life can restart a fresh. Some couples, especially those who have largely forgotten how nice sex can be, may need, despite not having a particular sexual dysfunction, sensate focus sex therapy.

Once it is decided to address the sexual aspect of the relationship, a varying percentage of the session time, from a few minutes to an entire session, may be dedicated to that. Most of the input would be in the form of sex education. Having convenient reading material may make things easier for the therapist. Some relevant points are listed in Box 6.

**Box 6**

1. Men and women may view sex from different angles.
2. Best way to turn your partner on is to be nice and caring to him/ her.
3. Add a little spice, attractive lingerie or having sex in a novel place like the bath, may take things to a new level.
4. Privacy (children need to sleep independently as early as possible), contraception and other practical problems such as a knee that has restricted movement following recent injury, need to be addressed assertively.
5. Frustration when expected sexual contact does not take place for whatever reason is real and normal.

Apart from the aspects discussed above, assertiveness needs mentioning as the single most relevant personal attribute to be addressed.

*Assertiveness*

Assertiveness is not only a personal attribute that many people lack, it can also be seen as a pattern of interpersonal interaction between the partners, a form of LIP responses.

Aggressive, passive and passive-aggressive interpersonal styles doom relationships. Each partner may have to recognize what their style is, if the therapist sees that as a major issue. In that case, the relevant partner may need individual help from the therapist, as well as from the other partner, to reduce non-assertive ways and improve assertive communication. Some may need overt full blown assertiveness training.

Poor assertiveness also impairs the ability of each partner to apply therapeutic interventions between the sessions. Therefore assertiveness has a pervasive relevance in most instances of therapy for couples. A few examples of poor assertiveness and possible positive outcomes following therapeutic interventions are given below in Box 7.

Box 7

Situation	Current LIP response	LIP response following improved assertiveness
Parents asking why the woman is not pregnant yet.	They both give various excuses as they feel that parents may look negatively at the woman for lack of fertility.	They both clearly announce that they have decided to wait few months and kindly request others not to comment/ ask about that for the next six months.
Woman's brother frequently calls her and asks if her husband is going to get a better job.	Woman pleads with him not to talk like that and not to refer to the job in the presence of her husband.	Woman tells her brother not to be bothered about her family's income but to be bothered about his family.
Man's mother frequently intruding into the kitchen/ bedroom and finding fault with the way the daughter-in-law keeps the house in order.	Woman being so grumpy (passive-aggressive) to husband, who becomes aggressive to her.	They both, especially the man, kindly and firmly tells mother it is time that they lived separately and invites her to move to another house/ next door annex or announcing that they would move out.

#### 6. Application of interventions

Possible interventions have already been discussed with the issues mentioned above. The general psychological and psychotherapeutic knowledge, as well as common sense of the therapist, are critically important in deciding what these interventions should be. Discussing the issues with the couple, both together as well as individually, is a way of getting them to suggest effective solutions.

Sometimes the issues are so complicated or apparently so insurmountable, certain unusual or atypical strategies may be needed. Combatting external factors impairing their cohesion may warrant directly addressing those factors by the therapist.

#### 7. Evaluation of progress to make adjustments

Although the Tool to Assess Nimbleness of the Unit could be used from time to time to continuously evaluate the relationship, in most cases it is not needed. The

empathic tool used to assess the bond, is quite adequate to evaluate the progress of the therapy. This tool, once activated, remains active till the end of therapy without much conscious effort from the therapist.

Box 8 gives some indicators that can be conveniently used to assess the progress of therapy, which also makes part of the empathic tool that assesses the bond.

**Box 8**

<b>Indicator</b>	<b>At the beginning of therapy</b>	<b>After few sessions</b>
Enthusiasm to update the therapist of between session happenings	Low OR very enthusiastic about updating on negative happenings.	High. Updates about more positive things. Negative things are reported with a note of a potential positive outcome.
Mood of each partner	More negative.	More positive.
Comments made by clients on therapy	Doubt of a positive outcome OR demands on therapist to change the other party.	Reduced doubting/ demanding OR overt praise or thanksgiving on therapy.
Humour during sessions	Absent or very low.	Higher level of humour.
Children, if present.	Less happy and active.	Happier and more active.

These uninvited responses are much more reliable than asking them directly what they think about progress.

## 8. Ending therapy

It is nice if a planned final session can be conducted. However, this hardly happens in real life. Therefore it is always important to treat each session as this might be the last session. This thought should be more prevalent as the couple is making progress. Therefore it is important to start, after some progress is made, giving messages that would be usually given at end of therapy. Such messages are given in Box 9.

**Box 9**

1. You need to see what things have changed now. Eg. you talk to each other in a more loving manner.
2. You need to understand how those changes were made. Eg. you started to refrain from using certain words and gestures in interacting with each other.
3. Now you can apply what you learnt, to address future issues.
4. The bond between any two partners rises and falls from time to time. If you are conscious, you can, sooner or later, make it rise each time it falls.
5. You need to accept bad patches in life and in your relationship. A bad time/ a fall in the bond, does not necessarily indicate that it is over.
6. Ultimately it is the two of you who can make the relationship work. All others, including your parents, are outside your primary unit.
7. When your children grow up, make sure that they become independent and assertive, and you let them go when they fall in love/ get married/ find a job/ enter the university.

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# Notes

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