Counseling Within the Consultation

Brief Integrative Personal Therapy

Cheong Pak Yean, Goh Lee Gan & Ong Chooi Peng

COUNSELING WITHIN THE CONSULTATION
Brief Integrative Personal Therapy

By

Cheong Pak Yean

Goh Lee Gan

Ong Chooi Peng

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Reviews about the book

"This is an interesting and concise book on counseling for medical students and doctors. Experienced doctors may have been practicing such consultations but it is now systematized beautifully!"

Dr. Lee Suan Yew,
Family Physician & Past President Singapore Medical Council

"This book… provides practical guidance on incorporating brief psychotherapy into our consultations. It contains helpful advice and real life scenarios demonstrating how we can put these skills into action each day to support the people who trust us for their medical care and advice."

Professor Michael Kidd,
President World Organization of Family Doctors (WONCA)
Executive Dean Faculty of Medicine, Nursing and Health Sciences
Flinders University

"[BIPT} is a very creative piece of synergistic works of three writers. It is unique as it has brought some major counseling and organizational concepts to the consultation room for the physicians."

Dr. Jessica Leong,
Clinical Director, Program for Master in Professional Counseling (Swinburne)
& Psychotherapist

"…Treatment is not just for symptom relief but also to develop coping strategies for the future… Their novel ideas incorporate existing schools and rich personal experiences in primary care."

Professor Kua Ee Heok,
Tan Geok Yin Professor of Psychiatry and Neuroscience,
National University of Singapore

"BIPT is eclectic and flexible, and does not specify a rigid structure to tackle issues. This makes it highly adaptable to different practices and styles of management depending on the doctor… It is relevant to any doctor in clinical practice, no matter their specialty."

Dr. Wong Tien Hua,
President Singapore Medical Association

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The cover depicts a mature tree with intricate branches within a rich abundance of fall leaves. The "tree of life" is an enduring symbol that appears in the art of eastern and western cultures, from ancient Egypt and Iran to China and Western Europe. This tree of life is part of a tapestry woven in Belgium, in the style of the Flemish tapestries.

About the Authors

Cheong Pak Yean

In 2004, after three decades of Internal and Family Medicine, Pak Yean underwent psychotherapy training leading to a Masters degree in professional counseling from Swinburne University. This counseling perspective allowed him to develop an integrative framework of consultation in his private practice. He shared this framework in the Sreenivasan Oration 2010, "Re-defining the Art of Consultation". The concepts were further refined in discussion with Kua Ee Heok, Wee Sin Tho, Goh Lee Gan and Ong Chooi Peng, and from feedback from counseling courses he conducted for medical students, doctors and professional counselors. Pak Yean is an adjunct associate professor in the Division of Family Medicine, National University Hospital System. He is a past president of the Singapore Medical Association and the College of Family Physicians.

Goh Lee Gan

Lee Gan's background is in Internal Medicine, Family Medicine and Public Health. He worked in both public and private sectors before joining the National University of Singapore in 1987. He helped to set up the undergraduate Family Medicine program, the postgraduate Masters in Medicine, and the Graduate Diploma in Family Medicine as well as the Graduate Diploma in Geriatric Medicine. He is currently a Professorial Fellow in the Division of Family Medicine, National University Hospital System. For his contributions as chairman of the Ministry of Health's AIDS Task Force, he was awarded the Public Service Star in 2005.

Ong Chooi Peng

Chooi Peng is a family physician who is privileged to count these two men as her teachers and friends. Since 1994, she has been involved in practicing, teaching and assessing Family Medicine, and is additionally interested in photography and writing. She is attached to the Division of Family Medicine, National University Hospital System.

Acknowledgements

Foreword

Developing an Undefeated Mind

Ten years ago, I invited Associate Professors Goh Lee Gan and Cheong Pak Yean for a meeting to discuss a change of paradigm in the practice of psychotherapy. A year later we were joined by Mr. Wee Sin Tho, then Vice-President of National University Singapore (NUS) Development Office, who has an interest in mindfulness therapy.

Each of us comes from a different training background and is not entrenched in any particular school of psychotherapy or "political persuasion". Working in Singapore, we know there is no luxury of time and psychotherapy has to be brief, maybe over 20 - 30 minutes. We are also cognizant of the fact that with complex problems a single interventional method or theory is too simplistic. Psychotherapeutic integration is motivated by a need to have a view beyond the restricted single-school approach to benefit the patient or client. Integration means an intent to increase therapeutic effectiveness by looking beyond a single-school approach (Feng, 2011).

Brief Integrative Personal Therapy (BIPT) evolves from, and transcends established schools of psychotherapy and represents an attempt to ascertain what therapy is appropriate for a particular patient or client. It is important to know what type of therapy fits what type of clients - what works best for them (Fonagy, 2010). Psychotherapy has to be more personal – we cannot be equipped with just one technique and apply it for all types of mental health problems. BIPT is a challenging clinical approach to individualize therapy for the person – the emphasis is the centrality of personhood.

Cultural issues on conflict resolution are explored with affirmation of cultural values and reinforcement of culturally sanctioned coping patterns. Compared with dynamic psychotherapy, BIPT is more structured and directive but not dogmatic. Treatment is not just for symptom relief but also to develop coping strategies for the future – building mental resilience or an undefeated mind. BIPT was presented at the Royal College of Psychiatrists International Congress in 2008 at the Imperial College, London.

A/Prof Cheong Pak Yean has been instrumental in thinking through a new framework with A/Prof Goh Lee Gan and Dr. Ong Chooi Peng. Their novel ideas incorporate existing schools and rich personal experiences in primary care. They have restructured the thinking processes in psychotherapy to help doctors re-examine their practice in the light of time constraint, cultural orientation and what is workable.

Psychotherapy is organic and will continue to grow and evolve. We do not assume that BIPT is the only solution for a busy therapist in an outpatient clinic in Singapore or anywhere in Asia. I am sure this primer will be helpful for therapists of different stripes. It is undeniable that brief therapy and integration are the psychotherapeutic *zeitgeist* of the 21st century in Asia (Kua, 2011).

Kua Ee Heok, MBBS, MD, FRCPsych, PBM
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References

Feng L, Cao Y, Zhang Y, Wee ST, Kua EH (2011). Psychological Therapy with Chinese patients. Asia-Pacific Psychiatry; 3:167-172.

Fonagy P (2010). Psychotherapy research: do we know what works for whom? British J Psychiatry, 197, 83-85.

Kua EH (2011). Academic psychiatry on the rise in Asia. Asia-Pacific Psychiatry. 3, 1-2.

Preface

This is a book that grew out of a technique that grew out of a need.

The need was this: to provide brief periods of useful counseling within the constraints of the physician's consultation. The physician's patients are clearly not the therapist's clients, yet many of them will face problems worth talking over from time to time. The quest for an answer began in 2008, when an informal group of interested individuals began meeting. These four men would meet for discussions over the next three years, and their discussions helped to give structure to a new approach. This was an approach to counseling within the medical consultation that was brief and personalized, and they called it BIPT. As you read, you will realize that BIPT is built upon standard counseling procedure as well as a novel blend of established therapies.

The four men whose deliberations helped to give rise to BIPT were Kua Ee Heok, Wee Sin Tho, Goh Lee Gan and Cheong Pak Yean. In particular, Sin Tho helped to develop the concept of mindfulness and its place in BIPT. Discussions with Ee Heok and Lee Gan brought clarity to nascent ideas and concepts. Pak Yean took these conversations and brought them into his medical practice and fleshed them out.

We hope that you will find this book interesting and relevant. Our greater hope, however, is that you will be inspired to consider brief counseling within your consultations to be achievable, reasonable and worthy.

Cheong Pak Yean

Goh Lee Gan

Ong Chooi Peng

Chapter 1: **Brief Counseling Within the Consultation**

Life is short, and Art long;
the crisis fleeting; experience perilous, and decision difficult.
The physician must not only be prepared to do what is right himself,
but also to make the patient, the attendants, and externals cooperate.

– Hippocrates, "Father of Medicine", 460BC - 377BC

Contents of this Chapter

- Introduction
- Getting the Fundamentals Right
- BIPT, in a Nutshell
- Key Points

Introduction

This is a book about counseling. What is the difference between the counseling styles of the professional therapist and the physician?

The essence of the *therapist's* style lies in his generous availability of time, over time. His patients have complex psychological issues and need counseling over an extended period. Sometimes this goes on for months and years!

When the therapist refers to "brief" therapies, he means that his therapeutic objectives can be achieved over five to ten sessions, rather than over years. Nevertheless, these sessions are conducted in 45-minute blocks of time.

On the other hand, the hallmark of physicians' consultations is our swift efficiency. Our encounters are marked by a strong biomedical focus. Even so, within our (truly) brief consultations, a number of our patients can benefit from brief periods of counseling. Patients face issues relating to problems of living, grief from new medical conditions or challenges of continuing care, such as adherence to treatment – all of which we can meaningfully address.

What is Brief Integrative Personal Therapy (BIPT)?

BIPT is a model of counseling that we have developed to meet this need. Physicians have long incorporated counseling elements into the medical consultation. Examples include the BATHE technique and motivational interviewing. These are defined techniques following prescribed steps that we use to achieve certain objectives.

BIPT takes a different approach. To begin with, it is not a set of prescribed steps or questions. We draw elements from various schools of psychotherapy and **integrate** them into the tasks of the consultation (Chapter 3). It is **personal** to individual patients, because a formulation of issues based on his own life narrative is combined with the usual evidence-based diagnostic perspectives (Chapter 2). Based on a combined list of both diagnosis and formulation, the appropriate psychological interventions are prescribed in **therapy**, together with the usual treatment modalities (Chapter 4 to 8).

We believe that some family physicians, so trained, will be able to use BIPT within their **brief** 15 to 20-minute consultation sessions. This is possible as they have already established therapeutic relationships with their patients, and have background information on the patients and their families. BIPT is thus applied

in the flow of our usual medical consultation. If we need more time, BIPT can be carried out as multiple staged interventions over several consultations in continuing care.

Getting the Fundamentals Right

Some basic communication skills remain indispensable in any clinical consultation. As a prelude, the right mood, right tone, right message and right context need to be in place. We should be serious and mindful of what we say. Our patients watch for consistency between what we say and what we portray non-verbally.

This is not a handbook of communication skills. There are excellent textbooks available for a full discussion of these skills. A personal favorite is Silverman and Kurtz's *Skills for Communicating with Patients*.

BIPT, in a Nutshell

Findings from the "usual" history and examination lead us to a diagnostic conclusion. With BIPT, the first task is to reach a whole-person formulation for our patient, describing his psychological state as well as his physical. Table 1.1 presents BIPT in a nutshell.

The entire process is built upon an **extended consultation**, involving an extension of our traditional physician roles, and employing extended skills of history taking. This extended consultation allows us to gather richer therapeutic materials which lead to the 4Ps of formulation and management.

The **4P Formulation** table describes the issues that we need to identify. This is a useful framework to keep in mind whenever our patient has "more" than a straightforward biomedical problem. It is part of the standard counselor's toolkit.

To ascertain the various issues i.e. the predisposing, precipitating, perpetuating and protective issues, we need extended relating and inquiry skills in the consultation. These skills are described in Chapter 3. The therapeutic material we obtain gives us an understanding of the patient as an individual social being in

the context of time. Associated tools we can use here include the genogram and the technique of life-space analysis.

We combine this therapeutic material with usual clinical data from history, examination and investigations to provide an integrated list of diagnoses and formulations.

Depending on the patient's integrated list of diagnoses and formulations, we can use one or more psychological approaches in addition to the usual biomedical treatment. Our aim is to address the patient's reason for encounter as well as the underlying reasons that contribute to it.

The **4P Management** table lists the various approaches that can be adopted, in dealing with the issues identified. We will be elaborating on these in the ensuing chapters.

The **pattern** approach is taken when we observe that a patient has problematic stories that impact on his personality and responses, over time. These stories can be taken apart, and new preferred stories may be re-constructed from his other past experience. Alternatively, instead of focusing on problems, new stories can be constructed by focusing on a solution.

We take the **problem** approach when we encounter problems and problematic behavior. Our strategies include straightforward problem solving, addressing behavioral issues, and identifying and addressing the cognitive distortions to a situation that result in a dysfunctional response.

The **process** approach, on the other hand, is taken to help our patient achieve physical, mental and spiritual balance in his situation.

Extended Consultation	Extended Roles Extended Relating Extended Inquiry
4P Formulation	Predisposing Issues Precipitating Issues Perpetuating Issues Protective Issues
4P Management	Pattern Approach Problem Approach Process Approach Positive Approach

Table 1:1: Extended Consultation with 4Ps of Formulation & Management

Finally, we can use the **positive** approach in all three above contexts, i.e. when patterns are observed through time, when situational problems are identified, and in relating the patient to his situation.

We will elaborate on the above ideas in the following eight chapters. In chapter 10, we will put it all together in a case study of a woman called Dorothy.

Key Points

- Brief Integrative Personal Therapy (BIPT) has been developed to provide brief periods of counseling within the medical consultation, to deal with problems of living, grief of new medical conditions, and challenges of continuing care.

- Communication skills provide the tools by which we engage the patient, in order to achieve shared views on prognosis and solution to problems experienced.

- BIPT is a framework for formulation of a counseling problem and the selection of an appropriate therapeutic approach. It may be remembered as a systematic extension of the traditional consultation.

- The list of formulations, even the simplest one, forms the basis upon which we execute BIPT.

Suggestions for Further Reading

Silverman, J. and Kurtz, S. (2004) *Skills for Communicating with Patients.* 2nd ed. Radcliffe Publishing.

Stuart, M. R. and Lieberman, J. A. (2008) *The Fifteen Minute Hour: Therapeutic Talk in Primary Care.* 4th ed. Radcliffe Publishing.

Chapter 2: **Making It Personal**

Medicine is the science of uncertainty and the art of probability.

– Sir William Osler, "Father of Modern Medicine", 1849 - 1919

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- Introduction
- The Case for a New Paradigm
- Evidence or Narrative?
- Tools for the Art
- Hierarchy of Human Organization
- Key Points

Introduction

How does an encounter between two persons become a useful therapeutic tool?

The practice of medicine involves Science and Art. We teach Science in medical school. Science is rigorously defined, tabulated and appraised. Art we traditionally leave to be caught in time, with clinical practice. We less often subject Art to characterization and measurement. It is sometimes understood as hospitality extended to patients, or as the "clinical instinct" honed by experienced physicians. In truth, the Art in a consultation is much more than either.

To understand this Art, we should visit two terms, **nomothetic** and **idiographic**. These were coined by the philosopher Wilhelm Windelband (1848-1915) to describe two distinct approaches to knowledge. Each approach corresponds to a different way of looking at our world.

The nomothetic approach refers to the tendency to generalize. We derive universal laws to explain what we observe. Referring to the consultation, disease labels are assigned to patients with shared characteristics. The idiographic approach, on the other hand, is the tendency to be specific. We try to understand meaning and quality, as observed by the unique person in his bio-psychosocial environment.

We can think of the Art of medicine as a person-centered or personalized way of approaching our individual patient. If we think of Art as an "idiographic concept" in this way, it becomes possible to understand and to teach it, and not simply hope to catch it. This chapter attempts to describe this Art, and how practicing it can help us meet our patient at the point of his need.

The Case for a New Paradigm

Clinical medicine focuses on the function and dysfunction of body systems, including the brain. Increasingly, we understand how physiological systems function and how they interact in health and disease. Additionally, functional MRI studies have been able to localize discrete psychological functions in the brain. All the same, a global theory of mind remains elusive – we still do not understand how consciousness and complex psychological states emerge from the interactions of biological, neurological sub-systems.

For now, we use the *reductionist* approach to come to terms with the science of clinical medicine. This approach holds that a complex system can be understood in terms of its simpler parts, or components, as we "drill" downwards. Universal laws of physics, chemistry and biology can be applied to predict the interactions between the components.

However, the reductionist approach poses a great challenge when we attempt to study the whole person, rather than the parts. By "whole person" we refer to a person's psychological as well as physical aspects. New properties, for e.g., new entities or patterns can arise when we consider the entire person. A simple example may be our revulsion at the thought of a *Fear Factor* episode of eating snakes, even though there is no physiological reason why we cannot consume snake meat. New, unique properties cannot be predicted from scientific studies of simpler components, because they themselves do not exhibit such properties. This *emergence* of new properties frequently complicates our consideration of the whole person.

To best profit from both the reductionist and whole-person approaches, and to better understand the physical and the psychological person, we need a new *paradigm* to augment our familiar evidence-based medicine, or EBM. This new paradigm is **narrative-based medicine**, also called the idiographic approach, or the Art of Medicine.

Evidence or Narrative?

We are familiar with the framework of EBM. We have our representative samples and randomized trials. We test hypotheses, generalize results to broad groups, and extrapolate the results of a group to our individual patients. This helps us define the general rules that groups of individuals follow. In other words, it is good to help us classify people, and patients.

For example, consider a middle-aged man who is sleeping fitfully and has lost his appetite, weight, and energy. He no longer enjoys meeting his friends for an evening at the coffee shop, and finds going to work every day to be an enormous effort. Clearly, the DSM criteria for major depressive disorder provide us with a framework and we know we need to consider depression in this man.

Narrative medicine, on the other hand, assumes that each human is unique. Instead of quantitative measurements, it uses a qualitative framework that focuses

on individual experience. This helps us gain a fuller understanding of the individual.

Consider our patient above. As we explore his symptoms, we realize that he recently discovered that his wife has been having an extra-marital affair. His construction business has not been doing well. His unique experience, or narrative, provides us with a deeper understanding of why he is depressed. Without this narrative perspective, we would not be able to help our patient much, beyond telling him that he appears to be depressed.

Consider another example. A 70-year-old woman sees her physician every two to three months for backache and knee pains, which are assessed to be due to minor osteoarthritis. Each time she attends, she asks if she might have cancer. She has been asking her physician this for three years now. His reassurances usually suffice, until her pain and her question resurface three months later. The next time she does this, her physician could choose to reassure her again, because her physical findings remain consistent with mild osteoarthritis. Alternatively he could choose to probe her anxiety to see why she has this persistent fear of cancer.

Tools for the Art

Evidence-based medicine has dominated patient care over the past three decades. Narrative-based medicine augments and enriches it. In this section, and in the following chapters, we propose to set forth some tools by which to practice narrative-based medicine.

A "whole-being" model of a person is suggested in Table 2.1. This person comprises several parts in a *hierarchical* relationship with each other. In the bottom three rows, the physical body and its systems, including the brain, is represented. Above the physical body, a mind-brain interface is conceptually placed between the body, with its physiological organs and systems, and the mind, with its structures and psychological systems. Thus, the whole person, having mind and body, comes into existence. This person lives in a physical and social environment, within a community, to survive, reproduce and thrive. Through time and space, culture and living eco-systems emerge.

When we interact with the whole person, we clearly need to interact with his **mind-brain interface**, his mind or **psychological structure**, and his **larger environment**, in addition to his **body**.

We propose the following tools by which to understand these other aspects of our patient. These tools are the process approach, the problem approach, and the pattern approach. They will be elaborated upon in Chapters 5 to 7.

Process Approach: The mind-brain interface is infinitely complex. If we were to observe it through time, it would be continuously interacting and changing. If we could freeze it at a moment in time, we could better understand it. We can do this by being aware of, or mindful of, the NOW in time.

At any point, the mind-body interface is also having myriad experiences. If we could freeze it for a moment in space, we could better understand the experiences and see how they integrate to form our *reality*, *self*, *value-ing* and *potency* (Mahoney). Psychotherapeutic tools have been developed to explore these fundamental structures.

Mindfulness, humanistic therapy, existential therapy and awareness therapy, which are the tools of the process approach, are briefly described in Chapter 7.

Problem Approach: When we work with patients' psychological responses to stimuli which are both internal and external to a situation, we call this the problem

approach. Since these responses are varied and wide-ranging, we use varied tools from cognitive, behavioral and emotion-focused therapies, as described in Chapter 6.

Pattern Approach: Across time and space, when we relate to significant others and to groups and communities, patterns can be observed. One approach is to view these patterns as stories from our environments and our past, which have become incorporated into our identities. Many of these patterns are multi-storied and multi-dimensional; patterns are formed around themes and plots which become engrained through time. Tools to process problematic stories into more adaptive ones are developed from post-modern psychotherapies instead of the traditional psychodynamic schools. They include the Narrative Therapy of Epston and White, and will be described in Chapter 5.

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Hierarchy of Human Organisation

Selective tools to understand the bio-psychosocial order in a person

(Hint: start reading from the bottom of this table)

MAN IN HIS ENVIRONMENT	USEFUL APPROACHES	COUNSELING TOOL-KIT	INSIDE THE PERSON	OUTSIDE THE PERSON
Ecosystem, communities and cultures Psycho-social relationships	**PATTERN** Over time Others factors - sociology, economics, culture	Narrative therapy Solution focused therapy	Interactions between communities and environment, person and psycho-social environment, over time	
Mind Psychological structures	**PROBLEM** In the context of the situation	Cognitive therapy Behavioral therapy Other emotion focused therapies	Personality Emotions Cognition	Interactions between the situation and the person
Mind-Brain Interface	**PROCESS** Focusing on the HERE in space and NOW in time.	Mindfulness Humanistic therapy Existential therapy Awareness therapy	Soul / Spirit	Interactions between the consciousness that emerges from the mind-brain interfaces and the neurological sub-systems
Organ Systems -including Brain **Organs and Tissues** **Cells & Molecules**	**CLINICAL METHODS** **INVESTIGATIONS & TESTS** - including imaging and quantitative methods	Medicine Surgery Drug therapy Radiotherapy Surgery Physical therapy	Anatomy Physiology Pathology	Interaction between body and physical environment

Table 2.1: Selective Tools to understand the Bio-psychological order in a person

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Key Points

- The practice of medicine is both Science and Art. The usual approach is to gather scientific evidence so that diagnostic labels can be assigned to patients based on shared characteristics. The narrative approach seeks to understand the uniqueness of the patient, arriving at a formulation of the predisposing, precipitating, perpetuating and protective issues surrounding the reason for encounter.

- Formulation can be of a unique situation (Problem Approach), or of a series of situations with common characteristics through time and space (Pattern Approach), or of a "Here-and-Now" of the mind-body connect (Process Approach).

- BIPT is an attempt to go beyond simply understanding the human body, including the brain, to address the emergent mind-body interface (Process Approach), its interaction with situations in the external world (Problem Approach) and from thence to interactions over time and space (Pattern Approach).

References

Mahoney, J. M. (2003) *Constructive Psychotherapy: A Practical Guide.* Guilford Press. pp. 48-51.

Chapter 3: **The Extended Consultation**

If the doctor asks questions in the manner of medical history-taking,
he will always get answers – but hardly anything more.

– Dr Michael Balint, psychoanalyst, 1896 - 1970

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    - Detached vs. Engaged
    - Expert vs. Collaborator
- Extended Relating Skills
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    - Reflection
        - Empathy
        - Understanding
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    - Experiencing ICE
- Extended Inquiry Skills
    - Open Questioning, Active Listening
    - CAR-ACE the Patient!
- Key Points

Introduction

How does BIPT fit into our consultation?

Our traditional medical consultation runs in a linear fashion from history, clinical examination and investigations, to diagnosis and management. To incorporate BIPT, we need counseling tasks to run in tandem with the traditional tasks. In this chapter we introduce several concepts that are fundamental to this dynamic process of integrating counseling techniques into a medical consultation.

You could say that the fundamental requirement for a physician-counselor is that he should adopt an expanded mind-set. He needs to extend his disease-centered, evidence-based approach of consultation to include a person-centered, narrative-based approach, and be able to negotiate both smoothly. To achieve this, he needs an enhanced skill-set that includes extended relating and inquiry skills, skills of tracking and exploring life-spaces and genograms, and the ability to understand the patient's issues as a formulation.

Figure 3.1: Counseling Skills in BIPT with roles overarching relating & inquiry skills

Negotiating Extended Roles

As doctors, most of us have adapted ourselves to assume **comforting**, **detached** and **expert** roles in our interactions with patients. However, in order to counsel, we may need to **challenge**, **engage** and **collaborate** with them instead. Therefore these are three extended roles that we have to negotiate in medical counseling. We may need to shift between roles even within the same consultation. The challenge is to avoid doing so too abruptly.

Comfort vs. Empathic Challenge

To always comfort the patient is at the heart of Ambroise Paré's famous aphorism, *"to cure sometimes, to relieve often, to comfort always"*. At times, however, our patients need to be empathically challenged instead of comforted.

Empathic challenge is an art in consultation by which we can move a patient from an entrenched position, for example, a lack of motivation to stop smoking, to one which is more adaptive, for example, contemplating smoking cessation. Our challenge need not be aggressive or confrontational. Indeed it should be issued at the appropriate time and setting. We can present it as an invitation to stretch the possibilities, whilst affirming our faith in the relationship, and concurrent with our support for the patient to move on with life.

Detached vs. engaged

The traditional physician presents a congenial persona whilst maintaining an emotional distance from his patients. The counselor, on the other hand, may need to engage and affirm from a more intimate vantage point.

Internally, we should be aware of parallel processes at work. Firstly, there is the logical process, with our mind involved in detached empirical observation. The other is the intuitive process, engaged with this patient at this time. These processes are described by Roger Neighbour as the inner consultation of two heads, the organizer and the responder. In moving between the physician/counselor roles we may need to consciously shift between these two processes.

Expert vs. collaborator

Traditionally, we take on the role of the expert in the healing relationship. Using problem-solving skills and the hypothetico-deductive method, we arrive at diagnoses which we masterfully convey to the patient together with treatment plans.

However, these are days of rising chronic disease burden and increasing psycho-social somatized ailments. More and more, we need a collaborative, participatory approach for effective management. As illustration, we have found the three-part sandwich best for providing information or advice in the collaborative mode. This involves asking permission and giving the context, providing information and then seeking feedback to check the patient's understanding and plans. It differs in philosophy from the health education lecture.

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Extended Relating Skills

Presence in the Present: "Here, not there!"

To negotiate this new compact described above, we need to acquire extended skills of relating to the patient. A key dimension of this expanded skill is *presence*. The late Michael Mahoney, a pioneer constructive psychotherapist, wrote that *"we are born in relationship and it is in relationship that we most extensively live and learn."* He stressed the importance of cultivating *"the art of being humanly present to another person"* in the here and now, in time and space, in words, actions and spirit – in other words, being here and not there.

Presence is characterised by **congruence** in the extended roles described in above, active acts of **affirmation**, continual **reflection** or mirroring of the patient's emotions and thoughts, and shared **experiences** of the physician-patient dyad.

These skills of extended relating can be remembered by the acronym **CARE.**

Congruence

Congruence is sometimes called "genuineness" or "transparency".

We need to be aware of our extended roles because **role confusion** would result if we are not congruent in the therapeutic relationship. For example, when we need to switch from a collaborator's role to that of the expert, we may transit by saying, *"Allow me as your doctor to give you some advice about what you must do."* This will help avoid role confusion.

We also need to avoid **role diffusion**. For example, gestures of empathy given in a detached manner would not appear genuine. When we are fatigued and besieged with our patient's suffering, it becomes a challenge to remain congruent, genuine and positive.

Affirmation

We can affirm our patients directly, indirectly, or by seeding self-affirmation, by inviting the patient's perspective on how a positive unique outcome happened.

For example, consider an obese patient with diabetes, who lost weight through dieting. Direct affirmation says, *"You have lost 3 kg. This is great!"* Indirect affirmation says, *"Your diabetes is better controlled now because you have lost 3 kg."* To seed self-affirmation we say, *"Tell me how you managed to lose 3 kg so I can share it with my other patients."*

Reflection

One way for us to be with the patient is to provide continual reflection of the contents of his thoughts, feelings and behavior. Reflection is also called **mirroring**. This is done verbally and non-verbally, using body language, gestures and emotional interactions.

Empathy

Reflection of **emotions** is called empathy. Empathy can be expressed in words or with socio-symbolic gestures. A simple contextual statement, for e.g., *"That must have been difficult,"* at a correct moment in time, can be cathartic. At other times, we mirror our patient's feelings by our body language during the flow of the consultation. Keeping an attentive silence is strategic when our patient is emotionally absorbed.

Understanding

Reflection can convey that we understand the emotional message our patient is sending us. This is also called **validation**, and we do this by our body language or by the spoken word. For example, consider the angry patient who shouts, *"This is a lousy practice! I waited for more than an hour and the receptionist missed calling me when my turn came!"*

We can validate the patient by transmitting the following three messages, in words or body language: *"I heard you,"* *"I do not feel angry or insulted by what you said,"* and, *"You are important to me."*

Validating him like this does not convey a judgement on the accuracy or fairness of the content of his complaint.

Metaphors

Metaphors refer to the things that we **compare** our reality to. We need to listen carefully to the patient's preferred metaphor of the moment, to see whether they use visual, auditory or kinesthetic metaphors to represent their feelings. If the patient says, *"I see no future," "The impact was deafening,"* or, *"I had to carry the burden,"* we should reflect it using the same representational system, i.e. visual, auditory or kinesthetic metaphors.

This applies to carers too. Consider the mother who brings her daughter to the clinic. She looks intensely at the physician and then at her daughter in turn as each speaks. By doing so, she reveals that she is a visual communicator. It would be good to address her visually and to use visual imagery, for example, *"I see you are worried that your daughter will make a mess of her life,"* and, *"I have some suggestions to put the picture right."*

We must also pay attention to the use of **para-language** which comprises words or sounds uttered to reflect the conversation. Using the same family of para-language gestures would help to create rapport.

Modeling

We may model the patient's preferred **body language** to gain rapport. Consider a reluctant teenage boy brought into the consultation room by his mother. He refuses to sit down despite a direct invitation, communicating that *"I am not the patient – she is."* The physician could surreptitiously consult standing up.

The patient may be led to model or mirror our mood and behaviour. In the solution-focused pattern approach, we can adopt an optimistic stance to instil hope and possibilities in depressed patients.

Experiencing ICE

We also build upon the shared experiences**,** past and present, of the physician-patient dyad. These experiences emanate from the ideas, concerns and expectations or ICE, both ours and the patient's, in the encounter. It is useful if we explicitly

understand each component and its interplay within the individual, as well as its inter-activity within the dyad.

Traditionally, when physicians discuss their feelings arising from consultations, they refer to *transference* and *counter-transference*, or to *parent-adult-child transactions* between physicians and patients.

In BIPT, feelings are acknowledged to arise from the inter-activity between the physician's and the patient's ideas, concerns and expectations with regards to the reason for encounter of the consultation, and the ensuing management.

Consider the simple matter of antibiotic prescription for an upper respiratory infection. The physician makes a decision based on clinical judgement. This is the physician's idea of need. The patient has his own ideas about antibiotics – this is the patient's ideas of want for example, *"I always get well faster with antibiotics,"* or, *"I never take antibiotics. They may lower my future resistance and have many side-effects."*

Based on ideas alone, we have nine possible scenarios. Please refer to Table 3.1. Different sets of feeling may arise from each scenario, in the physician and in the patient. As physicians, we should be aware of the possibilities that may arise. When both needs and wants are complementary, as in situations 1, 5 and 9, the relationship is harmonious. In situation 3, we may have potential conflict as the differing concerns and expectations of both physician and patient come into play. When the physician's need and/or the patient's want are neutral, then we have a collaborative stance. In situation 4, the physician may have to clarify the request for a consultation and educate the patient. If the patient is worried because he is going on a trip and may not have access to regular medical services, then a prescription accompanied by clear instructions about when to start antibiotics may be reasonable.

Need (Physician) Want (Patient)	Want antibiotics	Neutral to "want"	Do not want antibiotics
Need Antibiotics	1	2	3
Neutral to 'need'	4	5	6
No need antibiotics	7	8	9

Table 3.1: Physician's idea of needs vs. Patient's ideas of wants:
Antibiotic Prescription in Upper Respiratory Tract Infection

We can also apply the ICE interactivity model to clinical situations that call for explicit informed consent, such as need for a surgical procedure, *vis à vis* the patient's want. The patient's want may be that the surgery cure the affliction without any risk of side-effect or disability. The physician must be aware of the interactivity, not simply to avoid a medico-legal entanglement, but so that he may best handle the patient's feelings and also at times his own.

Extended Inquiry Skills

In addition to **relating** to the patient in a novel manner, we also need to pay attention to clinical skills of **inquiry**. Michael Balint, who was renowned for his reflective Balint groups for doctors, cautioned that *"if the doctor asks questions in the manner of medical history-taking, he will always get answers – but hardly anything more."*

In medical school, many of us started by rote-learning sets of leading questions for specific presenting symptoms. We learnt to shuffle between sets of closed questions, searching for associative diagnostic labels. Such an exercise is pragmatic but is not always the most effective. Important data bearing on management may be missed.

Open Questioning, Active Listening

When we ask an open question, we are asking a question that cannot be answered reflexively. We want the patient to process our question, think of contextual issues, and to respond with his own self-generated inner questions. For example, a question like, *"Do you feel sad?"* may elicit a reflex *yes* or *no* answer on low mood. On the other hand, an open question of, *"How are you today?"* allows the patient to respond by answering self-generated questions – *"How am I feeling?"*, *"Is my pain better?"* and, *"Why is the doctor asking me this question? What should I say?"*

By actively tracking these responses, we are better able to sense our patient's perspective, and what he is thinking and feeling. In this way the Open/Free area of the Johari Windows is enlarged for therapeutic work.

The **Johari windows** model, developed by psychologists Joe Luft and Harry Ingham of the University of California, illustrates the effects of open questioning.

Doctor / Others

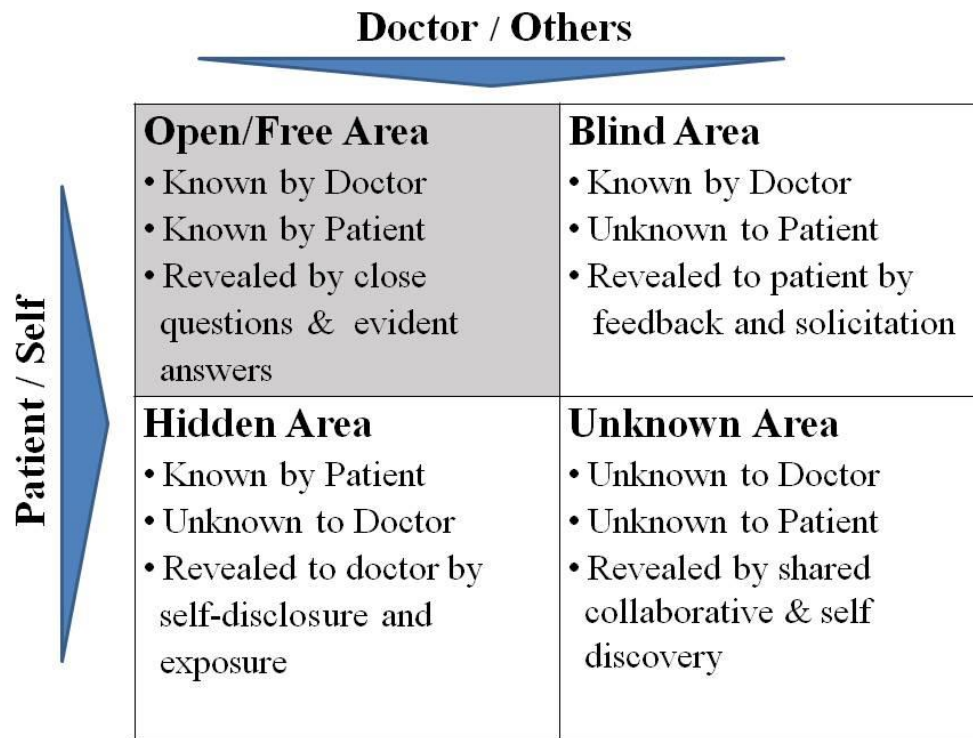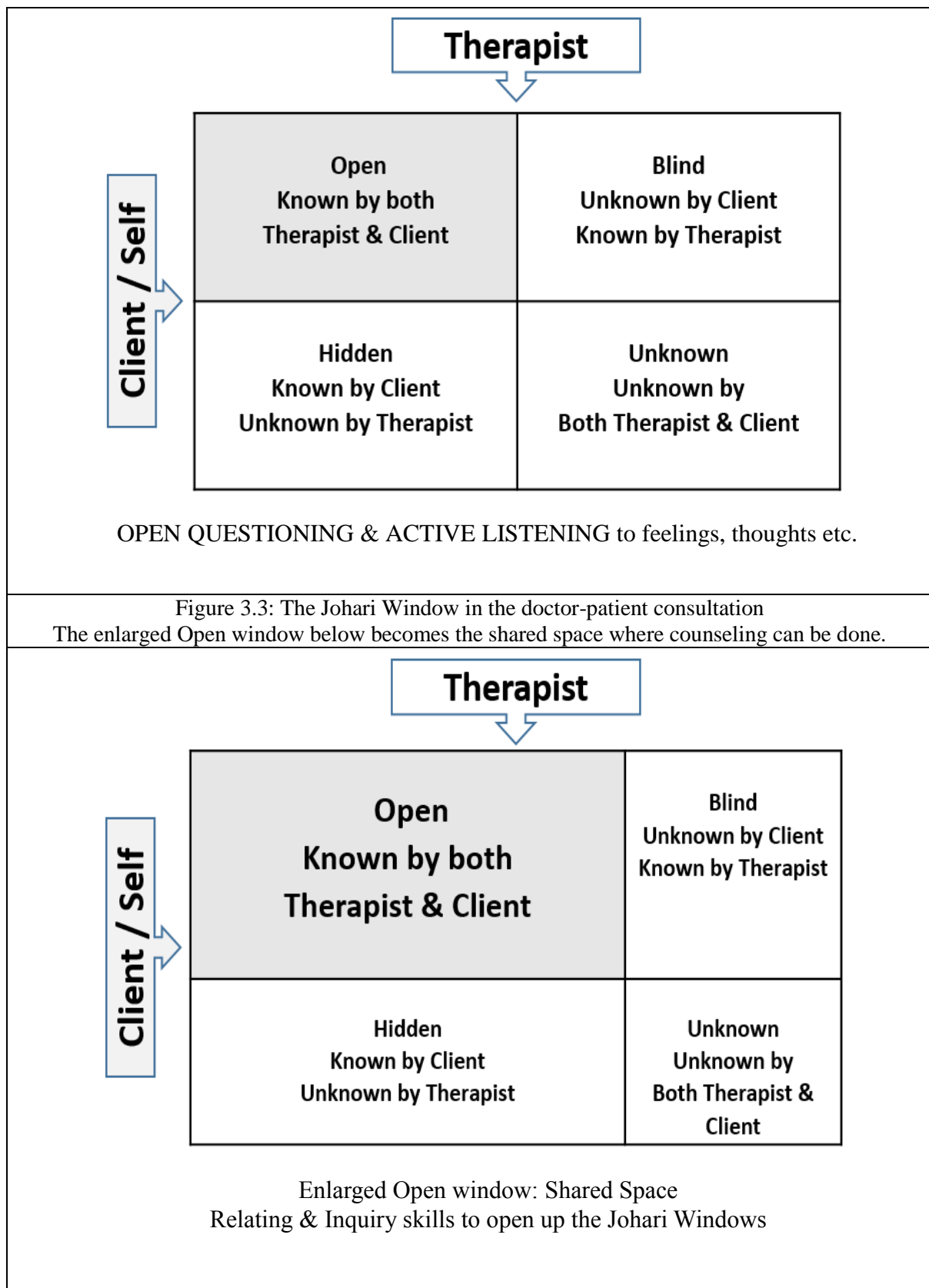| Open/Free Area	Blind Area
• Known by Doctor • Known by Patient • Revealed by close questions & evident answers	• Known by Doctor • Unknown to Patient • Revealed to patient by feedback and solicitation
Hidden Area • Known by Patient • Unknown to Doctor • Revealed to doctor by self-disclosure and exposure	**Unknown Area** • Unknown to Doctor • Unknown to Patient • Revealed by shared collaborative & self discovery

Patient / Self

Figure 3.2: The Johari Window in the doctor-patient consultation

In the Johari model, an open question or gesture is one that, when processed by the recipient, does not elicit a direct reflexive response. Instead it generates **contextual questions** or **emotions** in him that allows for expression of the answer from the patient's blind, hidden or even unknown windows.

Therapist

	Open Known by both Therapist & Client	Blind Unknown by Client Known by Therapist
Client / Self	Hidden Known by Client Unknown by Therapist	Unknown Unknown by Both Therapist & Client

OPEN QUESTIONING & ACTIVE LISTENING to feelings, thoughts etc.

Figure 3.3: The Johari Window in the doctor-patient consultation
The enlarged Open window below becomes the shared space where counseling can be done.

Therapist

	Open Known by both Therapist & Client	Blind Unknown by Client Known by Therapist
Client / Self	Hidden Known by Client Unknown by Therapist	Unknown Unknown by Both Therapist & Client

Enlarged Open window: Shared Space
Relating & Inquiry skills to open up the Johari Windows

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Although formal psychotherapy training hones the art of accessing these windows, many physicians can, and do, intuitively acquire such skills from experience.

Consider a middle-aged woman who attends for her blood cholesterol results. The physician casually asks, *"How's your family?"* intending to use this to segue into a discussion of family eating habits and cardiovascular risk factors. Unexpectedly, there is a shift of emotions and the woman's eyes well up. After a long while, she whispers, *"My husband died of pancreatic cancer a year ago."* Her physician stays silent and attentive. When he senses that the crest of pain has passed, he breaks the silence to say, *"I am sorry to hear this."* Several moments later, he asks, *"How are your children?"*

It is important to realize that the questions *"How is your family?"* and *"How are your children?"* are open questions only insofar as they are coupled with an attitude of active listening. Consider also how this physician expresses empathy, which is primarily with his attitude and his silence.

CAR-ACE the Patient!

Here, we present a generic framework to facilitate open inquiry, so as to enlarge the open/free area. It is a disciplined approach to asking questions that can deeply explore and analyze assumptions and concepts. This way of questioning is sometimes described as the *Socratic* style. Please refer to Table 3.2. The framework can be remembered as **CAR-ACE**.

Many of us start and also stop at **clarification** of symptoms. We clarify the length (time relationship), breadth (relatedness and context) and sometimes the depth (severity, emotions, cognition, spirituality). To open the Johari window wider, we may continue to probe into the **assumptions** the patient holds and the **rationale** (evidences) for them.

Clarification	Alternatives/Possibilities
Length: Time-line and period	Viewpoints:
	What may be another way to look at this?
Breadth: Relation to people, situation, environment, culture and beliefs	
	Challenging:
Depth: Feelings, thoughts, actions, interoception (sense of physiological state of body) and scaling	Are you implying that?
	What is the likelihood of that?
Assumptions	**Consequences (Best, worst and probable case scenarios)**
What have you assumed?	Can we generalize?
What can be assumed instead?	What is the outcome of each alternative?
	Is the result better/worse?
Rationale/Evidence	**Experiences arising**
How do you know it is correct/true/valid?	Insight after awareness, scaling
	Circular/relational inquiry: question-on-question and experience-on-experience

Table 3.2: The CAR-ACE Framework of Socratic Inquiry

With some training, we can ACE the inquiry by also exploring **alternatives** and possibilities, the **consequences** of expressed thoughts or scenarios, and also the **experiences** that arise therein. We can then actively seed and facilitate the **elaboration** of thoughts, feelings and beliefs.

Many of us face difficulty in using this open inquiry system because we are accustomed, as experts, to use directive and prescriptive language. Sometimes, however, it is more potent to let the patient arrive at a particular viewpoint by himself. We employ astute but respectful open questioning, rather than foist our viewpoint upon him. This would require us to be more patient and reflective, in the collaborative and not the expert mode. Because time is a scarce resource in a consultation, this approach should be used judiciously.

This chapter has introduced a number of concepts relating to the consultation. In essence, the extended consultation is the foundation upon which BIPT work is done. We summarize the above concepts in the following table.

Integrating BIPT Tasks into the Medical Consultation		
Presenting Complaints		Reason for Encounter
Building therapeutic relationship		Extended Relating
Personal Present & Past history		Extended Inquiry
Social and Family History		Genogram and Time-line
Focused clinical examination and investigations.	Data from clinical assessment processed in tandem with the extended therapeutic materials.	Tracking patient's mind and exploring issues in time, space and relatedness.
Analyzing significant clinical data, using hypothetico-deductive method to arrive at diagnosis		Understanding therapeutic materials generated from the above tasks.
Diagnoses	Integrative list of diagnoses and bio-psychosocial formulation for reason(s) for the encounter	Formulation of issues (predisposing, precipitating, perpetuating and protective issues)
Integrative management plan using one or more approach(es). • Pharmacological, surgical, radiological or physical therapies • Problem, pattern, process or positive psychological approaches (interventions)		

Table 3.3: Integrating BIPT Tasks into the Medical Consultation

Key Points

- Integrating counseling into the consultation requires us to switch between traditional comforting, detached and expert therapeutic roles, and novel challenging, engaged and collaborative roles.
- We use extended relating and inquiry skills to build a counseling relationship within the medical consultation.
- Extended relating skills can be summed up as being fully present for the patient, in the present. Extended inquiry skills enlarge the open Johari window so that there is shared understanding between us and the patient.
- One way to expand the open Johari window is to CAR-ACE the patient.

References

Cheong, PY. Sreenivasan Oration 2010: Re-defining the Art of Consultation. Singapore Family Physician No. 37 Vol. 1, 2011:, 54-60

Chapter 4: **Formulation & Therapy**

Each person's map of the world is as unique as their thumbprint.
There are no two people alike…
no two people who understand the same sentence the same way…
So in dealing with people try not to fit them to
your concept of what they should be.

- Milton Erickson, founder of
American Society of Clinical Hypnosis, 1901 - 1980

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- Introduction
- Formulation
    - Genogram & Time-line Analysis
    - 4 Ps of Issues for the Reason for Encounter
- Management
    - Integrating Formulation & Diagnoses
    - "Are We There Yet?"
    - 4 Ps of Psychological Approaches to Management
- Key Points

Introduction

What is psychological therapy? Very briefly, it is what we prescribe for bio-psycho-social problems.

With the biomedical model, we start with our patient's diagnosis. We devise management plans and therapeutic approaches based on his diagnostic label. These can include medications, physical therapy, radiotherapy or surgery. With bio-psycho-social issues, we also plan psychological approaches based on our patient's list of formulation of issues.

When we talk about psychological therapy, we often mention the school of psychotherapy that a particular approach belongs to. This refers to the major theory that underpins that group's teaching and practice. A famous example is Sigmund Freud's school of psychoanalysis, which emphasizes the role of the unconscious mind on our behaviour.

What about BIPT? This chapter describes where the BIPT approaches come from.

We also introduce a vitally useful tool in this chapter, the **genogram**. This, together with life-space analyses, enables us to make appropriate formulations and decide fitting therapy for our patient.

Formulation

Genogram & Time-line Analyses

The genogram is an essential tool in the physician-counselor's kit. It enables us, at a glance, to place our patient in a social unit, within a context, and with a relevant associated bio-psychological background.

We draw a genogram using information obtained from the extended relating and inquiry skills. Three sets of symbols are utilized in constructing the genogram, i.e. **basic** genogram symbols, links showing **social** relationships, and symbols showing the **emotional** relationships at play.
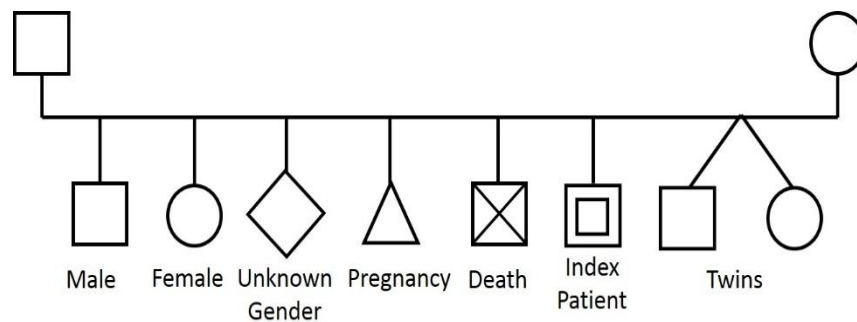
Figure 4.1: Genogram symbols

Individuals with descending age are drawn from left to right in a genogram. We draw the eldest person on the left and the youngest person on the right. With reference to Figure 4.1, the oldest child in the family is male, while the youngest in the family are the twins.
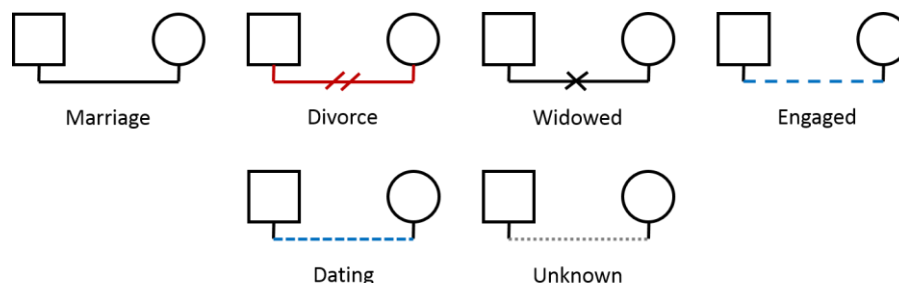

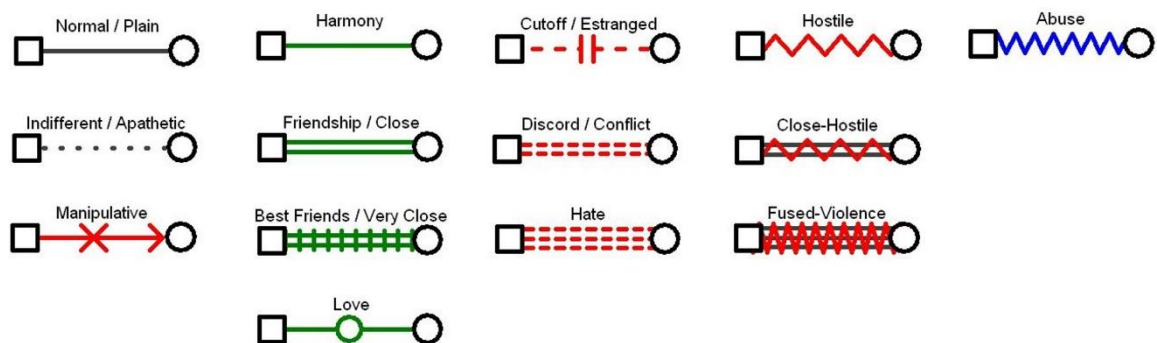Figure 4.2: Family Genogram symbols (social relationships)

Figure 4.3: Family Genogram symbols (emotional relationships)

The genogram forms the starting point for analyzing the patient's life-spaces.

Let us consider Dorothy, a young female patient. A record of significant events in her life can be drawn to analyze her life-spaces.

There are three ways to do this:

(1) A chronological table of significant events with the first column indicating the date and the others a description of the events:

(Date)/Age	Significant Events in Dorothy's life
Birth	Dad abused mum (his wife) in a fused-violent relationship. No physical violence towards Dorothy but she is emotionally abused. Indonesian maid as surrogate mother; distant relationship with biological mum.
17	Dad took a mistress from China after retiring and withdrawing CPF money at 55 years old.
18	Mistress left with dad's money. Increasing violence by dad against mum to get her money led to personal protective order, apparent suicide attempt and eventual reconciliation.
19	Dorothy commenced first year university studies in Singapore.
20	Dorothy manipulated by dad against mum (who now had control of the finances). Dorothy's academic performance deteriorated; she was in constant state of vigilance and anxiety.

Table 4.1 Significant events in Dorothy's life

(2) A time-line of the significant events with dates of (or age at) milestones indicated, and comments on events:

Dysfunctional family   Dad's Mistress Dad disenfranchised
   Birth-Childhood   17-18 years   20 years
|_____|_____|_____|

(3) Mulitple genograms at significant periods of her life. This has the advantage of documenting the social and emotional relationships at sentinel periods.
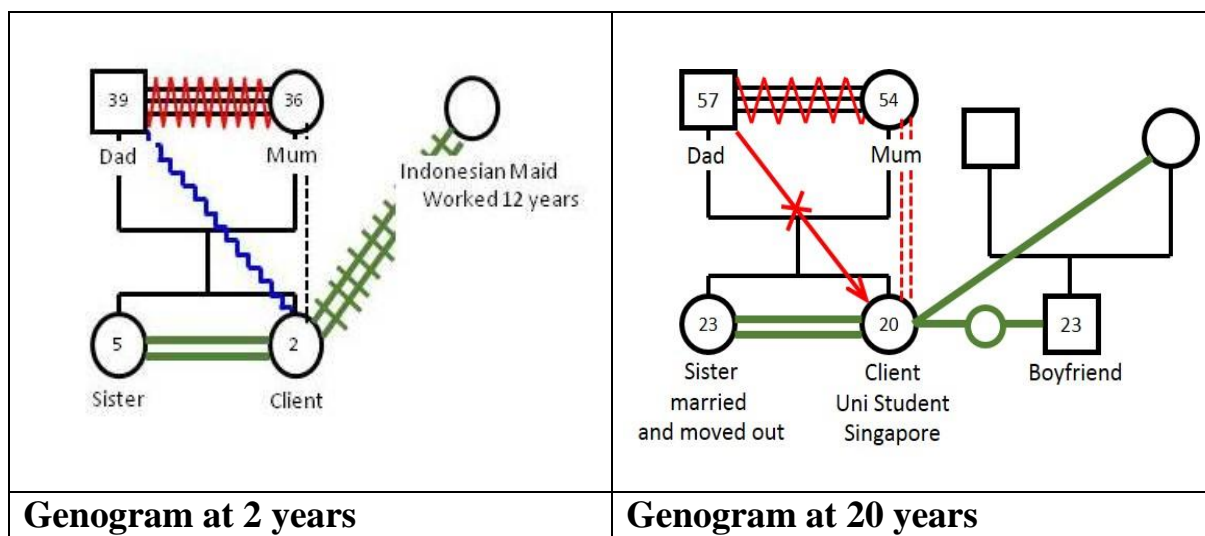

Genogram at 2 years	Genogram at 20 years

Figure 4.4: Dorothy's genograms at 2 and 20 years old

4Ps of Issues for the Reason for Encounter

To recap, we are able to gather a rich swathe of material from our extended consultation, using extended skills of relating and inquiry. After this, we construct the relevant genograms and attempt to analyze our patient's life-spaces. It is important to remember that we probably acquire the material over several, or many, encounters with our patient.

Our objective is to formulate a list of issues that are relevant to our patient, including the predisposing, precipitating, perpetuating and protective issues surrounding his reason for encounter. An example would be a formulation of the issues surrounding a diabetic patient's apparent unwillingness to adhere to recommended therapy. The issues could include his underlying personality, his shift work, his son's recent hospitalization, the high cost of his medications, and his wife's continuing support and partnership.

Try this the next time you face a patient that you feel has bio-psycho-social problems!

Management

Integrating Formulation & Diagnoses

Our eventual aim in gathering the therapeutic materials is to compile an integrated list comprising our patient's diagnosis categories as well as his psychological formulations. To continue the example of our patient above, part of his notes may read:

Issues:

48 y.o. Chinese man, truck driver

- Diabetes, poorly controlled, HbA1c 9%
- Peripheral vascular disease
- BP normal, kidneys normal
- Stubborn man, prefers to decide for himself
- Works shifts, irregular meals, eats out twice a day
- 12 y.o. son hospitalized last month
- Finds sitagliptin expensive, not taking regularly
- Supportive wife, homemaker

- followed by a simple genogram to show the important family relationships.

"Are We There Yet?"

A vital task at this point, before we proceed with management, is to assess the patient's readiness for change.

With a purely biomedical problem, when we reach a diagnosis for our patient's presenting complaint, we communicate this to him and recommend the next steps to be taken. We assume that our patient will agree with our conclusions and cooperate with our treatment. The physician and patient are both quite accustomed to this prescription.

With psycho-social issues, you may recall that one of the physician-counselor's extended consultation roles is that of an engaged collaborator. We need to collaboratively come to a formulation with our patient, and we need to assess if he is ready to accept treatment and change. The **stages of change** model is useful here – we need to see if our patient is in the pre-contemplation, contemplation, preparation, action or maintenance stage of change (Prochaska and DiClemente, 1983).

To continue the example of our diabetic man, let us say that we have come to the list of issues as stated in his notes above, and he agrees with us that they are an accurate representation of his situation. However, he believes that his current practice is as good as he can get it, which is to buy sitagliptin, which he is convinced is the best medicine for his current condition, and to take it every other day to save costs. He feels well and does not see any need for more aggressive management. This man is at the pre-contemplation stage and we will achieve little good by losing our temper at him in an effort to make him see the light.

However, over time and with some empathic questioning, he begins to see that better control is desirable. His son has been recovering well from his appendix operation and settling back into school. He is open to more action now. Our intervention at this stage could take a problem-solving approach, including a discussion of insulin therapy rather than continued sitagliptin. In particular, we need to address his perception that sitagliptin is the best for him, even though he is financially unable to take it as prescribed. Deeper questioning to probe his assumptions and exploration of alternatives will be useful here.

Consider another example. An abused wife may choose to remain with her abusive husband for various reasons. These may include a misplaced sense of security and the perception that she is to blame for her beatings. Before we know how to recommend the 4Ps of management, we clearly need to discover what stage of change she is at.

4Ps of Psychological Approaches to Management

The BIPT approaches incorporate the change processes and techniques of different schools of psychotherapy, and then systematically deliver them in a structured framework. Therefore, BIPT is considered *eclectic*. Table 4.2 compares the approaches taken with the biomedical model, the various psychotherapy schools, and BIPT.

Comparing Models of Therapies		
Biomedical models of diseases	**Schools of psychotherapy**	**Eclectic approaches of BIPT**
Scientific theory of diseases	Specific theory of mind	None assumed
Patho-physiology of diseases	Change processes	Selected change processes
Pharmacological therapy, physical therapy, radiotherapy or surgery	Change techniques	Eclectic change techniques within structured framework

Table 4.2: Comparing Models of Therapies

Four psychological approaches to therapy have evolved within BIPT, based on established schools of psychotherapy. These are listed below, together with the situations for which we might consider using them.

- When we identify troublesome personal life stories, we use the **pattern** approach. For example, consider a female patient who constantly questions whether what her physician tells her is "true". We discover that she grew up in an emotionally and physically abusive home. She now has difficulty trusting persons in authority, and constantly questions her physician's motivations in telling her she does not need to take medications to lose weight. We use narrative and solution-focused change techniques when we employ the pattern approach.

- When we recognize a problematic situation, we use the **problem** approach. This can be as simple as recognizing that our patient has insomnia because

he plays games on his computer for a couple of hours every night and goes to bed too stimulated to fall asleep. It can also be more complex. For example, we may realize that a young woman's palpitations are due to the excessive fears that she has every time her husband travels on business, because she associates airplane flights with crashes. In these situations we use problem solving techniques and work on our patient's cognitive and behavioral skills.

- When we want to address our patient's psychological balance, we employ the **process** approach. We recognize a place for this when our patient is grappling with questions of "meaning", or achievement, or priorities in life. With the process approach we try to help him focus on the HERE and NOW.

- Finally, we can use the **positive** approach concurrently with any of the other three. With this approach, we help our patient build his store of "happiness" by focusing on positive thoughts and being engaged in meaningful pursuits.

Key Points

- We choose one or more psychological approaches to deal with our patient's BIPT issues, depending on his personalized list of formulation of issues, just as we choose the biomedical treatment based on his diagnosis.

- The psychological approach we choose can refer to the pattern, problem, process, or positive approach, and can involve any one or more of these.

- Genograms and life-space analyses are useful tools by which we understand the therapeutic materials that ensue from the consultation.

References

Corey, G. (2012) *Theory and Practice of Counseling and Psychotherapy.* Wadsworth Publishing.

Gurman, A.S. and Messer S.B. (1995) *Essential Psychotherapies.* Guilford Press. Chapter 11. An Eclectic and Integrative Approach: Transtheoretical Therapy by James Prochaskha. pp. 408-414

Chapter 5: **Pattern Approach**

Your past is just a story.
Once you realize this, it has no power over you.

– Chuck Palahniuk, author of *Fight Club*, 1962 -

Contents of this Chapter

Introduction

This chapter describes how our stories define us, and how we can use this to help our patients.

Let's consider our lives. What is "real"? What does reality mean?

According to Western psychology, there are several different ways of understanding our world and experiences, or of perceiving reality. Modernists believe that our world must be observed and measured in order for us to know it. On the other hand, post-modernists, influential since the 1950's, believe that we know our world in multiple ways, including through observation, revelation, intuition and relationships. They believe that our reality can, at least in part, be socially constructed using language, using stories that create meaning.

Therefore, post-modern psychotherapies are based on the ideas of contextualism and plurality, as applied to life patterns. **Contextualism** refers to the idea that we need to understand the multiple stories that make up a person's self, within the context of time, place, his culture and his social connections. We can look at the stories and their contexts in various, different ways. Hence the life stories can be taken apart or de-constructed, and re-written or re-constructed, giving the idea of a **plurality** of self.

Self is therefore defined by multiple stories as well as multi-storied stories. This is also known as a plethora and a hierarchy of stories. In working with patients, problem saturated stories (PSS) can be replaced by preferred positive stories (PPS), re-constructed from events that actually occurred but were not previously taken into account.

BIPT adopts a post-modern approach to understanding patterns of individuals in development. We have been inspired by the work of Epston and White in Narrative Therapy and that of Insoo Kim Berg and de Shazer in Solution Focused Brief Therapy.

Listening to Their Stories

We can get to know a person's personality and understand his behaviour by listening to his significant past stories, or narratives. Patterns of past stories define the present plethora and hierarchy of stories that make up the person's "self". Our aim, when counseling, is to identify the experiences that form the stories, to understand how they are constructed and how the themes of these stories formed.

Rick Warren, in *The Purpose Driven Life* writes that *"rather than life being hills and valleys, I believe that it's kind of like two rails on a railroad track, and at all times you have something good and something bad in your life."* Our assumption is that the patient has, unconsciously or subconsciously, authored the problem stories by linking together significant negative events and ignoring the positive events.

Therefore, we would like to help him re-examine his life for negative events that can be re-framed, as well as positive events that were previously overlooked. The patient can then re-author his problem-saturated stories into preferred positive stories, which can be re-lived in the present and future. In this way the past, present and also future self are viewed more positively.

We can also help to co-create present and future preferred positive stories based on his hopes and dreams, as fixation on past stories may reinforce the problem-saturated stories. The key is to help our patient shift his focus from his problem to a solution.

Constructing the Preferred Positive Story

Four tasks to the PPS

There are four tasks that can be remembered as the four Rs, re-authoring, re-membering, re-framing, re-telling.

Re-Authoring – from Problem Saturated Story to Preferred Positive Story

1. A problem saturated story (PSS) has a negative story-line that links the negative events. These events are represented by the black holes. Present and future events are framed by this negative story-line. Positive events

that are not in agreement with the story-line are ignored or minimized, while negative events enrich the PSS into the dominant defining story.

2. Our task is to deconstruct the dominant story by first identifying discordance in it. This discordance is represented by the tenuous links between the black holes. The black holes themselves are also examined for context and significance.

3. Having deconstructed the PSS into its components and re-visited past events, our task is to look for the exceptions, which are represented by the stars. These are significant events that did not fit into the PSS and therefore were previously rejected and forgotten. The aim is to amplify the significance of these stars and then to re-author a preferred positive story (PPS) by infusing new meaning and plot.

4. If the black holes and the PSS prove resistant to de-construction, then a solution focused approach can be taken, using the patient's hopes and dreams to provide materials for the PPS, instead of dwelling on the past.
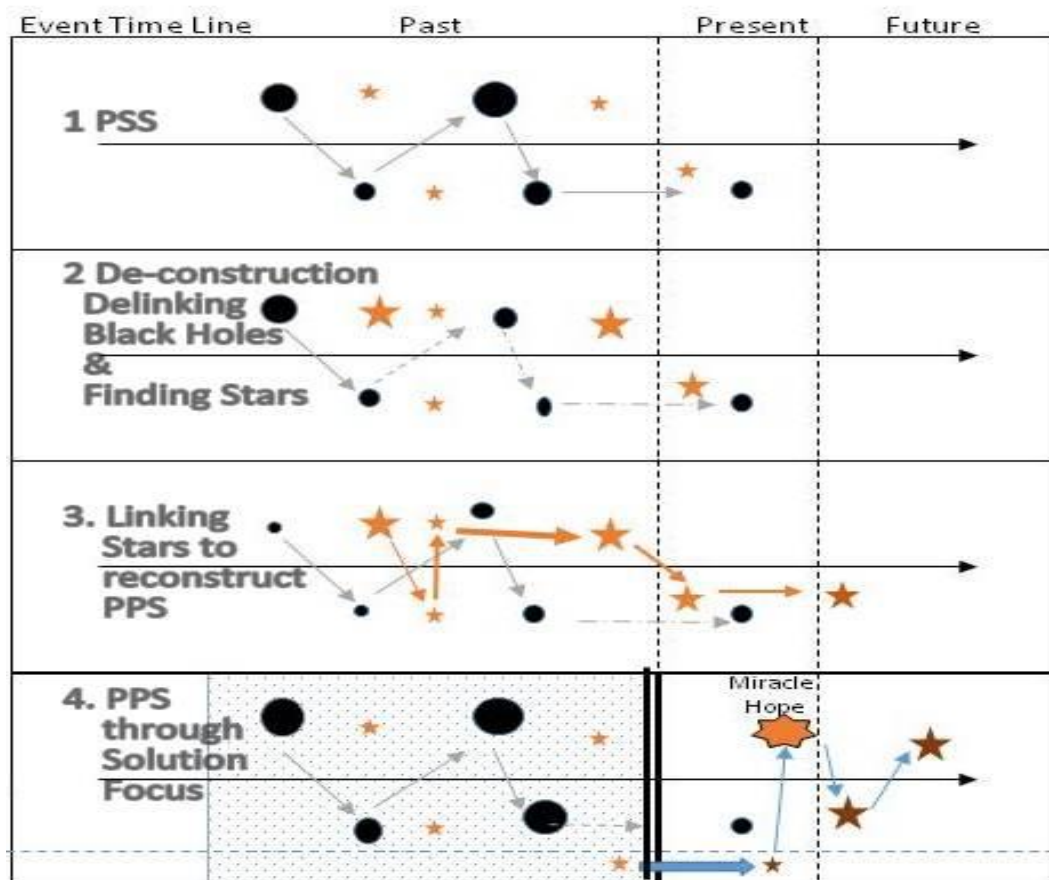

Figure 5.1: Schematic representation bref deconstruction, re-construction & re-authoring of life stories

The narrative tasks of re-authoring form a continuing conversation and progress is measured in small steps.

At times, the patient may have specific persons or events that were noxious in the past and are still causing suffering in the present. Re-membering and re-framing of such events may be necessary before the PPS can be authored.

Consider a 31-year-old woman, a social worker, whose marriage is suffering because she constantly responds immediately whenever her clients call for help in the middle of the night. Her father had died of a heart attack when she was twelve, and her mother, bed-ridden from advanced diabetes, had died a year later. Her father had been her mother's carer before his sudden death, and after his death, his 12-year-old daughter had taken over the nursing tasks. Her older siblings had been married and no longer living at home at that time.

This woman remembers her father talking to her whilst they waited for the ambulance. He had asked her to take care of her mother's needs if he died. This she had tried to do, but she has always felt guilty that her mother had also died within the year, and has always felt that she let her parents down.

On further questioning, she remembers that her father had also told her to look after herself. She also realizes that she could not have been a very good nurse simply because she had only been twelve then. She is able to de-construct her PSS and re-author a PPS that takes into account her father's injunction to care for herself, and becomes more willing to invest time in her marriage.

Re-Membering

Here, we are not using the term re-membering in the usual sense of recollecting past events. Instead we are referring to the act of reviewing the status of past and present significant persons or events, as members of the patient's present "Club of Life". In other words, we are trying to assess what they mean now to the patient. If the present meaning is still problematic, the patient can be helped to re-member so that the past person or event will not continue to create present problems.

For example, certain persons and events could have caused painful experience in the past – a derisive teacher who devalued a student's best efforts, a painful boy-girl relationship, or failure in examinations. When recollecting these persons or events in the present, the same past hurt will still be experienced in the present, if

the same membership status continues to be accorded as when it happened in the past.

Consider Cambridge professor Sir John Gurdon, who won the Nobel Prize for Physiology and Medicine in 2012 for his groundbreaking stem cell research. When he was 15 years old, his Eton science teacher had given him a damning report, writing that it would be a *"sheer waste of time"* for him to pursue science. Receiving the prize at 79 years of age, he showed reporters his secondary school report. It was a public act of re-membering.

Re-Framing

The visual phenomenon of reframing bi-stable images is well known. Rubin's vase, sometimes known as the figure-ground vase, belongs to a famous set of ambiguous two-dimensional forms developed around 1915 by Edgar Rubin, a Danish psychologist. We see the picture as a vase if we focus on the white area. If we shift our attention to the black area, we see a silhouette of two faces.
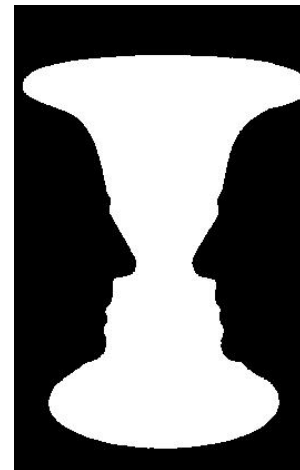
How we look at events in our lives is sometimes a function of what we focus on. With re-framing, we try to help our patient see his glass as half-full instead of half-empty.

Figure 5.2: Rubin's Vase

Let us consider re-framing metaphors. Metaphors are figures of speech that describe a subject by comparing it with another unrelated object. For example, we can say, *"She is as clumsy as a cow."* Metaphors can be reframed too, as the metaphor *"is not an ornamental flourish of language but an essential part of thought. Our ordinary conceptual system in terms of which we both think and act is fundamentally metaphorical in nature"* (George Lakoff). Patients do use metaphors to represent the themes of their PSS. By collaboratively re-framing the metaphor with the patient, the problem-saturated theme can be re-framed to a more adaptive one.

Sometimes, the destructive person or event becomes "fused" with the patient, i.e. it becomes internalized and is not easily re-membered or re-framed. In such cases, we can help the patient to externalize that destructive object from the hidden or

unknown Johari window into the open window. A name can be given to that object to personalize it, so that we can discuss the impact that the object still has on the patient in the present. The famous saying that summarizes this is, *"the person is not the problem, the problem is the problem."*

Re-Telling

Finally, we need to make the preferred positive story real. This is accomplished by telling and re-telling, and thus thickening the story. The telling can first be rehearsed in practice situations, and then executed in social situations. We can consider this *in-vitro* and *in-vivo* behavioral experimentation.

If we work with a group, story construction can also be done with re-telling through defining ceremonies. We can get the group, as an entity, to tell their shared story to outsiders. Such ceremonies, called definitional ceremonies in narrative therapy, give a sense of meaning, identity and pride (Barbara Myerhoff). We can then achieve further self-definition by re-telling the group story to other outsiders. This is the case with patient support groups.

Key Points

- In the pattern approach, we recognize that life experiences are selectively stored as narratives which may reflect a negative life pattern of thought. This is the problem saturated story (PSS).

- Patients can be helped to change their life pattern of thought and thus author and store their life experiences as preferred positive stories (PPS).

- The authoring of a PPS requires the accomplishment of the 4 Rs – Re-authoring, Re-membering, Re-framing, and Re-telling the life experience.

- When we do this consistently, the pattern approach creates present and future stories of hope for the sufferer.

References

Corey, G. (2012) *Theory and Practice of Counseling and Psychotherapy.* Wadsworth Publishing. Chapter 13 pp. 382-402 on Postmodern Approaches

http://www.dulwichcentre.com.au. Dulwich Centre: A Gateway to Narrative Therapy and Community Work

http://www.sfbta.org. Solution-Focused Brief Therapy Association

Chapter 6: **Problem Approach**

People are not disturbed by things, but by the view they take of them.

– Epictetus, Stoic philosopher, 55 - 135

Contents of this Chapter

Introduction

Every parent wants to know this: *just how do we deal with problem behavior?*

Behavioral issues can arise in two ways. Firstly, problem behavior may be the result of an inappropriate response to a preceding motivation. We call this a *maladaptive* response to antecedent stimuli. Secondly, problem behavior may result from inappropriate perception and interpretation of stimuli, giving rise to inappropriate thinking which results in inappropriate behavior. We call this *cognitive distortions* giving rise to *negative automatic thoughts* (NATs).

With behavioral therapy, we work with our patient's responses or his preceding motivations. With cognitive therapy, we work on how he perceives or interprets stimuli. Behavioral therapy can also be used together with cognitive therapy, and we call this cognitive behavioral therapy, or CBT.

If we find that the problem behavior does not involve cognitive distortions leading to NATs, our intervention becomes more straightforward. Problem-solving techniques can be applied, which should be specific, measurable, achievable, realistic and time-delimited. We can conveniently remember this as using **SMART** measures to solve a problem.

Behavioral Techniques

Behavioral techniques fall into two broad categories. Counter-conditioning is a category of techniques based on the work of Pavlov (1849-1936) and Wolpe (1915-1997). Contingency management is the other category, based on the work of B. F. Skinner (1904-1990).

Counter-Conditioning

Counter-conditioning is based on countering the **stimulus** and/or the **response**. We can also say that it works on the *antecedent* and/or the behavior, and is built on the principles of *classical conditioning*.

Stimulus Control

By this we refer to the strategy of avoiding an undesirable response by avoiding the inciting stimulus. For example, our patient who is on a diet can avoid the sight or smell of food, and hence avoid his food-seeking behavior and inappropriate eating. In a similar way, by controlling access to smoking cigarettes we can address a patient's tobacco addiction. Another strategy is to avoid situations that he associates with smoking, such as a weekend meal in a coffee-shop.

Assertive Response

We can coach our patient to respond to certain stimuli in a way he would not usually do. In this way he can increase the number of his possible responses to a situation. He can be coached to acquire a new, assertive behavioral response. Consider a diabetic patient who will be attending a buffet dinner. We can coach him to visualize the range of food on offer and to decide what he will choose to eat. Another patient with insomnia should be coached to consider his bed (the stimulus) only with sleep (the response), and not with any other activity such as reading or computer work. Hence if he is unable to sleep after a certain period, we teach him to get up and do something else and to only return to bed when he is sleepy again. Our smoker who is trying to stop can get his friends to keep him accountable.

Systematic Desensitization by pairing with Contradictory Stimulus

This technique starts by identifying the stimulus that produces the problem behavior, as well as another stimulus that produces an opposite, or contradictory response. The problematic stimulus is presented at a low intensity, which is systematically increased, whilst simultaneously pairing that stimulus with the contradictory stimulus. For example, an anxiety-provoking stimulus can be paired with a calming stimulus, eventually achieving a graded reciprocal inhibition of the response. In this way the undesired response is gradually reduced and eventually abolished. Let us continue our example of the smoker who is trying to quit. Instead of having a meal at the coffee-shop in the weekend with his buddies, which he associates with an after-dinner smoke, he is encouraged to meet them for a jog instead. In this way, he gradually stops associating his buddies with cigarettes.

Incidentally, this differs from the technique of flooding, which is based on the principle that responses to a stimulus will peak, and then decline, as long as the patient is not allowed to avoid it. With flooding, the patient is exposed for a prolonged time to the problematic stimulus, and attempts to replace his undesired response with a "better" one.

Contingency Management

Contingency management is built on the principles of *operant conditioning*. B. F. Skinner developed the principle that behavior is strengthened or weakened, contingent or depending on the consequence. This consequence can be a reward or a punishment. The response to the stimulus is reinforced by giving a reward or by removing the punishment. On the other hand, the response will be weakened if we remove the reward or impose a punishment. A terrible example of operant conditioning is the development of substance addiction because the initial pleasure was rewarding. Conversely, we can arrange with an alcoholic's wife for her to give him her undivided attention if he does not stop by the pub for a drink after work. If he does have alcohol, she is taught to withdraw her company for that night.

Cognitive Techniques

Cognitive therapy is directed at how we perceive and interpret the stimuli that we are presented with.

Contrary to what we like to think, we do not always react rationally to situations. Sometimes, certain cues from the situation will automatically trigger a response, which may be quite irrational or undesirable, in a "feed-forward" stance. We may not even be aware of the negative automatic thoughts (NATs) that are triggered, because these are in our sub-conscious. Consider the wife whose husband forgets her wedding anniversary. Her NAT is triggered, telling her that *"he doesn't really love me."*

We can often trace these NATs to cognitive distortions, which can be thought of as inappropriate ways of perceiving or interpreting the situation. These inappropriate ways may have been appropriate, or useful, in the past. In other

words, they were *adaptive* once. However, when we attempt to apply them automatically to present situations they may become inappropriate.

Table 6.1 presents a list of possible cognitive distortions and how we usually see them played out. In general, the pattern of cognitive distortions can often be traced to rules and attitudes that were developed to deal with previous unpleasant life experiences.

Cognitive Distortions	Common Parlance
Over-generalization	Black or white; all or nothing
Catastrophizing	Assuming the worst; expecting the worst
Selective Abstraction	Dwelling on the negatives
Disdaining	Disqualifying the positives
Mind Reading	Jumping to conclusions
Emotional Reasoning	"I feel it. Therefore it must be so."
Must-abating	Guilt formation
Labeling & Mislabeling	Assigning attributes of group to individual
Personalizing	"Poor me…"

Table 6.1: Cognitive Distortions and Common Parlance

During a consultation, we can suspect that NATs are involved when we notice a shift in emotion or behavior which is not congruent to the situation. For example, consider the wife whose husband has forgotten her wedding anniversary. As a result of her NAT telling her she is unloved, we may note that she is dejected to an unexpected extent. To identify the NATs lurking in the background, we can use a systematic way of questioning our patient, to probe at her deeper issues. Such a technique is described in the framework of extended inquiry in Chapter 3.

When we bring NATs to the open Johari window, our patient can better understand her emotional and behavioral response. In this way, the next time her husband forgets their anniversary, she can dispute her NATs and control her response.

An *aide-mémoire* of behavioural and cognitive techniques is given in the table below:

		Antecedent	Cognition	Behaviour	Consequence	Disputing	
1	**Counter-Conditioning**						
	Stimulus (Antecedent) Control	A	➡	B			Avoidance or association with stimulus
	Assertive Response	A	➡	**B**			Conscious choice from repertoire of behaviors to the stimulus
	Systematic Desensitization by pairing with contradictory stimulus	**AA'**	➡	B'			Pairing of calming stimulus (A') with noxious stimulus (A) to produce calming response (B')
2	**Contingency Management**						
	Contingency Management -Consequences feed-back to affect link of B from A	A	➡	B	**C**		Consequence (C) – the reward or punishment affects B
3	**Cognitive Restructuring**						
	Disputing NATs -Negative Automatic Thoughts arising from Cognitive Distortions	A	**NAT** **CD**	B	C	**D**	Cognitive Distortions (CD) engendering Negative Automatic Thoughts (NATs) are disputed (D)

Table 6.2: Summary of Behavioral & Cognitive Techniques

Legend: A=Antecedent (Stimulus) C=Cognitive (Distortion) B=Behavior (Response) C=Consequence D=Disputing.

Notes:
1. In Counter-conditioning, the antecedent triggers behavior.
2. In Contingency Management, consequences feed-back to reinforce or diminish behavior.
3. With Cognitive Restructuring, NATs arising from cognitive distortions are disputed.

Strengths-based CBT

There is a new development to use CBT principles and beliefs in the positivity movement (Padesky, 2013). New beliefs and behaviors are developed which promote positive growth, using imagery, client-generated metaphors, and therapeutic use of smiling and humor. Additionally, by working with generated and signature strengths, CBT can go beyond treating the problematic situation, to building resilience. Positive automatic thoughts, or PATs, are generated instead of NATs. The positive approach is further described in Chapter 8.

Key Points

- The basic concept in the problem approach is to determine whether the problem is the result of a maladaptive response to antecedent stimuli, or the result of negative automatic thoughts created by cognitive distortions.

- We use two broad behavioral techniques to deal with the maladaptive response to antecedent stimuli, i.e. counter-conditioning and contingency management.

- In dealing with cognitive distortions giving rise to NATs, we need to trace what the cognitive distortions are which have been taught or learnt, create an awareness of these, and take steps to counter them.

- Positive psychology can be incorporated into CBT to construct new positive behaviors, beliefs and to augment existing strength.

References

Padesky CA, Mooney KA. Strengths-based cognitive-behavioural therapy: a four-step model to build resilience. Clin Psychol Psychother. 2012 Jul-Aug;19 (4):283-90. doi: 10.1002/cpp.1795. Epub 2012 Jun 1. PubMed PMID: 22653834.

Beck, J. S. (2011) *Cognitive Behavior Therapy: Basic and Beyond.* 2nd ed. The Guilford Press.

http://www.beckinstitute.org. Beck Institute for Cognitive Behavior Therapy

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Chapter 7: **Process Approach**

*For the meaning of life differs
from man to man, from day to day and from hour to hour.
What matters, therefore, is not the meaning of life in general
but rather the specific meaning of a person's life at a given moment.*

– Viktor Frankl, founder of Logotherapy 1905 – 1997

Contents of this Chapter

- Introduction
- Mindfulness of Now in Time
  - Emptying the mind (Attention, Intention, Dissociation)
  - Filling the mind (by a higher spiritual order & positivity)
- Experiencing of Here in Space
- Key Points

Introduction

The key word is balance.

The process approach deals with the integration of the spiritual aspects of our self, or our spirituality, with the functioning of our physical body and brain. By spirituality, we refer to the aspects of the relationship that we have with a higher being or higher cause, which gives meaning to our lives. This is not a reference to a practice of religion. An atheist who seeks meaning to life is grappling with aspects of his own spirituality.

In process work we strive to help our patients achieve a balance between conflicting demands on his attention and priorities. The assumption is that in achieving balance we also achieve a reduction in our stress levels, and improvement to our mental and physical health.

The approach focuses on our consciousness of the HERE and NOW, in space and time. You could say that we aim to be here – not there, and in the present – not the past or the future.

Being in the present is achieved through being mindful of NOW. In other words, we strive to have a present-focus, and try to minimize dwelling on past failures or future uncertainties.

Being HERE is important, especially in light of the fact that our lives are limited in time and we are finite beings in a much greater whole.

Mindfulness of Now

Having a focus on the present helps us to achieve an inner state of harmony of our mind processes, or stillness, which is detached from the constantly changing nature of our world.

We can take various approaches to achieve this. The more common understanding of mindfulness is that of **emptying the mind** by the discipline of meditation or even physical deprivation. There is an opposite, or antithetical, practice to attain that same goal, by **filling the mind**. To fill our mind, we bring the parts of our self to be submitted to a higher spiritual being. We do this by knowing, trusting and obeying this higher being. A secular, or non-religious,

approach is to fill the mind with meaning, accomplishment and positive emotions. Both practices aim to attain stillness.

Consider a jar of water. Stillness can be achieved whether the jar is totally empty or totally filled with water. There is not any more or less turbulence, when the covered jar is shaken, whether it is completely empty or completely filled. Emptying and filling are thus antithetical yet complementary disciplines to attain inner stillness. From the stillness of the present, we have less to bemoan of the past and less to fear of the future. We can therefore move beyond our anxieties, begin learning from and accepting the past, and look to a future hope and optimism.

Emptying the Mind – Attention, Intention, Dissociation

When we meditate, we give our **sustained focused attention** to the present meditative experience, on a moment-to-moment basis. In psychological parlance, this refers to a state of awareness in which each thought, feeling, or sensation that arises is acknowledged and accepted as it is, without questioning or judgement. When the mind is emptied, or freed from the distraction of internal and external mental noises, new insights and awareness may emerge.

With meditation, the intention is to direct **attention**. One way of learning meditation is by deep breathing exercises. Another method is to practice progressive muscle relaxation and to **intentionally** focus our attention on experiencing a certain part of our body. **Dissociation**, which describes a psychological detachment from the immediate surroundings, can then be induced. For example, a technique such as *guided imagery* can be used to bring about dissociation involving our senses. This dissociated state is sometimes termed a-volitional experience, with or without a-volitional response, when it is used in *hypnotherapy*.

Filling the Mind – By a Higher Spiritual Order & Positivity

An antithetical approach to emptying the mind is to fill the mind to the brim with the spirit of a higher being. We practice this by the discipline of **knowing** through

manifest teachings, and of **trusting** that the teachings to be **obeyed** are divine. For example, one of the steps of the Alcoholics Anonymous program espouses the filling of the mind by a higher spiritual order.

In secular terms, the mind can also be filled with positive psychology, for example with meaning of life, accomplishment, and positive emotions. One example is attaining flow. Flow is defined in Wikipedia as *"a state of absorption where one's abilities are well-matched to the demands at-hand. Flow is characterized by intense concentration, loss of self-awareness, a feeling of being perfectly challenged."* In the parlance of today's youth, this is also described as being *"in the zone."*

Experiencing of Here

Therapies that work on "here" are characterized by respect for the *client's* subjective experience. Therapists trust their clients to make constructive, conscious choices to balance their psychological and physical processes. Broadly, there are three approaches. *Humanistic* therapies are based on the belief that each of us can realize our full potential through **finding positive meaning** in our lives. *Existential* therapies address our anxieties that arise from **having to create our identity** in a world that lacks an intrinsic meaning. Finally, *awareness* therapies seek to "red-integrate" or to **restore us to wholeness**, rather than simply address our component parts.

An example of the **humanistic approach** is the Unconditional Positive Regard of person-centered therapy developed by Carl Rogers. This is based on the client himself as the agent of change. It seeks to bring him to a position where he trusts himself, is open to experience, is able to self-evaluate and has a willingness to continue growing. This is a process commonly referred to as *self-actualization*.

There is no specific technique in this approach. The therapist guides and engages the client by congruence and accurate empathic understanding, and communicates this to the client by "unconditional positive regard" and acceptance. The therapy therefore is non-directive and provides an environment for self-growth, acceptance and integration.

The **existentialistic approach** believes that as human beings, we are able to reflect on and decide the way we want to live. However, awareness of this freedom can lead to existential anxiety, or anxiety relating to our very existence. This is because

there may be no certainty of the correctness of the outcome of our choice. This anxiety is heightened by the established facts of the lives of mortal beings, i.e. sickness, suffering and death.

By raising awareness of the client's anxieties and the ways in which these may be constricting his choices to act, the therapist makes him more aware of how his self is defined. He is helped to arrive at alternative choices and action. Irvin Yalom dwells on directly addressing our fears of death, or our "death anxieties". An example of successfully facing death anxieties is the experience of some cancer patients, who describe their feeling that they are living more fully, after they have faced the initial numbness of their diagnosis.

Viktor Frankl, another existential psychotherapist, based his therapy on helping a client deliberately define a meaning in his life. Frankl was interned in the Auschwitz concentration camp during the Second World War. There, he observed that the severely debilitated prisoners who were able to find a meaning to their suffering, survived. Those who lost hope died. He subsequently said that *"those who have a why to live can bear with almost any how."*

Both these approaches are a celebration of man's ability to rise above uncertainty and anxiety.

The third approach of **red-integration** raises awareness of every part of one's self, even those parts that are hidden or disenfranchised, and of owning all the disparate parts. Red-integration refers to the restoration of the whole, from discovering and re-owning hidden or disenfranchised parts, and not merely to reintegration of parts that have been separated. A well-known example is Gestalt therapy from the German word *gestalt* that relates to the "whole". Clients are helped to become aware of what they are doing, how they are doing it, how they feel and change, and to accept and value what they are. Through perceiving, feeling, and acting, the client experiences wholeness in space.

Bill Clinton, the former President of the United States, famously denied engaging in sexual indiscretion with a young female intern, even in the face of DNA evidence. It was a disregard for this reckless part of his personality that had led him to indulge in the sexual indiscretion in the first instance. His predecessor Jimmy Carter, on the other hand, who publicly confessed that he had *"committed adultery in my heart, many times,"* was probably less vulnerable when sexually tempted, because he had acknowledged and accepted this weakness.

A Disclaimer

It is paradoxical to discuss the process approach in disparate parts, when the experience of here and now is necessarily the experience of an entire whole. In reality, time and space are one. Explaining and learning the process approach is more than considering component words and cognition. Also, when we first encounter them, the explanations may appear to be overly simplistic. However, when we actually begin to learn more, we may well realize that we might have embarked on a never-ending, many-splendored journey.

Acknowledgements

Key Points

- The process approach deals with the integration of the spiritual aspects of our self, or our spirituality, and the functioning of our physical body and brain.

- It focuses on a consciousness of HERE and NOW, in space and time. In essence, we strive to be here, not there, and in the present, not in the past or the future.

- The process approach can involve the practice of meditation, spiritual disciplines, and meaningful involvement in life and work.

- It can also involve humanistic, existential and awareness methods of therapy.

References

Corey, G. (2012) *Theory and Practice of Counseling and Psychotherapy.* Wadsworth Publishing.

Gurman, A.S. and Messer S.B. (1995) Essential Psychotherapies . Guilford Press. pp. 190-200.

Frankl, V. E. (1997) *Man's Search for Meaning.* Rev. ed. Pocket Books.

Rogers, C. (1995) *On Becoming a Person.* Mariner Books.

Yalom, I. (2009) *The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients.* Harper Perennial.

Zeig, J. K. (2006) *Confluence: The Selected Papers of Jeffrey K. Zeig.* Zeig, Tucker and Theisen.

Chapter 8: **Positive Approach**

Success is not the key to happiness.
Happiness is the key to success.
If you love what you are doing, you will be successful.

– Albert Schweitzer, winner of the 1952 Nobel Peace Prize, 1875 - 1965

Contents of this Chapter

- Introduction
- What's Happy?
- The Three "Happy" Lives
  - o The Pleasant Life
  - o The Engaged Life
  - o The Meaningful Life
- Key Points

Introduction

This is a happy chapter. Many of us can picture the traditional therapist with his patient on the couch, exploring past and analyzing present scars. The positive approach pours a splash of cold water on this!

In 1998, the American psychologist, Martin Seligman and his colleagues introduced the positive psychology approach. This approach seeks to *"catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities."* Seligman defines this approach as one that *"seeks to understand and build the factors that allow individuals, communities, and societies to flourish."*

What's Happy?

Conceptually, the positive psychology approach centres around three "happy" lives. These happy lives, seeking to build the happiness store in each of us, form the key contribution that the approach has made to psychology.

When we work with patients, this approach can be used independently or synergistically with other techniques. For e.g., with the problem approach in strengths-based CBT, a positive way of looking at life's experiences can counter negative mental health factors. With process work, deliberately paying attention to the elements of our immediate experience can reduce stress and anxiety, and counter daydreaming, which is related to a reduction of happiness. When using solution focused brief therapy (SFBT), which is an example of pattern work, instead of focusing on past problems, we engender hopes and positive feelings for the present and the future.

The Three "Happy" Lives

The three "happy" lives of positive psychology are the pleasant life, the engaged life, and the meaningful life.

The pleasant life

The pleasant life focuses on positive emotions. When negative emotions are allowed to dominate, they have a damaging effect on our lives. These negative emotions include dissatisfaction with life, negative automatic thoughts, as well as low moods when we reflect on our lot in life.

Living the pleasant life consists of generating positive emotions about the present, the past, and the future, and learning the skills to amplify the intensity and duration of these emotions (Seligman et al, 2006).

Positive emotions about the past include satisfaction, contentment, fulfilment, pride, and serenity. Positive emotions about the future include hope and optimism, faith, trust, and confidence. These emotions, especially hope and optimism, help to buffer a person from depression. Positive emotions about the present include satisfaction from immediate pleasures as we try to savor experiences that we otherwise often rush through.

One strategy to encourage such positive emotions is to "count our blessings". As an exercise, write down three things that went well today. Take some time to tell them to a partner, giving an explanation for why each item has been selected.

The engaged life

The engaged life includes several concepts connected with it, such as flow, self-efficacy, personal effectiveness, and mindfulness. We can usefully cultivate these positive personal traits to result in a "happy" life.

Flow is the term we use for the psychological state that accompanies highly engaging activities. It was first used by a Hungarian psychologist, Csíkszentmihályi. When we are in a state of flow, our attention is completely focused on the activity, time passes quickly and the sense of self is lost.

Self-efficacy and personal effectiveness refer to the belief that our ability to accomplish a task is a function of our personal effort. Adopting and maintaining a healthy lifestyle is an example of high self-efficacy leading to positive change. Learning to have adequate **sleep** and physical and mental relaxation, enjoying healthy **meals** and food in moderation, participating in regular physical and spiritual **activities**, nurturing **relationships** with family, friends and colleagues, and avoiding **toxicity** in the form of tobacco, alcohol, sex and gambling – these can be conveniently remembered as **SMART** steps to a healthier lifestyle.

The meaningful life

We live a meaningful life when we use our talents to serve something, or some institution, that we believe is bigger than we are. There are a number of such positive institutions, including family, religion, politics, community and nation.

Seligman proposes that one way to live meaningfully is first to identify our highest talents, which he calls **signature strengths** (Petersen and Seligman, 2004). Each of us has things that we do particularly well and also enjoy doing. We could learn practical strategies to identify and use these signature strengths more.

One way to do this is to write down an account of a time when we were at our best. We can use this to identify our personal strengths, and when we recount this to other people, they can add their reflections to our insight.

We use our signature strengths to contribute to our self-development as well as to development of our community. **Accomplishments and achievements** refer to what we bring about, using our signature strengths, in our personal circumstances. **Mastery** refers to our ability to use our signature strengths to make sterling contributions to the institutions we belong to.

When we use meaning to transform our perceptions of our circumstances, from unfortunate to fortunate, we achieve the greatest benefits (Seligman *et al*, 2006).

Key Points

- The positive psychology approach promotes positive mental health and buffers the negative experiences in our lives, whether in school, at our workplace, within our family, or in the community.
- This approach hinges on our helping our patients lead three "happy" lives – the pleasant life, the engaged life, and the meaningful life.
- We can use positive psychotherapy exercises to help our patients develop skills that promote mental resilience and health.
- The positive approach can also be incorporated into the other three psychological interventions.

References

Seligman, M. E. P. (2012) *Flourish: A Visionary New Understanding of Happiness and Well-being.* Rep. ed. Atria Books.

Seligman, M. E. P. (2006) *Learned Optimism: How to Change Your Mind and Your Life.* Rep. ed. Vintage.

Chapter 9: **The Family Perspective**

All happy families are alike;
every unhappy family is unhappy in its own way.
- Leo Tolstoy, Russian novelist, 1828 – 1920

All happy families are more or less dissimilar;
all unhappy families are more or less alike.
- Valdimir Nabokov, Russian-American novelist, 1899 - 1977

Contents of this Chapter
- Introduction
- Counseling and the Family
- Beyond the Genogram
- Happy & Unhappy families
- Understanding the Family
- Managing the Family
- Helping the Patient and His Family
- Key Points

Introduction

In BIPT, do we bother with the family? Should we?

We traditionally define the family to include parents and their children. Our postmodern definition is more inclusive; we consider the family as a group of people with *"strongly supportive, long-term roles and relationships who may or may not be related by blood or marriage"* (Rackel). An individual could therefore be a member of several families. In this age of social media, we could even belong to virtual families! The family has physical, emotional, and intellectual driving forces, and patterns of activity reflecting growth, organization, communication, and adaptation, and these all exert their impact on the individual (Rackel, 1998).

Hence, we recognise that the family can have positive or negative impact on the individual. As a result, when we seek to understand our patient's family perspective, we may uncover another dimension of ill-health.

In other words, sometimes we may have no option but to bother with the family as well.

Counseling and the Family

We can take three approaches to the family in counseling. Firstly, we can work with the **family within the person**, referring to the individual's internalized family. Secondly, we can work with the **individual within his family**. Finally, we can work directly with the family as a whole entity, i.e. the **family and its individuals**.

Our understanding of our patient is incomplete if we do not explore his relationship with his family. This is the internalized family that he tells us about – the family within the person. In truth, this is the family we work with most often. If we also know other members of our patient's family, with time, we gain the second perspective of the individual within his family. Achieving the third perspective is more challenging. If we have an established relationship with only our patient and a few other family members, we find that our role is primarily as patient, rather than family, advocate. Occasionally, however, we may be co-opted as an expert advisor to the family, or even "join" the family as a member.

Beyond the Genogram

We can think of the family as a group of inter-related individuals that react to external changes, individually and as a group. When we try to understand our patient and his family, a metaphor from the field of imaging is helpful. We can consider looking at the family through lenses and filters.

In photography, we use different lenses to focus on the details and on the big picture. In the same way, we need to study our patient as an individual and in the context of his big picture, i.e. his family. Also, we use filters to modify what we see in a picture, so that certain features become more distinct with certain filters. When we work with the family, filters are useful to help us analyze different facets of a family.

We use these lenses and filters to frame different views of the same family, in a similar way to how we use different maps of the same territory to add to our final understanding of the terrain.

Understanding the Family

Michael Mahoney proposes that there are five sub-systems that help maintain order in a family, much like how physiological systems maintain order in an individual. These are examples of filters by which we view different facets of the family.

Mahoney describes the sub-systems as follows. **Relatedness and relationships** within the family are established through social and symbolic processes, and may change throughout life. The **ordering processes of experience** refer to the spoken and unspoken patterns such as rules and routines, rituals and roles within the family which impose structure upon members' interactions. The **active agencies** refer to causes supported by the family as well as its goals, so that we get an idea of what motivates family behaviors. **Development** is the process by which families incorporate the values and beliefs of their culture into the fabric of the family. Finally, **self-identity and family-identity** are built on physical, spiritual, and social patterns and rules. These can be conveniently remembered as **ROADS**.

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We need to add two additional filters. We should pay attention to **culture** and **gender**. A multicultural perspective makes the individual more complex, and we may need to challenge dominant cultural views. Gender roles are both well-established and rapidly changing, and affect both the family and its individuals.

Managing the Family

Earlier in the book, we suggested using the extended consultation, family genograms and life-space analyses to arrive at formulations for the individual patient. The family is more complex than the individual. Additional steps to a formulation may include having to "join" the family to understand it from within. We also need to look at the family through different lenses and filters to get our different angles.

Approaching the family from various perspectives, as described above, will help us gather richer therapeutic materials which we can use to draw different "maps" of the family. Each of these maps is different, and each map is *"not the territory"* (Korzybski). However, they all contribute to a better understanding of the family and its components, and to a more comprehensive list of formulations for this family. As with individual patients, the list of formulations for the family forms the basis for intervention, and will include predisposing, precipitating, perpetuating and protective issues.

When we work with families, the same broad 4Ps of management can be used, i.e. the pattern, problem, process and positive approaches.

Happy & Unhappy Families

As a generalization, we can say that we have happy and unhappy patients, and we can echo Tolstoy's observation that there are happy and unhappy families.

At one extreme, functional, "happy" families are characterized by a sense of integrity, caring, clear conviction of values, effective communication and negotiated decision making. Family members may be widely diverse, and are encouraged to achieve independence whilst remaining connected to the family. One important characteristic of happy families is adaptability.

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On the other hand, dysfunctional, "unhappy" families are characterized by chaos or rigidity, and either over-involvement in each other's lives, or lack of genuine involvement (Sturge-Apple et al, 2010). Personal values of family members may be adopted from authority figures or in opposition to authority, communication can lack effectiveness and decision making can be biased. It has been said that heads of unhappy families are unwilling or unable to adapt in the face of change.

When we follow our patients and their families over time, we realise that most families are fluctuating mixtures of happy and unhappy features. Every such family has its own strengths and vulnerabilities, and we can be effective in helping families capitalize on their strengths and dealing with their vulnerabilities in healthier ways.

Loss in the family

Over time, families change through members leaving the group through death, separation or relocation. The remaining family members need to reorganize the remaining structure. They will need to fill new roles and accept new responsibilities as relationships are modified. Most of us successfully adapt to these changes. Unfortunately, some losses result in dysfunctional consequences that may require therapy.

Helping the Patient and His Family

When we try to understand a family in terms of its struggles to be functional, we can better make the appropriate formulations and intervene meaningfully. Also, helping individuals from dysfunctional families recognize that there are healthier ways to respond to situations is sometimes the start of a more functional individual and family.

That said, we do not always engage the family, nor is every family that we engage a dysfunctional one. Our involvement with the patient may represent the full extent our interaction with him. This is especially so in a patient with a straightforward biomedical problem, for example, an acute back-sprain, for which he needs symptomatic treatment and rest. On the other hand, even in a straightforward biomedical case, it is useful to know that our patient with backache will have difficulty resting because he has to help to lift his invalid

father when he gets home. We may need to engage the family more, and engage more of the family, in managing a young woman with post-partum blues. Occasionally we may formally engage the whole family in a discussion about an older woman's declining cognition and need for institutional care.

To put it simply, we are better able to help our patient when we pay attention to his family.

The family in BIPT

The family perspective helps our patient recognize family relationship factors in his psychological ill-health. With this understanding, what we choose as the BIPT technique will depend on what is most appropriate, whether it be the pattern, problem, or process approach. In tandem with the other approaches, the positive approach will help the patient engage his family in healthier ways.

Family therapy

Family therapy is based on the idea that the patient is a symptom of family dysfunction and therapy is therefore directed at the whole family system. Treating the "diseased family" often requires specialized training and is to be distinguished from treating the "diseased patient in a family" and helping the family care for him. This book does not describe family therapy.

Key Points

- The individual and his family are closely related. We may need to understand the relationship before we can help our patient.

- The family is a complex system made up of multiple sub-systems. Looking at it from multiple perspectives will help us arrive at a better understanding of the family and its members.

- Most families are fluctuating mixtures of happy and unhappy features.

- When we help a patient from a dysfunctional family recognise that there are healthier ways to respond to situations, this is sometimes the start of a more functional individual and family.

References

Corey, G. (2012) *Theory and Practice of Counseling and Psychotherapy.* Wadsworth Publishing.

Gurman, A.S. and Messer S.B. (1995) Essential Psychotherapies . Guilford Press. Chapter 14.

Mahoney, J. M. (2003) *Constructive Psychotherapy: A Practical Guide.* Guilford Press. Chapter 3.

Yeo, A. (2006) *On Wings of Storm.* Armour Publishing.

Typologies of Family Functioning and Children's Adjustment During the Early School Years. Melissa L. Sturge-Apple, Patrick T. Davies and E. Mark Cummings. Child Development Volume 81, Issue 4, pages 1320–1335, July/August 2010

Chapter 10: **Putting It Together**

*...best when they can use both lenses, that is, the wide angle lens and zoom lens.
In other words, they are good in general medicine
but can narrow down their interests in a particular field.*

\- Lee Suan Yew,
Family physician and past president, Singapore Medical Council

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Introduction

We would like you to meet Dorothy.

This detailed discussion of her case will help to illustrate much of what has been described in the preceding chapters.

Extending Consultation to Counseling

One weekday morning, a young Chinese woman attended her family physician's clinic. Dorothy was 20 years old and a second year university undergraduate. She needed Dr. Lim to certify that she was medically unfit to sit her year-end examinations. It turned out that Dorothy had been cutting classes the whole year and had not been studying well, even though she had topped her class in her freshman year.

Dr. Lim knew Dorothy's family well. Her mother had attended on many occasions with various injuries. These had been inflicted by her husband, Dorothy's father, although her mother had always pretended that the injuries were accidental. In fact, two years ago, Dr. Lim had assisted Dorothy's mother in obtaining a personal protective order against her husband. This was when the physical abuse had escalated at a time when Dorothy's father's mistress had cheated him of his retirement money. Dorothy, with her older sister and her mother, had moved to a safe house for a period of time in order to avoid contact with her father. Soon after this, Dr. Lim had been summoned to the family home to find Dorothy's father with his wrist slashed in an apparent, unsuccessful suicide attempt. Both parents had reconciled after this event.

When she had been much younger, Dorothy had usually been brought to the clinic by the family's domestic helper. In recent times Dorothy had seldom visited, until this past year. Over the past year, however, Dorothy had attended frequently for various minor ailments, and each time had requested a medical certificate to excuse her absence from classes. This time, Dr. Lim informed Dorothy that he was prepared to assist her in her request to be allowed to sit the supplementary paper. However, he imposed the condition that she would attend his clinic weekly for counseling sessions. Dorothy had in fact been sent by her university authorities for counseling (to another counselor) for her frequent absences, but

she had not found the sessions helpful. Dorothy agreed to attend Dr. Lim's sessions in return for the medical certification.

Dr. Lim was able to obtain significant therapeutic materials from the first session, because an extended therapeutic relationship already existed between him and Dorothy. From his prior knowledge of the family and from what Dorothy related, he constructed genograms and time-lines, made a formulation of the relevant issues, and proceeded to use the problem approach and the pattern approach to counsel her.

As she worked with Dr. Lim, Dorothy was able to gain insight into her cognitive distortions and her ensuing negative automatic thoughts. She became aware that her family circumstances were causing her psychological state, and described her role as similar to that of "glue", trying to keep her parents together. She was taught to re-frame the "glue" metaphor, and re-authored her personal story to one where she was the oil instead of the glue in her parent's relationship, and re-lived it. This proved to be successful in restoring her to emotional stability and she was able to perform well at her supplementary examinations.
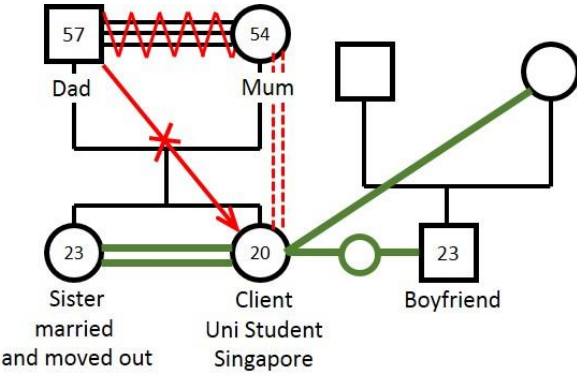
Genogram & Time-line
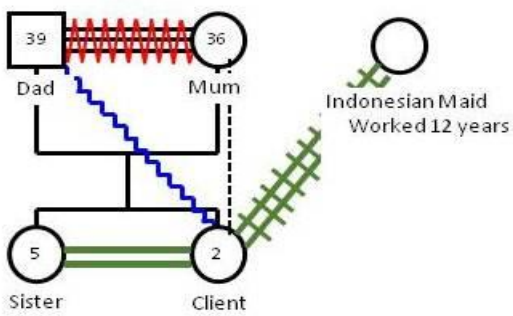
This is a time-line of recent events that led to a change in family dynamics which affected the 20-year-old Dorothy.

Dad retired at 55 years and withdrew his CPF money.	Acquired a young mistress from China.
Mistress impoverished dad before leaving him.	Escalating violence towards mum in attempts to get at the family savings.
Mum and children obtained protective order and moved to safe house.	Dad "attempted" suicide.
Dad reconciled with family and vowed to behave.	Mum still working and holding the purse strings; demanding time & attention from dad.
Elder sister married and moved out.	Only three left in the family, with weak / perverse executive sub-system.
Dorothy attempted to assume role of parental child to stop parents' bickering.	Unsuccessful attempt at being glue "blew her world asunder".

Table 10.1: Dorothy's Genogram & Time-line

Following are some statements that were made by Dorothy during the course of her sessions with Dr. Lim. They describe her significant childhood memories and give us an idea of her context, and also helped Dr. Lim to direct his deeper questions in a meaningful way.

Dorothy said that she was frightened by *"dad and his tantrums, when he came home drunk."* *"So I would hide under the bed in the special bed-sheet pocket sewn by [my maid]. [This is how] I learnt not to be afraid of dad."*

Of her mother: *"[Mum] does not care. She should not have gotten married."* Her mother was *"often absent; anxious."*

She described the physical abuse: *"[My sister] and I were forced to watch dad beat mum up"* because her mother had not obeyed her father's orders.

During a family holiday to Malacca, her father threw her sister out of the car, after her sister intervened in a quarrel between husband and wife.

Dorothy received nurturing, emotional affirmation and physical comfort from the family domestic helper from the age of two years. *"She just knew how to speak to us in our own different ways. For me – I used to be afraid; very shy; I would always hide and refuse to eat [when my parents quarreled]."*

She was close to her sister. *"I was laughing so hard in the afternoons with [my sister] and the maid until I couldn't breathe."*

She remembered the emotional pain she went through when the helper returned permanently to her home country.

Formulation

The above materials form the basis for the following list of formulations.

Formulation for Dorothy's Anger and School Failure

- Predisposing Factor: Violent, abusive father, who after losing his CPF money to his Chinese mistress, attempted suicide. He was subsequently reconciled to his estranged family but mother now assumed dominance.
- Precipitating Factor: Sister married and moved out of the family home. Dorothy was left alone and manipulated by her father into a coalition against her mother.
- Perpetuating Factor: Dorothy was frustrated in her self-appointed role as the parental child, attempting to be the "glue" between her parents to prevent the break-up of her family.
- Protective Factors: Her childhood domestic helper had been a nurturing proxy mother. She had current close emotional relationships with her boyfriend and her sister. She was also *psychologically minded* and therefore able to reflect and acquire insight with therapy.

Problem Approach

Reproduced here are two series of conversations that Dr. Lim had with Dorothy. They serve to illustrate how, by systematic questioning and CAR-ACE-ing the patient, Dr. Lim was able to elicit Dorothy's cognitive distortions and subsequently to suggest alternative thought patterns. This is an illustration of the problem approach.

For convenience, Dr. Lim is referred to as "T" (for therapist) and Dorothy as "C" (for client).

Situation 1: "THE OLD MAN IN CHINATOWN"

T: How has last week been? **[Open question]**

C: *Bad. My dad asked me to accompany him to Chinatown to give some Chinese New Year presents to an old man in Chinatown. I was furious. He is still with the China woman. The old man in Chinatown is a friend of the China woman.* **[Cognitive distortion of "jumping to conclusions" based on the word *China*. The father's Chinese mistress had precipitated a family crisis, one year ago.]**

T: How do you know that they are friends?

C: *He told the family during the discussion of his mistress, that he got to know the China woman through a guy in Chinatown.*

[CLARIFICATION]

T: Was the discussion recent?

C: *No, a year ago. Maybe my dad was not the one who mentioned it. I think it was my mother who told me.*

[Challenging the ASSUMPTION that she had heard her father telling them about this man.]

T: How did your mother know about the relationship?

C: *I do not know. I did not ask. But it is obvious – the old man must be the one who introduced him to his mistress. He could be the boss of a brothel or bar there.*

[RATIONALE or reason for the client's assumption. This is an example of the Socratic "vertical descent questioning" to identify the series of automatic thoughts.]

T: If there was this connection, why would your dad ask you to accompany him to visit the man?

C: *Don't know. Never thought about that.*

[Rational response to challenge NATs.]

T: Did you ask your father how he knew the old man?

C: *Yes, but I kind of do not believe him. He said that he was shopping for Chinese New Year goodies in Chinatown; was caught in a thunderstorm. This old man*

had an umbrella and sheltered him to his car. He was touched. He found out where he lived.

[Evoking ALTERNATIVES. Client disdained the positive thought that her father could indeed be touched by the gesture of this old man living in Chinatown.]

T: How could you find out if what your dad tells you is true?

C: *Go along with him.*

T: Yes, why not tell your dad that you would go along with him.

C: *Ok, will do.*

[Finding out the CONSEQUENCES or OUTCOME of pursuing alternatives. *In vivo* behavioral technique of experimentation and inquiry.]

Subsequently, Dorothy, her father and her mother (who asked to go along) visited the old man in Chinatown. The story of how her father had met the old man on the rainy day turned out to be true. This was related during her next session with Dr. Lim.

Dr. Lim went through Dorothy's thought record of the situation with her.

THOUGHT RECORD OF SITUATION OF "THE OLD MAN IN CHINATOWN"
Clarification of Situation
Dad asked me to accompany him to visit old man in Chinatown.
Assumptions & NAT in arising from cognitive distortions
Assumption: The old man is a friend of dad's Chinese mistress. NAT: Dad must be meeting his Chinese mistress again.
Thought: I believe it 100 %.
Feeling: I felt mad and sad (Scaled at 9 /10)
Rationale (Evidence) to support the above thought
He told the family during the discussion last year that he had met his mistress through a man in Chinatown. Maybe it was mum who said that.
Alternative thoughts to situation
1. When I asked him how he met the old man in Chinatown, he said that the old man had sheltered him with his umbrella to his car when he was caught in a downpour during his new year shopping. Dad said that he wanted to show gratitude to him when he was on his next shopping trip there. Maybe Dad loves the elderly and genuinely cares for them.
2. If the old man is really connected to the China mistress, why would dad ask me to accompany him to Chinatown?
3. What would you advise if your best friend were in your situation: Just go and find out.
4. What would you do now: I would go.
Consequences
Worst: If I do not accompany dad to visit the old man, dad thinks I am siding with mum.
Best: If I do go, I may make a new friend and dad and I can bond; spend time together.
Probable: At least I would know that my dad was not linking up again with the China mistress.
Experiencing after visit and finding no link between old man in Chinatown and the mistress
Negative thoughts about Dad: Scale 5/10
Negative Feelings: 3/10

Situation 2: **"MUM AND THE HAMSTERS"**

T: The hamsters belonged to your elder sister, who has moved to her own home. You mentioned that your sister's hamsters were displaying signs of severe boredom. How did you know?

C: *The hamsters were, like, very fidgety and not eating normally. I looked it up on the internet and it was obvious that they were suffering from boredom from the way they ran around. I told mum that she had to do something or they would die and Chieh (sister) would be upset. What mum did was really pitiful. All she did was coo to them in that shrill irritating voice of hers. I think the hamsters got worse.* **[Cognitive distortion of emotional thinking. Felt that mum was incompetent and then convinced herself that the hamsters were bored to justify her feeling]**

T: How did the hamsters' mental health become your mother's responsibility?

C: *She agreed to look after them. She is an adult and should ease their suffering. I am irritated that she is incapable of even caring for living things, never mind her children. [It's] like she could not care for us when we were young. The hamsters will suffer depression, starve and die. Chieh will be upset.* **[Cognitive distortion of over-exaggeration. Also must-abating extended statements of "should".]**

T: Did Chieh instruct your mum about the upkeep of the hamsters?

C: *Yes, about feeding them and cleaning the cage.*

T: Why not ask Chieh if there are additional things to watch for, to see whether her hamsters are bored and what to do?

C: *I asked her by SMS tonight but [it's] not much use as my mum is so incompetent. I lost my temper and scolded her for trying to act cute and not easing their suffering.*

T: So you scolded her because she is not taking care of the hamsters for Chieh. Why not tell Chieh to talk to mum directly?

C: *Ok, since they are not my hamsters anyway.*

T: What would happen to the hamsters if they just had food and hygienic conditions, even if they were bored? **[Testing consequences of NAT]**

C: *I don't know for sure.*

T: So on reviewing, you now see that there are some assumptions and negative automatic thoughts that you made. What is the intensity your belief and bad feelings now?

C: *Much less. But I still think mum is incompetent; [she] cannot relate to living things. My sister thinks so too. We think that mum and dad do things deliberately to harm us. We made a pact never to have children.*

T: If you continue to have the negative thoughts, you will continue to be angry. You can control how you feel towards it by testing your thoughts. Record such thoughts and bring it along every time you come.

C: *The irritating way she coos loudly in her shrill voice to the hamsters in front of me still irritates me. I think she is trying to show to me that she knows how to care, after my outburst that the hamsters would die because of her.* **[Cognitive distortion of personalization.]**

T: Ok, why not try an experiment. The next time she does this, go to your room, shut the door and see what happens.

C: *Ok.*

Dorothy reported during the next session that her mother behaved in the same way even when she (Dorothy) did not seem to be around. She felt that the behaviour was attention-seeking and pathetic, and found it irritating. However, she agreed that her mother's tone of voice and behavior were consistent with her mother's usual style, and that the "display" was not directed at Dorothy. She also agreed that the hamsters were thus far unharmed.

This is how the CAR-ACE framework was used in situations 1 and 2 in counseling Dorothy.

	Situation 1	Situation 2
Situation	Father wants Dorothy to accompany him to Chinatown to visit an old man.	The hamsters are displaying severe signs of boredom
Clarification (C)	She does not want to go as she thinks he is going to visit a friend of the Chinese mistress.	Sister married, moved out of family home and left the hamsters in her mother's care. Dorothy researches online and thinks they are displaying severe signs of boredom and are going to die.
Assumptions (A)	He is going to visit a friend of the Chinese mistress.	The hamsters are going to die if she does not do anything. It is mother's responsibility to care for the hamsters.
Rationale (R)	During a discussion, the father told her family that he had met his Chinese mistress in Chinatown.	Sister placed hamsters in mother's charge; mother is the only one who can handle them
Alternatives (A)	Dad loves the elderly and genuinely cares for them.	She feels that this is a reinforcement of her assumption that her mother is incapable of caring for living things.
Consequences (C)	Worst case: She will not accompany him. The father will break up the family. Best case: She will accompany him and befriend the old man.	Worst case: The hamsters will die; Dorothy and her sister will be angry at her mother. Best case: Hamsters will be alright and continue to live.
Experience (E)	Dorothy accompanied her father, who turned out be genuinely visiting an old man who was not related to any Chinese mistress in Chinatown.	The hamsters survived.

This is how the situations triggered negative automatic thoughts that led to the shift in emotion and the maladaptive behavior.

	Situation 1	Situation 2a	Situation 2b
Situation	Father asked her to accompany him to Chinatown to visit an old man.	Hamster perceived to be stressed.	Mother was cooing at hamsters in a weird way.
Automatic thoughts	He is going to visit a friend of his Chinese mistress.	Mother is irresponsible and incompetent to care for living things, including children.	She is attention seeking.
Meaning of automatic thoughts	He is going back to his mistress and will break up the family.	She fails as a mother.	She is not acting like an adult.
Emotions	Anger.	Anger and sadness.	Anguish and sadness.
Behavior	Not going to Chinatown with father.	Disapproval of mother's behavior.	Disapproval of mother's behavior.

After five sessions, Dr. Lim observed that Dorothy had gained insight into her issues, and invited Dorothy to reflect on the sessions and how they had changed her perspectives.

Dorothy said that in the first two sessions, she had felt even more agitated and had felt like *"wringing [Dr. Lim's] neck"*, as *"I was dying of thirst and you refused to give me water."* Instead, Dr. Lim kept challenging her with his extended inquiry questions. She learnt to look for water by exploring her negative automatic thoughts and her troublesome relationships with her parents.

This set the stage for the next phase of re-authoring her story.

Pattern Approach

The pattern approach focuses on listening to a person's stories in order to identify problematic patterns, and helping him to reframe and re-author new stories. The following section shows how Dr. Lim used pattern work to help Dorothy reframe her metaphor and re-author her story.

"FROM GLUE TO OIL"

Client (C): *I feel now that I am not really a factor [for the problems at home]. Now I see it as a war between my dad and my mum. My mum actually does it (her attention seeking behaviour) because she wants attention from my dad. My dad finds it super irritating. He raises the volume of the TV to shut her off. Mum will then come around to watch TV with him.* **[Insight into family conflict and how it affects her.]**

T: How are you involved in the war?

C: *I feel like I am their "glue".* **[Metaphor of glue]**

T: Why do you think that you are the glue?

C: *My dad will say, "If you are not home, I would not come home."*

T: Your dad is making you [the glue]. You should tell your father, "On the other hand, she is your wife and my mother. You should reconcile with your wife and not need me around." You need to express yourself as you cannot always be the glue unless you…

[Triangulation in the family. Dad attempts to recruit her against mum.]

C: *…stay at home and be part of the war.* **[Awareness of consequence of being the glue.]**

T: There are differences between them, just as there are differences between anybody. They should learn to reconcile them. You are the daughter of both mum and dad. How about your mum; did she ever tell you that?

C: *That if I am not home, she does not want to come home? No, she sort of survives on her own.*

T: So your dad tries to recruit you. What do you think about it now? **[Guided association using Socratic questioning technique.]**

C: *Honestly, I do not give a damn.*

T: Going beyond this, is there something more positive?

C: (pauses) *I do not know. He wants me around; at home.*

T: Why should that be the case?

C: *So that he does not quarrel with my mum.*

T: He has to handle that himself.

C: *I don't really get you.*

T: If he thinks that, and continues to think that, whenever there is a quarrel and you are not around, then you feel responsible.

C: *Say that again.*

T: If he thinks that, and you allow him to think that you are the glue (and you believe that), if you are not around and they quarrel, you will feel responsible. In the first session, you told me that you are worried that as your sister is not around, it falls on you to keep them together.

C*: Isn't that a psychological game?*

T: I would say it's an emotional bind. Some may even say blackmail, that "You have to do this, otherwise you are responsible." The truth is that …

C: *… because glue usually sticks.*

T: That is why the word glue is not good for you. If you are the glue and the glue is not around and something breaks, then you will feel responsible. **[Examining maladaptive consequences of the glue metaphor.]**

C: *That is right.*

T: That is why if you keep thinking this way, you will feel bad. You can't study and when you are around, you feel you must always play an active part to keep the peace.

C: *That's right, like keeping both of them involved. Even going to the supermarket, I have to run to my mum and then she will say, "Where is dad?" Then I have to run to my dad and then … okay, okay.*

[Caught in the mum-dad war and triangulated, she was in a constant state of anxiety, with occasional outbursts.]

T: Are you talking about now?

C: *Now, now.*

T: The role you now play is worth examining. The concept of the glue is not very useful as a metaphor. Glue means that you are responsible. Think of something else if you want to use a metaphor. Think of yourself as oil, a lubricant. When you are around, things go more smoothly. Sometimes like now, things are going smoothly and don't need oiling. There is no storm. You can be positive and add oil. **[Changing the metaphor (assumption) of role to a more useful one.]**

C: (nods in agreement) *Ok.*

T: For example, the next time if your dad ever brings up this matter, you could say something like "she is your wife too; you want me to stay a spinster all my life?" **[Use of paradox and humor in disputing.]**

C: (laughs) *Yeah.*

T: If you use a paradox like this, your dad may suddenly realize that he cannot demand it of you or else "my daughter would be a spinster and stay around all her life."

Dr. Lim's position as Dorothy's family physician and a familiar fatherly figure was important. He was able to leverage on this and extend the old comforting role into a challenging one. The detached doctor for her medical ailments became the collaborator, engaging her in exploring her problems and patterns, and helping her to re-author her problem saturated story by reframing it.

Systems Perspectives

It is useful to view Dorothy and her family through the filters described in Chapter 9. Some of the filters we can apply here include relationships, ordering processes in the family, self-identities and culture. In the paragraphs that follow, try to identify the different facets of Dorothy's family that are brought into prominence when we look through different filters.

Dr. Lim's involvement with the family was limited to his interactions with Dorothy. Her father was not brought in to the sessions because Dorothy said that her father had told her university counselors to *"fxxk off"* when they had requested his presence. Her mother, she said, was too uninterested to attend, and besides was working full-time.

Dorothy came from a dysfunctional but nevertheless stable family. Her mother had accepted the physical abuse, and over the years, the family had settled into a rigid structure of dominance and submission.

The family's domestic helper, who had acted as a surrogate mother to the young Dorothy, had protected and nurtured her. As a result, Dorothy had grown up in relative security and had not emerged from her childhood traumatized. Her older sister had also been a shield between Dorothy and the worst of the family squabbles.

In due time, this stable state was disrupted by a series of external events. There was the social phenomenon of young women coming to Singapore to seek their fortune. Her father retired and withdrew his CPF savings. These two events intersected when Dorothy's father took a young woman from China, whom he had met in Chinatown, as his mistress.

Following this, the physical violence escalated to such an extent that a personal protective order was obtained against Dorothy's father, for his wife and two daughters. The three women moved out of the family home to avoid contact with him. At around this time, the mistress absconded with the bulk of Dorothy's father's savings, leaving him impoverished and seeking reconciliation.

The family identity now underwent a dramatic change. Instead of father as abuser and mother as passive recipient in a fused-violent marriage, the relationship was now a hostile one, with the mother trying to approach the father, who now eschewed violence but also rejected his wife's advances.

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Dorothy's older sister, who had been a stabilizing factor in the family, got married and moved out.

Dorothy was left unable to cope with home and school.

Summary

A 20-year-old Chinese girl spent years in a dysfunctional family with a dominating, violent father and an abused, emotionally detached mother. She emerged from this chaos to a new order a year before we first meet her. The turning point was marked by escalating physical violence from her father who was then entangled with a mistress from China; he was next abandoned by the mistress, attempted suicide and subsequently negotiated a return to his by-then estranged family.

The post-crisis order was a fragile one. Her father, back in the family, was now disenfranchised, and actively sought to manipulate her into a coalition against her mother. Her mother was over-compensating for years of domination and abuse with clinging and demanding behavior. This new order was characterized by incessant bickering between her parents.

Dorothy's response was to attempt to become a "parental child" – essentially the parent to reconcile her two parents. Her unspoken hope was that by her peace-making acts, she would be the "glue" that would hold their marriage and relationship together. Over time, her frustrated attempts led to anxiety, which resulted in temper tantrums and failure at school.

Her home situation had dramatically worsened when her older sister moved out following her marriage. In fact, this had been the last straw that had tipped Dorothy over into her performance failure.

Fortunately for Dorothy, bleak as her childhood years were, her family had had a domestic helper who had been a nurturing proxy mother to her, and had provided stability and affection. In addition to this, Dorothy had over the years developed a close emotional relationship with her older sister. She was also fortunate to have a supportive, understanding boyfriend.

Acknowledgement

Names and details have been changed in the description presented here. Nevertheless the conversations are derived from a series of encounters in a family practice clinic and are supported by documentation.

Conclusion

We hope that this account has demonstrated how BIPT techniques can be usefully and satisfyingly employed in the family physician's consulting room.

A thousand mile journey begins with a single step. Perhaps the first step to effective counseling within our consultation is simply this: to realize that it can be done, and to actively cultivate the mindset that seeks to do it.

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Epilogue

Build a better mousetrap, and the whole world will beat a path to your door.

– (attributed to) Ralph Waldo Emerson 1803 – 1882

In this book, we have attempted to put together a simple introduction to a complex skill. This is an ambitious, necessary and herculean task. It is ambitious because complex skills do not lend themselves easily to ten chapters of a slim volume. On the other hand, it is necessary, as we have found BIPT to be doable and worth sharing. Finally, it is herculean because the approach draws inspiration from an entire other world of psychotherapy, and attempts to marry this with the world of clinical medicine.

Our task notwithstanding, the long journey to day's end is marked by dogged practice and honest reflection. We hope that we have challenged and inspired you to begin this journey to become a physician-counselor.

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Appendix

SREENIVASAN ORATION 2010

RE-DEFINING THE ART OF CONSULTATION

A/Prof Cheong Pak Yean

ABSTRACT

The re-defined Art of consultation, beyond clinical instinct and hospitality can be put into practice in three ways to complement the scientific approach. Firstly, the healing ambit of the doctor-patient relationship can be extended with better relating and inquiry skills. The doctor can extend his role from an expert to that of a collaborator, from comforting to challenging, and from being detached to being engaged. Secondly, the totality of idiographic and nomothetic data so gathered in this extended consultation can be abstracted as a formulation of issues related to the reason for encounter to complement the usual list of diagnoses. Thirdly, specific skills from psychotherapy can be learnt to augment the potency of "doctor as medicine".

Keywords: Art, Consultation, Idiographic, Formulation, Psychotherapy

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INTRODUCTION

I have not met the late Dr. B.R. Sreenivasan personally but have read about his distinguished public career as the Vice-chancellor of the University of Singapore, President of the College, President of the Singapore Medical Council and President of the Singapore Medical Association. The late Dr. Wong Heck Sing, another of the College founding fathers, told me that despite the high offices he held, he was at heart very much the passionate clinician practicing general medicine in the community. The theme of this Oration given in his memory would honor that passion.

Two paradigms come readily to mind whenever the Art of consultation in medicine is broached. The first is that of Art as "clinical instinct" and the other is that of Art as "hospitality".

The *Art of Consultation* was also the title chosen by Dr. G.F. Abercrombie for the 5th James Mackenzie lecture given in 1958 at the Royal College of General Practitioners (RCGP).[1] The Art in his view was akin to "clinical instinct" and he quoted from Dr. Mackenzie's book *The Future of Medicine* to define it. In 1923, Dr. Mackenzie wrote of *"the curious knowledge which some physicians & general practitioners acquire after many years' practice. The knowledge is undefinable, and they are unable to express the reasons in language sufficiently clear for the uninitiated to understand."* Art so defined is therefore the matured clinician's personal warehouse of heuristics from which mastery of practice emanates.

The second paradigm of the Art of Consultation is that of hospitality. There are many salubrious attributes of this paradigm about according patients kindness and respect more so when they are sick and suffering. However, trends of commercialization of healthcare pose a pernicious danger to morph the hallowed doctor-patient relationship to that of a provider-client relationship. Attributes like satisfying clients' wants and comfort and avoiding complaints from unhappy clients come to the forefront. Hospitality in such a relationship may then become just another commodity that is exchanged in the healthcare marketplace.

We need to move beyond these two paradigms of Art.

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OF SCIENCE & ART

The practice of medicine is both Art and Science. Science is taught but the Art is left to be caught with time.

Doctors are scientifically trained to gather salient facts from the patient's history, clinical examination and laboratory investigations. Based on the knowledge of diseases and the constellation of pertinent facts gathered, the patient is then assigned to one or more disease groups, each defined by shared characteristics. The management of the patient then proceeds from the established guidelines of how such groups are best managed. This is the basis of the practice of evidence-based medicine.

Some doctor-educators have cautioned the over-emphasis on this disease-oriented approach and its preoccupation with generating labels. Dr. Y. Pritham Raj wrote a satire in the Annals of Internal Medicine, Nov 2005 titled *Lessons from a Label Maker*.[2] He observed that medical students *"quickly learned that navigating the world of medicine required an ability to correctly identify and label medical disorders"* even when patients sometimes do not quite fit the requirements of the labels. He observed that inappropriate labels once adhered to *"left gummy marks that could not easily be removed."* The plethora of labels generated for a particular patient over time tends to obfuscate rather than clarify management of the whole patient.

A fixation on this scientific approach to consultation can inadvertently foster a culture of label-making and also fragmentation of care as disparate sub-specialists stake exclusive ownership of labels. At times, it can lead to medicalisation of social issues e.g. labelling usual sadness in life as depression.

A case has been made to re-define the Art beyond clinical instinct and hospitality that can complement the Science of consultation. Sir William Osler (1849-1919) exhorted doctors to *"care more particularly for the individual patient than for the special features of the disease."* Such a person-centered approach can be rooted in the Art of consultation to balance the disease-centered approach based on Science.

To understand this Art, we can revisit the two terms:

Nomothetic and *Idiographic*, first coined by the Kantian philosopher Wilhelm Windelband (1848-1915) to describe two distinct approaches to knowledge, each

one corresponding to a different intellectual tendency, and to a different branch of academe.

The Nomothetic approach is the tendency to generalize, to derive laws to explain objective phenomena in the natural sciences, and is used to assign disease labels to patients with shared characteristics. On the other hand, the Idiographic approach is the tendency to specify, as expressed in the humanities, to understand the meaning and qualia of subjective phenomena. This can be used to focus on the complexities and uniqueness of the individual and his/her bio-psychosocial environment. This latter approach has also been referred to as person-centered medicine or Narrative-based Medicine (NBM) for its focus on the individual and his/her story. The former, disease-centered or Evidence-based Medicine (EBM) focuses on diseases and its scientific evidences.[3]

We need both approaches to manage the whole person (Figure 1). Albert Einstein (1879-1955) was reputed to have said, *"Not everything that can be counted counts, and not everything that counts can be counted."*

The challenge in the Art of consultation as a humanistic discipline is to seek understanding of how and what may be the varied issues confronting the individual. The issues can range from the obvious to an amalgam of psycho-social factors enmeshed with bio-medical diseases. Rigorous training in eliciting salient qualitative data, integrating the data and its interpretation in context, are skills needed in the Art. New perspectives to training and practice are needed so that the validity of such interpretations is anchored on the reliability of the data obtained and the plausibility, the "hows" to explain the problems in that individual. This is in contradistinction to the "whys" as ferreted out by reproducible evidences using the scientific method.

Figure 1: The Art & Science of Consultation

Art (Idiographic Approach)	Science (Nomothetic Approach)
Person-centered Medicine Narrative-based Medicine (NBM)	Disease-centered Medicine Evidence-based Medicine (EBM)
Specify - focuses on complexities and uniqueness of individuals	Generalize - assigns patients with shared characteristics to groups with labels
Validity judged by reliability of data gathered & plausibility of explanation	Validity in group can be tested by scientific method based on evidences
Seeks understanding of the "how" and "what" reasons for problems	Seeks explanation of the "why" - causes of the diseases
Management based on person's unique story or narratives	Management based on EBM Guidelines of the labeled group

ART RE-DEFINED

In this Oration, three perspectives of the re-defined Art are examined. The first is an extended doctor-patient relationship requiring wider relating and inquiring skills. The second is Art as the added mental discipline to arrive at an explicit formulation of the reason for encounter (RFE) in addition to diagnoses. The third is Art as the special skills that can be learnt from psychotherapy to augment the potency of "doctor as medicine".

1. Art as the extended Doctor-Patient relationship

In practising the Art in consultation, there is a need to navigate between the dual roles of the doctor as expert and as collaborator, the stance of being detached and engaged, and also the comforting and empathic challenging of the status quo. Negotiating this new compact requires attention to clinical skills of relating and inquiry.

Doctor as both expert and collaborator

Traditionally, the doctor takes on the role of an expert in the healing relationship. Sir James Mackenzie advised doctors a century ago that *"when the patient and physician come first together, it often happens that there is an unconscious struggle who is to be dominant. Many patients come full of ideas as to the nature and cause of their sensations and eager to impart their own opinions. Or they come with a bundle of notes, which they insist on reading. This must be quietly and firmly repressed. The story of their life must be reserved until the examination is finished and their replies must be limited to the sense of the question asked."*[4] The practice milieu has not changed. The inquisitive and assertive patient is not born with the advent of the Internet age.

However, with the increasing burden of chronic diseases and problems of functional impairment with longevity, Dr. Daniel Sands pointed out at an American Academy of Family Physicians meeting in October 2010 that "participatory medicine" does improve healthcare for both patients and physicians. *"Doctors need to let go and admit they don't know everything. From the patients' standpoint, patients have to be comfortable taking more ownership and getting more engaged in their own care. Patients have to know that healthcare is not a spectator sport."*[5] There is thus a need for doctors to be both expert and collaborator, the patient to be both patient and participant.

Detached and engaged

A consultation is a dynamic meeting of the mind and heart of the doctor and the patient for therapeutic purposes. Most times, doctors present a congenial persona but maintain varying emotional distance from their patients. Internally however, doctors should be aware of parallel processes at work. The first is the logical mind involved in nomothetic work and the other the intuitive mind in idiographic work. Both processes are not mutually exclusive. Clinical judgment at times arises from what is called valuing (emotional judgment) when only a certain subset of possible actions are considered because of unconscious emotions at work.

Patients also need to be emotionally engaged to be affirmed. Affirmation may be direct, indirect or self-affirmation. Doctors can overtly affirm their patients, directly or indirectly. In a collaborative relationship, the doctor can also seed

recursive affirmation by the patient himself or herself by inviting the patient's perspective of how a positive unique outcome happened.

Empathy can be expressed in language or socio-symbolic gestures. A simple contextual statement like *"That must be difficult/ heart-breaking/ painful,"* at an emotionally pregnant moment in time can be cathartic. At other times, the doctor's empathy is the unspoken mirroring of the patient's feelings in the flow of the consultation. It is a continuing challenge for those doctors burned out with heavy workload and besieged with the pain and suffering of their patients to remain congruent, genuine and positive. Peer support such as a Balint group is important to preserve these qualia.

Comforting and Emphatic Challenging

Comforting the patient always is the centerpiece of the famous aphorism of Ambroise Paré (1510-1590) *"to cure sometimes, to relieve often, and to comfort always."* However at times, patients need to be emphatically challenged instead of being comforted.

Emphatic challenge is an Art in consultation that can move the patient from an entrenched position, for example, a lack of motivation to stop smoking, to one that is more adaptive. The challenge need not be aggressive as in confrontation and should be issued at an appropriate time and setting. This can be presented as an invitation to stretch the possibilities in an affirmation of faith in the relationship concurrent with support to move on with life.

Relating Skills

Negotiating the new compact described above requires attention to the clinical skills of relating. The late Michael Mahoney, a pioneer constructive psychotherapist wrote that *"we are born in relationship and it is in relationship that we most extensively live and learn."*[6] He further observed that *"our language lacks words to convey adequately our social and symbolic embeddedness"* and stressed the importance of cultivating *"the art of being humanly present to another person"* in the here and now, in words, actions and spirit - being here and not there.

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A systems view can also be taken of the doctor-patient dyad. The terms *transference* and *counter-transference* of the doctor and the patient are legacies of Freudian psychoanalytic traditions, and are best avoided as these terms may be enmeshed with the deterministic tenets of primordial instincts and needs. Dr. Eric Berne's Parent-Adult-Child (PAC) model of Transactional Analysis is easily understood. Dr. Jeffrey Young, the innovator of Schema Therapy, uses a more sophisticated model of schema interplay.[7] However, these models too are nomothetic.

Useful in negotiating this compact is exploring the idiographic precepts of "Ideas, Concerns, and Expectations" (I.C.E.). It must be emphasized that the doctor and the patient each have I.C.E. of a clinical situation. It is useful to explicitly understand each component and its interplay within the individual and interactivity within the dyad. The doctor can then decide to go for congruence, to roll with resistance or to accept the discordance so long as the therapeutic outcome is achieved.

Inquiry Skills

Negotiating the new compact also requires attention to clinical skills of inquiry. Dr. Michael Balint, who was renowned for his reflective "Balint groups" for doctors cautioned that *"if the doctor asks questions in the manner of medical history-taking, he will always get answers – but hardly anything more."*[8]

Many medical students first learn medicine by rote-learning sets of leading questions that are often asked in response to specific presenting symptoms or scenarios. They then imbibe the hypothetical deductive diagnosis model and so in consultation shuffle from one set of closed questions to another in search of associative diagnostic labels. Such an exercise may be expedient but not always effective. Important data that bear on management may be missed. Open questioning and active listening skills must be incorporated.

Two psychologists Joe Luft and Harry Ingham researching human personality at the University of California in the 1950's developed the so-called "Johari Window Model" to understand the human mind (Figure 2). An open question/gesture is one that when cognitively processed by the listener may not just elicit a direct associative response but generates in him or her contextual questions or emotions that allows for expression from the patient's blind, hidden

or even unknown windows. Although formal psychotherapy training hones the art of accessing these windows, doctors do intuitively acquire such skills from experience. Incorporating simple psychotherapy frameworks to link these rudimentary acquired skills are enabling.

An example of such a framework to facilitate open inquiry based on Socratic questioning technique is proposed (Figure 3). Many doctors start and also stop at clarification of symptoms. They clarify about the length (time relationship), breadth (relatedness and context) and sometimes the depth (severity, emotions, cognition, and spirituality). To open the Johari Windows wider, doctors may continue to probe into the assumptions the patients hold and the rationale (evidences) for them. With some training, doctors can "A.C.E." the inquiry by also exploring the Alternatives and possibilities, the Consequences of each expressed thought/scenario and also the Experience(s) that arise therein. The doctor can actively seed, facilitate and sense such disclosures and elaboration of thoughts, feelings and beliefs.

Many doctors face difficulty in using this open inquiry system as they are acculturated as experts to use directive and prescriptive language. It is more potent to allow the patient to arrive at that same viewpoint by astute but respectful questioning rather than inserting the same viewpoint into them. This would require doctors to be more patient and reflective in the collaborative and not the expert mode. For sure, it could only be judiciously used, as time is a scarce resource in a consultation.

Figure 2: The Johari windows in doctor-patient consultation
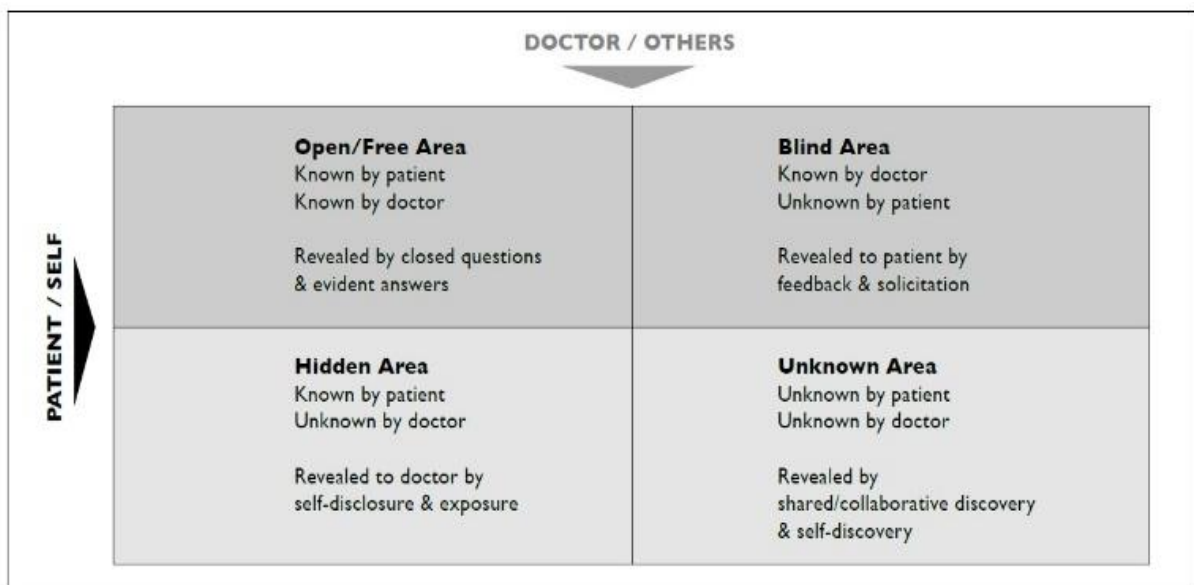
Figure 3: Techniques of open inquiry inviting self-generation of questions & contextual answers

Clarification	Alternatives/Possibilities
Length: Time-line, period Breadth: Relation to people, situation, environ, culture, beliefs Depth: feelings, thoughts, actions, interoception and scaling	Viewpoints: What may be another way to look at this? Confrontation: Are you implying that? Likelihood that?
Assumptions	**Consequences**
What have you assumed? What can be assumed instead?	Can we generalize? Outcome of each alternative Is result better/worse?
Rationale/Evidence	**Experience**
How do you know? To be correct, true, valid	Circular inquiry of question-on-question & experience-on-experience

2. Art as Formulation of issues of Reason for Encounter (RFE)

Art is needed as the added mental discipline to arrive at an explicit formulation for the RFE in addition to the diagnosis. In the disease-centered approach, the focus is on gathering evidences to arrive at nomothetic diagnoses. In the person-centered approach on the other hand, the focus is on conceptualizing the salient bio-psycho-social issues into an idiographic narrative. Visual tools can be used to provide insight. The connectedness of family and significant others and their emotional bonds can be drawn as genograms. A time-line of significant life and medical events, work-life rites and putative stages of bio-psycho-social development can be charted.

The analogy of using various lenses to provide perspectives can be employed to make sense of the admixture of idiographic and nomothetic data so gathered. Expanding on his 1995 Sreenivasan oration *Dare to Dream*, Past President of College, Dr. Lee Suan Yew commented in a 2004 interview that *"GPs/ Family Physicians are best when they can use both lenses, that is, the wide-angle lens*

and zoom lens" in managing patients.[9] The wide-angle lenses provide the panoramic vista of breadth and linkages while the zoom lenses focus in and out to provide contextual substance and depth.

The doctor could then arrive at a formulation relating to the presenting problem structured as succinct statements (narratives that can be remembered as the 4Ps) as to what may have predisposed, precipitated, perpetuated the problem and also what could have protected it from getting worse. Most doctors do have tacit narratives of their patients. However, conceptualized as statements, the "4Ps" formulation can be used together with the list of diagnoses, impairments, disabilities and handicaps of that patient to provide an integrative view for management (Figure 4). At other consultations where no definite diagnosis can be arrived at, the formulation per se can be used as the basis to manage the patient. There is no need to assign a label when there is inadequate evidence or when it is not useful to prematurely assign one.

Figure 4: Bio-psycho-social Formulation of RFE & Diagnoses

Formulation of Reason for Encounter (RFE)	Diagnoses List
Predisposing Factors	Diseases
Precipitating Factors	Impairments
Perpetuating Factors	Disabilities
Protective Factors	Handicaps

3. Art as augmentation of "doctor as medicine"

The third perspective of Art is the special skills that can be learnt from psychotherapy to augment the potency of "doctor as medicine". Dr. Michael Balint is best remembered for his famous aphorism *"the doctor himself/herself is a powerful medication."* Lessons from psychotherapy can be integrated into the art of consultation to augment this potency

Various doctors have introduced elements of psychotherapy into the medical consultation. Stuart and Lieberman's BATHE counselling method prompts the doctor to find out about the Background, the Affect, what is exactly Troubling the patient, how he/she is Handling it and then Empathizing with the patient's

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predicament.[10] Dr. Roger Neighbour believes that there is an "Inner Consultation" in the doctor's mind between two "heads" he called the intellectual Organiser & the intuitive Responder. These two heads consult in parallel to the external doctor-patient encounter.[11]

Translating skills learnt from psychotherapy, an interest group (Prof Kua EH, Cheong PY, Goh LG, Voon and Wee ST) from the National University of Singapore has developed a program called Brief Integrative Psychological Therapy (BIPT) to teach the application of basic psychological skills to help understand and formulate interventions to the life struggles of patients.[12] Viewing the encounter from a trans-theoretical stance, we proposed four areas of intervention (4Ps) viz. Problem Work, Pattern Work, Process Work and Positive Work to achieve psychological balance.

Briefly, Problem Work covers two areas - problem-solving skills and Cognitive Behavioral Therapy (CBT) skills. As to CBT, the principles of behavioral interventions are counter-conditioning (Pavlov and Wolpe) and contingency management (Skinner). Cognitive work involves the identification of negative automatic thoughts (NATs) arising from cognitive distortions (Beck and Ellis) and disputing them (Figure 5). These interventions can be used in diverse clinical situations such as addiction management, engendering health-seeking behavior and ensuring continuing care.

Pattern Work deals with the Problem Saturated Stories (PSS) held by patients that impede healing. Narrative Therapy tools pioneered by Epston and White can be used collaboratively to re-author, re-member, re-frame such PSS and after re-construction into Preferred Positive Stories (PPS) re-tell them.[13] Solution talk techniques developed by Shazer and Kim Berg can also be very useful to elicit unique positive outcomes to create the positive present and future story[14] (Figure 6).

Process Work deals with psychological processes of mindfulness and polarities. Mindfulness anchors the person on the here-and-now, free from burdens of the past and anxieties for the future, and on the present without judgment or expectation. Work on polarities deals with awareness of the disparate and detached parts of self which need to be owned and managed.[15]

Positive Work anchors on the work of Positive Psychology (Seligman and Csikszentmuhalyi) which *at the subjective level is about valued subjective*

experiences of well-being, contentment, satisfaction in the past, hope for the future, and flow and happiness in the present.''[16]

Figure 5: Behavorial & cognitive principles of problem work

Counter-Conditioning	Contingency Management	Cognitive Therapy
A→B: Antecedent-Behavior	A→ B→ C (Consequence)	A →Belief→ B →C Disputing
Stimuli (Antecedent) Control Assertive Response (Behavior)	Behavior arising from antecedent strengthened or weakened contingent on consequence.	Negative Automatic Thoughts (NATs) from cognitive distortions. (Beliefs) pop up in response to A (situation).
Systematic Desensitization: graduated incremental stimulus (starting small) to overcome avoidance reaction	Behavior strengthened if add positive or remove negative consequence.	Identifying and Disputing NATs to weaken maladaptive behavior in response to antecedent (situation).
Reciprocal inhibition: Pairing stimulus that produced contradictory response with the original stimulus, thereby weakening response to original stimulus	Behavior weakened if add negative or remove positive consequence. Operant (Skinnerian) Conditioning.	Inquiry skills from Socratic questioning are used viz. Clarification, Assumption, Rationale, Alternative, Consequence & Experience. (C.A.R. A.C.E.).

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Figure 6: Narrative therapies in pattern work (after Epston-white and Shazer-kim Berg

Narrative Therapy	Solution-focused Therapy
Problems because individuals construct meaning of life in Problem Saturated Story (PSS)	Solutions may have no direct relation with problems.
Replace PSS with co-constructed Preferred Positive Story (PPS)	Co-create present and future story by shifting focus from problem to solution.
Externalize, Elicit unique outcomes, co-construct preferred story by Four R's of Re-author, Re-member, Re-frame, & Re-tell.	Elicit Exceptions, go for small changes, scale, amplify & repeat.

Doctors can additionally learn "externalization" talk to metaphorically excise embedded problems, externalize them as transitional objects and then subject them to the collaborative attention of the healing doctor-patient dyad. For example, Mr. Tan who is diagnosed with cancer, should never be referred to as the cancer patient and the disease should not be referred to as *"your cancer"* to embed it. Avoiding such "totalizing" language, Mr. Tan's problem should just be referred to as having a problem of cancer now being treated. Externalized, Mr. Tan's problem now has a separate identity. It is now subjectified and detached psychologically from his body so that the focus is not on Mr. Tan's self but the "thing" by whatever name the doctor and patient choose to call it. This psychotherapeutic sleight of hand is useful.

Although in-depth psychotherapy training is needed to hone more complex skills, many psychotherapy interventions are intuitive and doctors with good people-handling skills and clinical presence can learn and apply the skills through brief training to this aspect of the Art of consultation.

CONCLUSIONS

In conclusion, the re-defined Art of consultation beyond clinical instinct and hospitality can be put into practice in three ways:

(1) The healing ambit of the doctor-patient relationship can be extended with better relating and inquiry skills. The doctor can extend his role from an expert to that of a collaborator, from comforting to challenging and from being detached to being engaged;

(2) The totality of idiographic and nomothetic data gathered can then be abstracted as a formulation of issues of the RFE to complement the usual list of diagnoses for holistic management; and

(3) Specific skills from psychotherapy can be learnt to augment the potency of "doctor as medicine".

Even though I have not met the late Dr. B.R. Sreenivasan personally, I believe that he would agree with this humanistic exposition of the Art of Consultation. Another President of our College, the late Dr. Koh Eng Kheng wrote in Dr. Sreenivasan's obituary (August 1977) that "He was a scholar in every sense of the word and his knowledge of the classics was greatly to be admired. His love of Shakespeare made him the complete physician." We would be honouring his memory by practicing medicine as both Art and Science in that tradition.[17]

References

1. Abercrombie GF. The Art of Consultation. J Coll. Gen. Pract 1959 February; 2:5.

2. Pritham RY. Lessons from a Label Maker. Ann Intern Med 2005 November; 143: 686-7.

3. Charon RJ. Narrative Medicine: A Model for Empathy, Reflection, Profession, and Trust. JAMA 2001; 286:1897-902.

4. Mackenzie J. Principles of diagnosis and treatment in heart affections. London: Henry Frowde, Hodder & Stoughton, 1916:93.

5. Sands D. Illness in the Electronic Age -- How Participatory Medicine Improves Healthcare: An Expert Interview. Medscape (WebMD) 30 Sept 2010

http://www.medscape.com/viewarticle/729706. [Cited: 11 Nov 2010.]

6. Mahoney M. Constructive Psychotherapy - A Practical Guide. In: New York: Guilford Press, 2003: 7. ISBN 1-57230-902-4.

7. Young JE. Schema Therapy A practitioner's guide. In: New York: Guildford Press, 2003: 177-206.

8. Balint M. The doctor, his Patient and the Illness. In:London: Churchill Livingston, 1957.

9. Lee SY. Dare to Dream II. The College Mirror 2004 March; 30:6-8.

10. Lieberman JA, Stuart MR. The BATHE Method: Incorporating Counseling and Psychotherapy Into the Everyday Management of Patients. J Clin Psychiatry 1999 April; 1:358.

11. Neighbour R.The Inner Consultation. London: LibraPharm Ltd, 1996: 56-8.

12. Cheong PY, Goh LG. Developing an Undefeated Mind - Tools for mental resilence. The College Mirror 2009 June; 35(2):18-21.

13. Morgan A. What is narrative therapy? Dulwich Centre. [Online]

http://www.dulwichcentre.com.au/what-is-narrative-therapy.html. [Accessed 12 Nov 2010]

14. Kim Berg DJ. Interviewing for Solutions. Belmont CA: Thomson Brookes/Cole, 2008. ISBN 978-0-495-11588-5.

15. Kua EH, Wee ST. Mindfulness and meditation – a study in Singapore. Poster presentation. 14th Scientific Meeting of the Pacific Rim College of Psychiatrists, Brisbane. 26-28 October 2010.

16. Seligman M, Csikszentmihalyi M. Positive Psychology – an Introduction. American Psychologist 2000 Jan; 55 (1): 5-14.

17. Koh EK. Obituary BR Sreenivasan. J Coll. Gen. Pract 1977 August: 510.

Glossary

Chapter 1

Therapist – In this book, the term *therapist* refers to a trained mental health professional that is trained to interact with a client in order to explore his thoughts, feelings and behavior. The purpose of the therapist-client interactions is to solve a problem or to achieve a higher level of functioning. The therapist can be a psychiatrist, psychologist, a licensed counselor, a physician with training in therapy, or a social worker.

Chapter 2

Reductionism – This is a philosophy that states that a complex system is the sum of its individual parts, and therefore the complex entity can be studied and understood if we focus on the individual parts and their interactions with each other. Simply put, reductionism states that an organism is the sum of its parts.

Emergence – In philosophy, this term refers to the process in an organism, whereby new patterns and entities arise from the interaction of the organism's smaller component entities. The new patterns are not however manifested by the smaller component entities. For e.g., a person's psychological processes such as thought, reflection, and feelings, which arise from the interaction of his neurological sub-systems such as his sensory, autonomic, motor systems etc. Emergence states that the organism is greater than the sum of its parts.

Paradigm – In discussions of knowledge and how we approach it, paradigm refers to a distinct concept or pattern of thinking, about how something should be done. Evidence-based medicine is a way, or paradigm, of providing medical care based on a disciplined application of the best available knowledge about a condition.

Hierarchy – is the arrangement of a number of items in such a way that some items are grouped above, below or at the level of the others, in a fixed relationship.

The next four terms are described as they were defined by Michael Mahoney (1946-2006). Dr. Mahoney was an influential pioneer of constructive psychotherapy.

Reality – this is defined as the perceptual constancies that we experience.

Self – this refers to the consciousness that we have, of our identity and being.

Value-ing– this refers to the emotional judgment that we make about something.

Potency – this refers to our power to survive and to thrive.

Chapter 3

Socratic Method – refers to a method of inquiry and discussion between individuals that is aimed at fostering critical thinking. It is named after the famous ancient Greek teacher-philosopher, Socrates. A Socratic style of questioning refers to an emphasis on examining the student's (or in BIPT, the patient's) assumptions and beliefs around an issue, so as to move towards more rational thinking.

Chapter 4

Eclecticism – The word *eclectic* comes from the Greek and means "to choose out". Hence, eclecticism in psychotherapy refers to the therapist's willingness to use ideas from more than one school of psychology, i.e. to "choose out" the best ideas and to apply them to his client.

Chapter 6

Cognitive Distortion – Simply put, a cognitive distortion is an inaccurate thought. It refers to the wrong interpretation that we make, of a set of facts that we are presented with.

*Negative automatic thought*s – this is a form of cognitive distortion, whereby our mind constructs *negative* interpretations of what we *think* is happening to us.

They are *automatic* in the sense that these negative interpretations happen without our conscious decision and deliberation.

Adaptive – Adaptive behavior is useful behavior that helps us to adjust to a situation. Complying with school regulations is an example of adaptive behavior.

Maladaptive – Maladaptive behavior, on the other hand, is behavior that results in us not adjusting appropriately to the environment or situation. To wilfully disobey the teacher and incur his wrath is clearly maladaptive.

Antecedent – this word refers to something that happens before something else.

Classical conditioning – This is a kind of learning where a new behavior is learned via association. The classic example is Pavlov's dogs, which were taught to salivate at the sound of the bell because the bell was struck whenever the dogs were fed. The new behavior was that of salivating to the sound of the bell.

Operant conditioning – This is another kind of learning where behavior is modified by what happens before the behavior as well as what happens after. Unlike classical conditioning, which deals with the stimulus, operant conditioning uses reinforcements and punishments to change behavior.

Classical and operant conditioning theories are two major categories in learning theories, which attempt to describe how an organism learns. They deal with the learning of behaviors.

Chapter 7

Guided imagery – This is a program of directed thoughts and suggestions to *guide* a person towards a relaxed, focused state. The therapist offers a series of *imagery* suggestions, typically in a one-on-one setting but sometimes also in a group situation.

Humanistic psychology – This is a perspective that holds that people are inherently good, and it gives emphasis to the concepts of free will, personal creativity, wholeness, potential, choices and growth. It is the perspective that underpins much of "modern" education practices and training methodology. Humanistic *therapies* are built upon this perspective.

Existential therapy – This is a form of psychotherapy that is built on the belief that our inner conflicts arise from our confronting the meaning of our lives and existence. The technique focuses on the person as a unique individual and on the choices that shape his life.

Awareness, or *Gestalt therapy* – This is a technique that focuses on perceiving, feeling and acting of experiences, as opposed to interpreting and re-interpreting of attitudes. The emphasis is more on what is happening, or the process, than on what is being discussed, or the content, and the therapist's aim is to help his client develop awareness, or insight.

Self-actualization – Simply put, this term means to realize one's full potential. It sits at the peak of Maslow's hierarchy of needs and he identified several characteristics of self-actualized people, for e.g., self-acceptance and realistic self-perception, spontaneity and openness, personal responsibility and ethics, and a continual sense of wonder.

Hypnotherapy – This is a form of psychotherapy used to direct a subconscious change in a client in the form of new responses, new thoughts, feelings or behavior. It is undertaken with the client in a state of *hypnosis*, which is a psychological state similar to sleep but with the client in a state of heightened awareness and increased suggestibility. This form of therapy has been applied to management of anxiety and stress, weight control and addictive behaviors, among other examples.

Client – In psychotherapy parlance, the client is the person that the therapist works with, much like the patient is the person the physician works with.

Chapter 10

Psychological mindedness – This refers to the quality that a person has, of being willing to reflect on his internal and external experiences and being able to recognize meaning beyond superficial appearances. To put it very simplistically, it is the quality that we mean when we say a person has insight.

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Italics in this index indicate a word or term that appears in the Glossary.

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About the course

The book provides awareness. Join us for the course. Learn how to engage your patients in a deeper way. Test out your skills in the consultation room. Bring back your challenging encounters. Enjoy a richer perspective!

Concepts of BIPT have been used in training courses for professional and student counselors. BIPT is now primed to help doctors re-examine their practice in the light of time constraint, cultural orientation and what is workable.

Course objectives
▪ To introduce formulation and counseling concepts to medical practitioners
▪ To develop practical skills for brief counseling in the medical consultation

Who should attend?
Doctors, counsellors and healthcare professionals

Who should I contact to find out more about the course?
For enquiries regarding the courses, email: specialistmedicalclinic@gmail.com

COURSE FORMAT
Pre-course directed study

Course Module I:
Extended roles, relating & inquiry, genograms & time-line, to formulations. Devising an integrative bio-psychosocial plan.

Course Module II:
Pattern & Problem Approaches - defining life stories, developing adaptive responses to situations.

Clinical applications in own practice

Course Module III:
Process & Positive Approaches – in the HERE & NOW, positivity work.

Course Module IV:
Clinical supervision in small groups & presentation of own cases.

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- Counter-Conditioning
- Contingency Management
- Cognitive Restructuring

Process Approach
- Mindfulness of Now
- Experiencing of Here

Positive Approach
- Pleasant Life
- Engaged Life
- Meaningful Life

Sometimes what a doctor offers his patient is not a pill but his presence.

Counseling Within the Consultation describes a framework by which a busy physician can use the short consultation to address his patient's problems of living in addition to his physical problems.