Effective Psychological Interventions

In Primary Care

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Dr Tan is an Australian-registered clinical psychologist who holds a professional doctorate in clinical psychology. He has worked extensively in the mental health, forensic and healthcare field in Singapore and Sydney. He has provided psychological assessment and psychotherapy for persons with various mental illnesses, persons with dementia as well as for persons suffering from health-related issues e.g. chronic pain, sleep, HIV, and Irritable Bowel Syndrome. Dr Tan is also experienced in developing community mental health programmes. He has a special interest in Person-Centred and Experiential Psychotherapy.

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Dr Tan is an Australian-registered clinical psychologist who holds a professional doctorate in clinical psychology. He has worked extensively in the mental health and healthcare field in Singapore and Australia for about 10 years. He has provided psychological assessment and psychotherapy for persons with mental illnesses spanning from anxiety disorders to personality disorders, as well as for persons suffering from health issues e.g. chronic pain, sleep, cardiac problems, diabetes, and renal failure. Dr Tan is also experienced in developing community mental health programmes.

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Yang Chek has been in the nursing profession for the past forty years. She was from the pioneer batch of graduates with the Master of Nursing Degree conferred by the National University of Singapore in 2006. Besides being registered as an Advanced Practice Nurse in Mental Health, she was also a certified substance abuse and gambling counsellor. She has many years of experience in psychiatric nursing in various areas, including subspecialties such as forensic psychiatry and addiction medicine. She also provides training for nurses, doctors, other health care professionals and community volunteers.

Foreword

"Congratulations to Dr Peh and his team of trainers for getting into print, this handy book on effective psychological interventions. The authors have decided to focus on intervention strategies as the primary thrust of this book. The knowledge and application of skills in the preceding steps of case assessment and formulation in the reader is assumed.

The intended readership of this book is primary healthcare providers and this book will be of use to many – family doctors, nurses, and allied health professionals. The latter will include psychologists, physiotherapists, occupational therapists, speech therapists, and dieticians.

I am told that this book will be a companion information resource to the skills training modules on psychological interventions that Dr Peh and his team will be conducting in the coming year for primary care professionals. Nothing beats having a book to refer to catch up on details after the day's training is over.

In this book is the survival guide on techniques to promote behaviour change, cognitive change, mindfulness, relaxation, and very importantly, good sleep."

Associate Professor GOH Lee Gan
[BBM, MBBS (Singapore), MMED (Internal Medicine), FCFP(Singapore), FRCGP, FRACGP, Fellow Wonca]
Professorial Fellow, Division of Family Medicine, Department of Medicine, National University Health System, Singapore
8 October 2015

A/Prof Goh passionately believes that family doctors should develop to the best of their capability, and over the last two decades has contributed actively to the development of Family Medicine in Singapore. He is co-author of the book "Counselling Within the Consultation: Brief Integrative Personal Therapy".

Acknowledgements

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Special thanks go to Mr Ian Shen, Executive, and Ms Karen Kan, Senior Manager, EHA, for the layout and administrative assistance in the production of this book. Thanks also to Dr Tan Wee Chong and Dr Tan Wee Hong for the graphics used in this book, as well as to Dr Andrew Peh for use of the photographs of his paintings. We also wish to thank Dr Wee Moi Kim and Ms Lina Farhana Binte Rosle for their help in proofreading.

The description of the psychological interventions in this book has been adapted from various clinical handbooks. In particular, we wish to acknowledge the contributions from the following:

- David Mee-Lee, M.D. (2005). Motivational Interviewing: Helping People Change. The Change Company.
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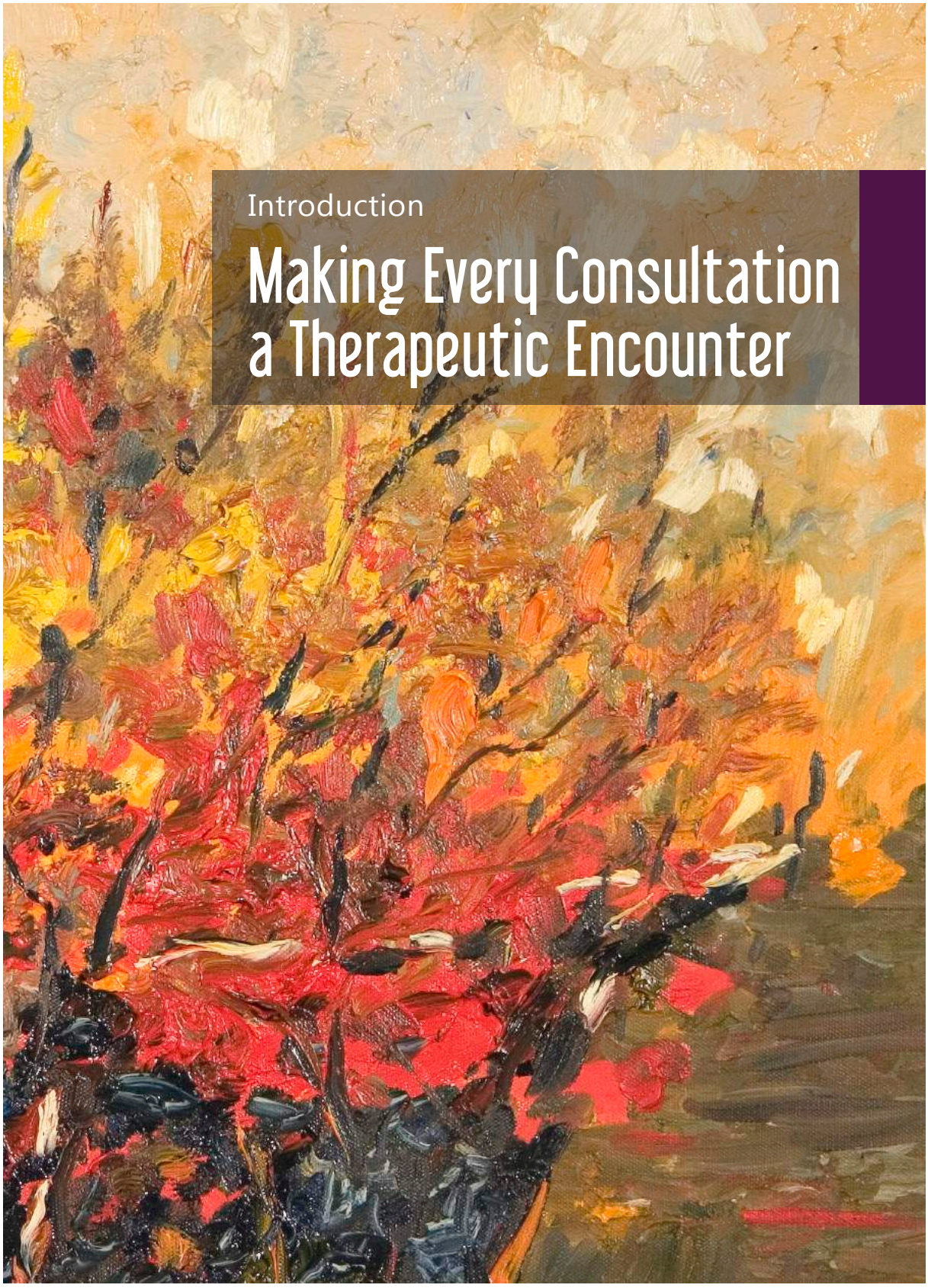


Introduction

Making Every Consultation a Therapeutic Encounter

"What we achieve inwardly will change outer reality."

Plutarch

Mental healthcare should be accessible, affordable and timely. For adjustment disorders, mild to moderate anxiety and depression, the right siting for treatment is in primary care. Recognising this, much effort have been made in recent years to train primary healthcare providers – family doctors, nurses, and allied health – to have the capability to deliver mental healthcare to their patients within the community.

Is prescribing patients just medication adequate?

Evidence-based treatment for mild emotional and psychological conditions is psychotherapy, not medication. For moderate to severely ill patients, they often respond better to a combination of medication and psychotherapy.

We know that even with placebos the patients do recover. The so-called placebo effect is not inert, as commonly believed. It is an active ingredient in the clinical consultation – whether medical, surgical or

psychological – which has a positive effect on health. It is believed that the placebo effect arises from the psychotherapeutic factors that occur during any clinical session.

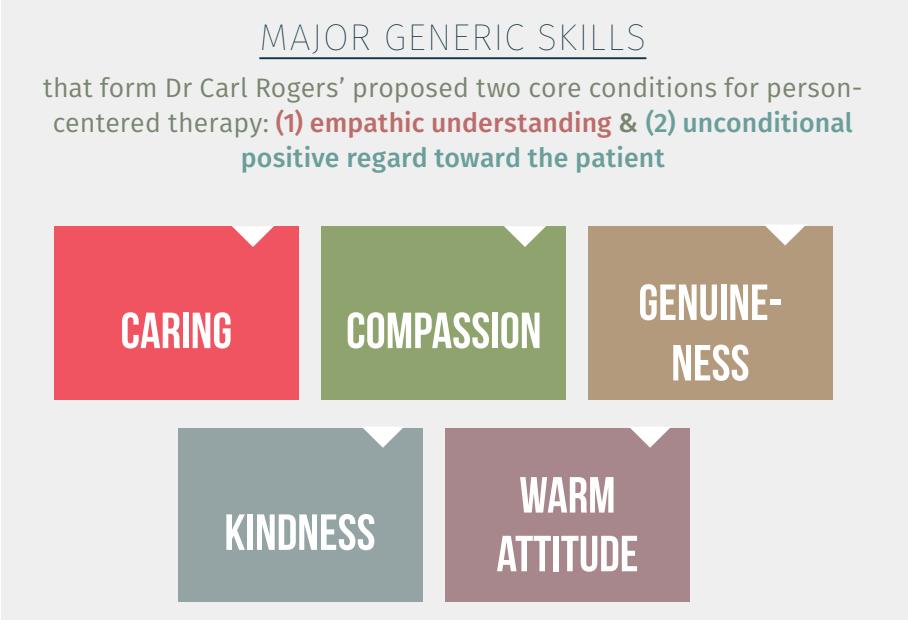
What has trust got to do with it?

At the heart of medical professionalism is trust, which is the main ingredient for a good doctor-patient relationship. Trust denotes the cognitive and emotional aspects of a patient towards the doctor; what a patient thinks about the doctor and how the patient feels toward the doctor – these determine the extent of trust a patient has for his or her doctor. If we wish to attain the best treatment outcome, we should try to promote a positive psychotherapeutic experience for the patient in every consultation.

How then does a doctor gain trust from a patient?

According to Dr Shaun Shea in his book "Psychiatric Interviewing: The Art of Understanding", the doctor needs to engage the patient. This process refers to the ongoing development of a sense of safety and respect, from which the patient feels increasingly free to share his or her problems, while gaining an increased confidence in the doctor's potential to understand him or her. This requires empathy, which is the ability to accurately recognise the immediate emotional perspective of another person while maintaining one's own perspective. Some doctors are naturally empathetic; for those who are not so, it is a skill that can be learnt.

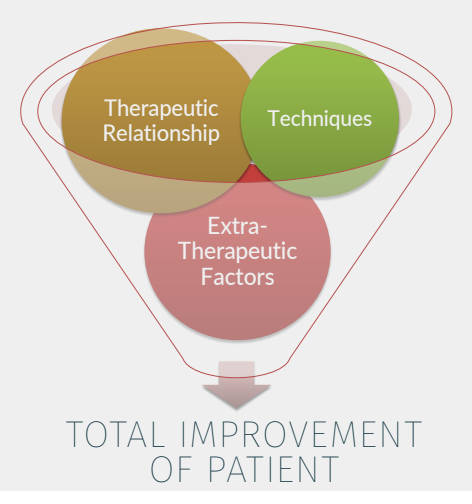
If the doctor is able to convey a warm attitude and sense of caring, compassion, kindness and genuineness, the patient will readily grow to trust that doctor. These are the so-called major generic skills which form two of Dr Carl Rogers' core conditions: empathic understanding and unconditional positive regard toward the patient.



Does a patient with a psychological or emotional condition require specialised treatment with psychotherapy to get better?

In the book "Every Day Gets a Little Closer: A Twice-told Therapy", Dr Irvin Yalom, a prominent psychotherapist, and his patient agreed to write separate journals of each of their sessions in which they relate their descriptions and feelings about their therapeutic relationship. On the day that the therapist thought he had carried out a brilliant technique, the patient's description of the session simply dwelt on one seemingly insignificant act by the therapist!

It is said that of the total improvement a patient makes, only one-third can be attributed solely to techniques, another one-third to the therapeutic relationship, and the last one-third to extra-therapeutic factors. Dr Scott Miller is a renowned clinical psychologist who has studied the area of using measures to predict outcomes of psychotherapy sessions. In his book "The Heart and Soul of Change: Delivering What Works in Therapy", he examined the common factors underlying effective psychotherapy and brought the client-therapist relationship back into focus as one of the key determinants of psychotherapy outcome. Family doctors can also increase their therapeutic effectiveness substantially by paying attention to the therapeutic relationship.

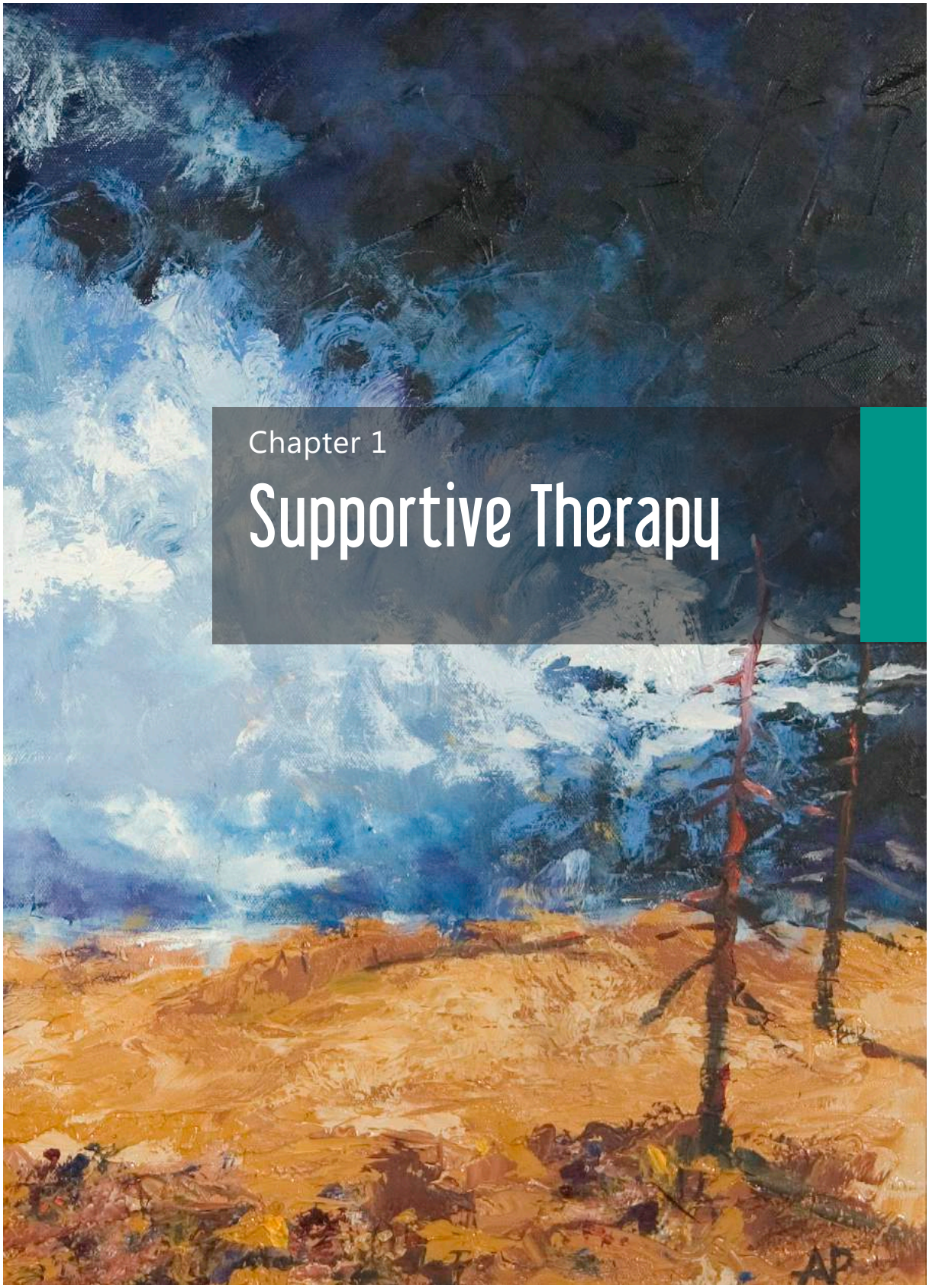


So while techniques are helpful, a family doctor does not need specialised training in psychotherapy to be able to achieve best outcomes. It is more important to hone basic skills such as active listening and expressing empathy, and use them effectively to establish a good therapeutic relationship.

Where can a family doctor obtain training in psychological interventions?

Counselling services may be readily available, but some patients may not be keen to be referred to such services. Therefore one of the competencies a family doctor may wish to achieve is that of carrying out brief but effective psychological interventions with their patients. This book offers information about such brief interventions, which are evidence-based treatments suitable in primary care.

Skills training may be arranged with the authors, who are clinical staff of the Health Wellness Programme (HWP) under Eastern Health Alliance (EHA). HWP provides support for patients who are being treated for emotional and psychological conditions by their family doctors within the community.



Chapter 1

Supportive Therapy

"The most precious gift we can offer others is our presence."

Thich Nhat Hanh

Dr Long had just about completed examining his 20-year-old patient, Darren. He had seen Darren since the patient was a young boy and knew him to be very healthy and fit. Hence, he was more than a bit puzzled as Darren had fallen ill very frequently over the past two months, complaining of symptoms of flu and fever. Dr Long decided to explore this with Darren. Unexpectedly, Darren started to tear, saying that he was feeling very stressed. This chapter will illustrate how Dr Long used a simple therapy framework to explore the issues and provide support to Darren.

Why Should Busy Family Doctors Provide Supportive Therapy?

Because of their already heavy workload, it is understandable that family doctors would baulk at having to provide supportive therapy for their patients. They may be concerned that this would take up too much of the limited consultation time. Another reason is that many family doctors do not feel adequately trained to provide supportive therapy.

Research has demonstrated that patients' medical outcomes benefit from their family doctor's application of supportive therapy during the medical consultation. For instance, Kim, Kaplowitz and Johnston (2004) have found that patients who received empathic communication from their doctors reported greater satisfaction and were more adherent to medical treatment. Indeed, a study conducted by Hojat and colleagues (2011) found that diabetic patients who had highly empathic doctors were more likely to have good control over their Hemoglobin A1c and LDL-C than those who had doctors with little empathy.

More recently, Pollak and colleagues (2011) repeated these findings, adding that patients also perceived that their sense of autonomy was supported by their doctors where treatment decisions have to be made. This sense of autonomy is one reason why patients are more adherent to treatment when they receive empathic understanding from their doctor. Another reason why supportive therapy could benefit patients' medical outcomes is that many patient visits are due to psychosocial issues. The psychosocial stressors and their resultant impact on lifestyle would affect the physical illnesses. It is hence important to address these psychosocial issues as part of comprehensive medical treatment.

What Is Supportive Therapy?

Supportive therapy can be considered a time-limited process of building upon the therapeutic relationship (in this case, the doctor-patient relationship) to provide the patient with a sense of being supported emotionally. It is also the foundation upon which the other brief interventions discussed in this book are applied – the doctor almost always needs to start building up a therapeutic relationship before offering other interventions.

Supportive therapy comprises two elements:

- A directed dialogue (made up of a loose sequence of steps)
- Use of some important interactional skills

This can be incorporated into the regular medical clerking. It is usually brief and can be conducted within the span of a regular medical consultation. Central to this whole process is the concept

EMPATHY - HOW TO WALK IN THE PATIENT'S SHOES

To the best of his or her ability, the doctor tries to experience what the patient is feeling. This experiencing of the patient's feelings can be achieved by considering a combination of several factors:

- Some prior knowledge about the patient as a person (i.e. personality and background)
- Observing the patient's verbal and non-verbal responses
- Imagining oneself in the patient's shoes
- Recalling experiences that one has had that are similar to the patient's experience.

For instance, should a patient have been just diagnosed to have a chronic illness, how would he or she feel upon receiving this news? In order to arrive at a rough sense of the patient's feeling, the doctor can consider the following:

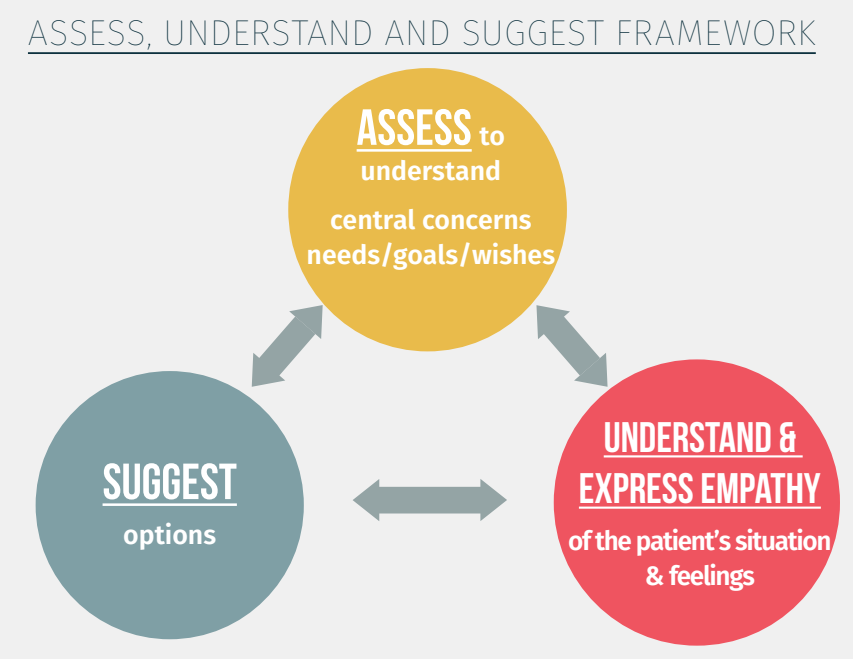
- What is the patient's background and personality like?
- What is the patient saying and doing right in front of the physician?
- Imagine what it would feel like to receive such a diagnosis.
- Recall a similar experience of receiving bad or momentous news.

and practice of physician empathy. Put in another way, empathy refers to the doctor feeling *with* the patient, not merely feeling for the patient. The directed dialogue and the interactional skills are used to increase physician understanding and empathy, and to demonstrate that empathy to the patient.

A Simple Framework for Supportive Therapy

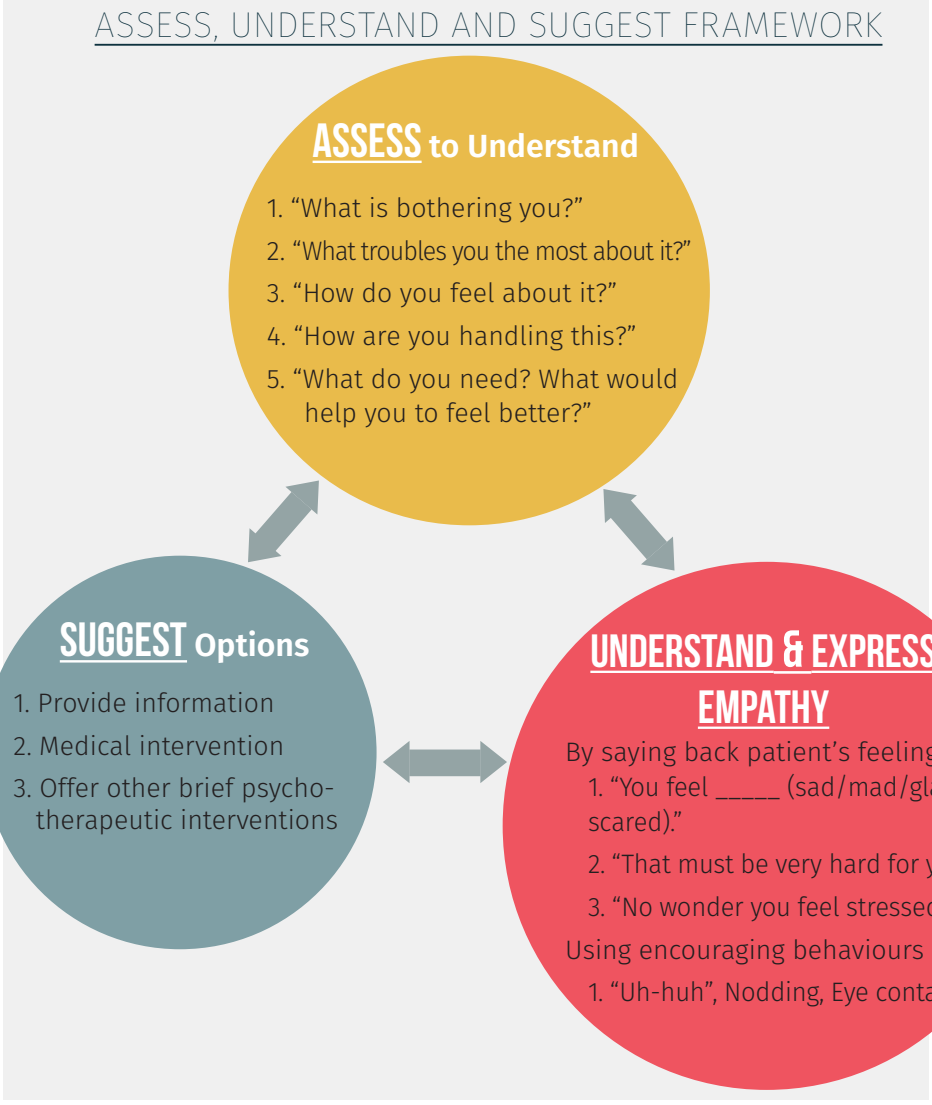
The framework is encapsulated by the acronym AUS – Assess, Understand and Suggest.

It should be noted that the three steps (AUS) are not necessarily conducted in a linear sequence (e.g. A → U → S). Rather, the dialogue can move and be repeated between any of these steps in any order. Oftentimes, it might cycle between the A and U steps before moving to the S step. The doctor needs only five to 10 minutes if they follow this framework. Within the Assess and Understand steps, there are some simple interactional skills that the doctor could use to drive the dialogue.



What are some of these interactional skills?

By using various interactional skills, the doctor finds out more about the patient's concerns and demonstrates his or her empathy for the patient. It would then be easier for the doctor to suggest options for the patient. Here is an overview of the interactional skills, with standard examples for these skills:



1. Asking questions

This is easier for doctors to do as it is not very far removed from the usual diagnostic interview. However, the questions need to be asked in an open-ended fashion. These are questions to which the patient would answer with more information and details, as opposed to a straightforward "yes" or "no".

Examples of open-ended questions include:

"**What** happened?"

"**When** did it happen?"

"**Where** were you at that point?"

"**How** did you feel then?"

"**Which** aspect of the incident most affected you?"

"**Why** was that so?"

The following question formats are useful:

- The doctor could open the conversation by asking: **"What is bothering you?"**
- Once the patient describes their concern, the doctor can focus in on the central part of the concern by asking: **"What troubles you the most about it?"**
- Once the central concern is identified, the doctor could explore the patient's feelings by asking: **"How do you feel about it?"** This provides material from which the doctor could express their understanding and empathy.
- The doctor could also get an idea about what would help the patient by asking either: **"What do you need?"** or more specifically **"What would help you feel better?"**
- As part of the assessment, the doctor could also ask about the patient's coping by asking: **"How are you handling this?"**

2. Reflecting Feelings

This is a more difficult interactional skill to apply. There are a few reasons why reflection of feelings could pose some challenges for doctors (and most people). They might be uncomfortable with addressing emotions, and there might be the concern that identifying with patients emotionally could affect and overwhelm the doctor's own emotions. Within Asian cultures, there is an added level of reservation about exploring emotions. Nonetheless, as with any medical procedure, the doctor will become more comfortable and confident with reflecting feelings after some practice.

REFLECTING FEELINGS 1

Think back to a time when you had a very engrossing conversation. If you were doing the talking, what did the other person do to make the conversation so engrossing? If you were the one listening, how did you listen to make the conversation so engrossing?

Think of the mannerisms of a good listener.

Reflection of feelings involves the doctor saying back what he or she has heard the patient say, or imply, about feelings. It focuses on the patient's feelings, as opposed to facts. The doctor, in the act of saying back to the patient what he or she believes the patient is experiencing, is demonstrating empathy. It requires the doctor to put him or herself briefly and quickly in the patient's shoes, get a sense of the patient's feelings, and then saying this back to the patient.

REFLECTING FEELINGS 2

You don't have to get the feeling accurate. All you have to do is to demonstrate to the patient that you are making the effort to understand them.

The whole process is summarised as follows:

Doctor listens to the patient

Doctor puts him or herself in the patient's shoes to understand the patient's feelings

Doctor reflects the patient's feelings

The following format can be used when reflecting the patient's feelings:

- When the patient describes their feeling, the doctor can reflect that by saying: "You feel _____."
- Alternatively, the doctor can say: "No wonder you're feeling _____."

Here is an example:

Patient (in an agitated high-pitched voice): "I'm super stressed out! I've got so many things to do at work, and now my mom wants me to help her book this holiday in Bhutan by tonight!"

Doctor: "You feel super stressed out. It's all so overwhelming. You're also upset with your mom."

Patient: "Yeah!"

Doctor: "You've got so many things to do, no wonder you're feeling this stressed."

There are times when the doctor gets overwhelmed by the patient's story or concerns and may not know how best to respond.

In this case, he or she can simply be attentive to the patient, in the following manner:

- Put aside the case notes or keyboard
- Sit facing the patient and lean slightly forward
- Maintain eye contact with the patient
- Nod or use other encouraging sounds (e.g. "uh-huh", "yeah", "I see", "ok" or "yes")

READING PATIENT'S FEELINGS

You can sometimes guess how the patient is feeling by looking at their expression, posture and behaviour.

For instance, anxiety can come across as frowning, agitated movement of the hands, restlessness and fidgeting in the seat, and sighing.

Think back to how you behave when you feel sad, mad, scared or glad.

Here is an example:

Patient (in an agitated high-pitched voice): "I'm super stressed out! I've got so many things to do at work, and now my mom wants me to help her book this holiday in Bhutan by tonight!"

Doctor: (Faces the patient squarely, looking into her eyes, leaning forward slightly)

Patient: "Do you have any idea how overwhelmed I am right now?"

Doctor (nodding her head): "Uh-huh."

This approach is a useful fallback if the doctor is struggling to apply reflection of feelings.

TIP

THE BASIC EMOTIONS

There are generally a few broad types of emotions:

- Sad – including any degree of low mood, unhappiness
- Mad – including all degrees of anger
- Glad – including happiness, elation, relief
- Scared – including all degrees of fear, terror, worry, anxiety

Think to yourself: If I were in this situation, what is the main emotion I would feel?

If the doctor is unsure of the exact emotion to reflection, generic terms "stressed" or "upset" can be instead. Another broad term is "confused".

E.g. "You're feeling stressed and upset because of these problems."

To summarise, the doctor can combine various ways to get a sense of what the patient is feeling, including observation of patient's behaviour, imagining himself or herself in the patient's situation, and listening to how the patient describes the feelings (see the Tips above). To say back the patient's feelings, the doctor can follow a standard response format (see above) or simply nod or make encouraging sounds to show attentive interest.

Note: The dialogue might sometimes move back and forth between the Assess step and the Understand step several times.

THE BASIC EMOTIONS

It helps for the doctor to briefly calm his or her mind before engaging in the conversation. A doctor, who is preoccupied with the list of waiting patients and the paperwork, could hardly pay attention to the patient.

Here is a method to briefly calm your mind before starting the dialogue:

1. Breathe in comfortably and deeply through your nose, letting your abdomen rise
2. Breathe out fully and slowly through your mouth, imagining that you are breathing out the concerns, stress and worries you have for the moment
3. Repeat the first two steps five to 10 times

3. Offering options

This is typically the final step, after the doctor has understood the patient's concerns and demonstrated empathy by reflecting the patient's feelings. When the patient feels heard and sometimes a sense of relief at having verbalised concerns, he or she might be more able to accept the doctor's suggestions.

Some of these options or suggestions are:

1. Giving information or advice
2. Performing psychoeducation
3. Listing various choices and weighing the options with the patient
4. Providing further medical treatment if necessary
5. Carrying out some other brief psychotherapeutic interventions described in this book

At this point, the doctor could also provide encouragement and give feedback to the patient. Reinforce his or her personal strengths and sense of self-efficacy ("You've done great to be coping so far" or "I'm really impressed with how you've managed to cope so far") wherever possible. At the same time, the point of self-responsibility needs to be emphasised to the patient if lifestyle changes are required.

What the doctor does in this step is based on the understanding obtained from the other two steps.

Dr Long's session with Darren:

Dr Long decided to spend a few minutes finding out about Darren's stress: "What's bothering you, Darren?"

Darren revealed that he was struggling with his school work and he had a quarrel with his girlfriend recently. His mother was also recently diagnosed with liver cancer.

Dr Long: "How do you feel about all of these problems?"

Darren almost spat out these words, "So many things to handle all at one time make me depressed. Scared! I don't know!" He clasped his head in his hands.

"I see you're feeling sad and scared. No wonder you're so stressed." Dr Long, putting himself in Darren's situation, could readily understand these feelings.

Dr Long: "Of these problems, what troubles you the most?"

ASSESS UNDERSTAND SUGGEST

Dr Long's session with Darren (Continued):

Darren mumbled, "I guess it's my mom's cancer. That's what I'm scared about." He looked up at Dr Long.

Dr Long: "Yeah, that's a scary thing, to learn that your mom has cancer."

Darren nodded vigorously. He felt relieved that his fears were acknowledged.

Dr Long: "Can I check with you, what would help you feel better?"

Darren took some time to think about this. "Maybe, if I had more information about my mom's cancer. I'm really scared that she might die."

Dr Long: "Yes, you feel very scared that your mom might die from the cancer. Maybe I can give you some information about that..."

This dialogue would have taken no more than five minutes. Nonetheless, it provided Darren with a sense that Dr Long cared about him, beyond his flu symptoms. Notice also that Dr Long did not need to apply the Assess and Understand steps many times over. He just needed to apply these steps occasionally during the entire session. By simply going through these two steps, Dr Long discovered what was causing Darren's stress. Dr Long had also gathered sufficient information about the psychosocial factors to provide additional help for Darren.

TIP

WHAT IF THE SESSION TAKES TOO LONG?

1.Before you start the dialogue, you can let the patient know that it will be short.

E.g. "Let's talk about this for a couple of minutes."

2. If you are aware of time and needing to end, simply let the patient know that you need to end the session.

E.g. "You're going through a lot and it's very stressful. Unfortunately, I've got to stop our chat now because of we've run out of time. I hope things improve for you soon."

When Should Supportive Therapy Be Used?

In general, it is useful for most clinical encounters. Here are some situations which would particularly benefit from supportive therapy:

- **Obvious emotional distress** – When the patient shows emotional distress during the consultation. The doctor could spend a few minutes simply using some of the interactional skills to provide relief for the patient.
- **Patient voices concerns** – When the patient voices concerns, whether it is about his or her medical treatment or about psychosocial problems, the doctor could attempt to find out more about those concerns, or simply provide empathic understanding.

- **Before offering other psychotherapeutic interventions –** It is recommended that the doctor engages in some of the interactional skills with the patient before introducing any of the other psychotherapeutic interventions in this book. This would help the doctor understand what the patient's central issue is and hence identify the most suitable psychotherapeutic intervention. It also enables the patient to feel heard, making him or her more open to considering the other psychotherapeutic interventions offered.

When is Supportive Therapy Unsuitable or Inadequate?

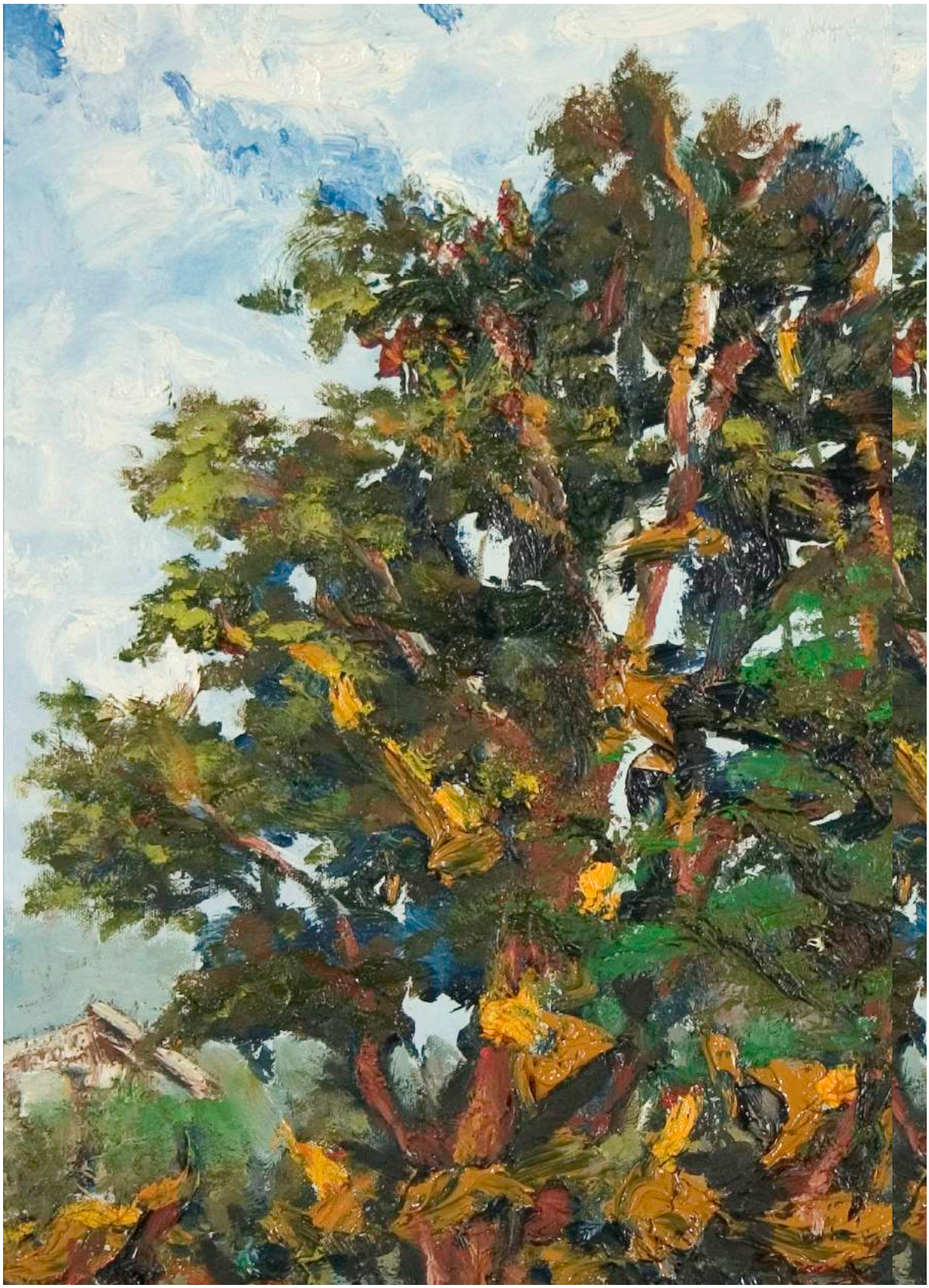
The following are some conditions for which the doctor should not use solely supportive therapy or may find it unsuitable:

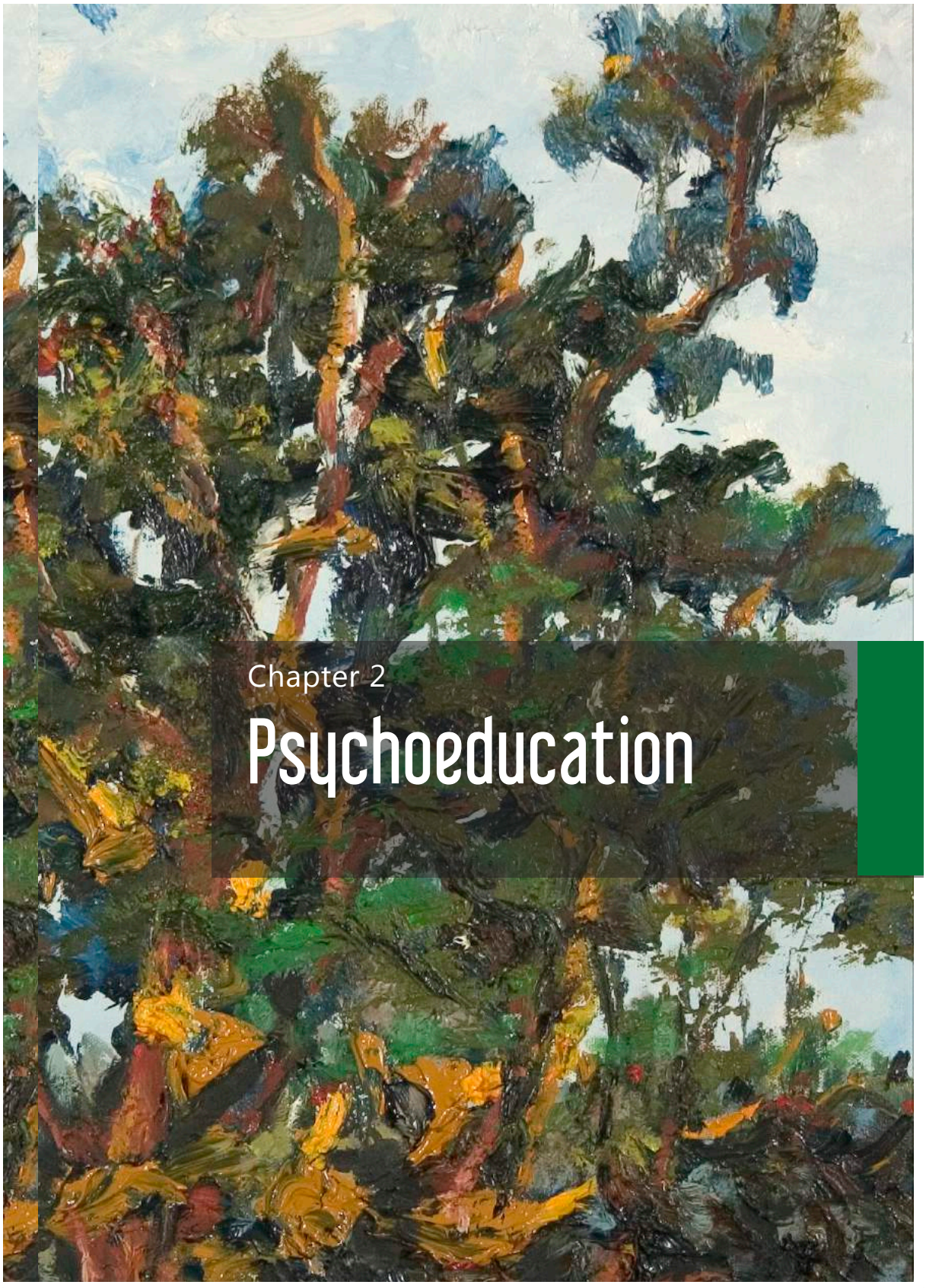
- **Severe and disruptive personality disorder –** this refers to patients with fixed patterns of emotional and interpersonal problems that are pervasive i.e. affect many areas of their lives such as work, family, and relationships. Supportive therapy might open up a protracted dialogue with these patients, and even escalate their emotional problems, especially if they are also paranoid.
- **Acute psychosis –** this refers to patients who are experiencing hallucinations or hold fixed false beliefs i.e. delusions. Medications are needed to treat persons who suffer from acute psychotic disorders. Supportive therapy can be provided when the symptoms remit.

- **Actively suicidal** – Patients who are actively suicidal require more intensive and immediate care. They will also take a lot of time to manage, and are best treated by a multi-disciplinary team. The doctor should instead arrange for such patients to be seen at a hospital emergency department.
- **Substance abuse** – this refers to patients who currently have a severe alcohol use disorder or are abusing illicit drugs. Their lives are often severely affected by their substance abuse and treatment may require intensive and multi-disciplinary team management. Supportive therapy is inadequate as a sole treatment modality for this problem.
- **Victims of violence** – the doctor might encounter patients who are the victims of physical and/or emotional abuse. These patients may suffer from post-traumatic stress disorder (PTSD), which requires intensive therapy. Supportive therapy can be used but would not be sufficient as an intervention for PTSD.

Key Points at a Glance

1. Supportive therapy can be used during the patient-doctor interaction to enhance the quality of care to patients. It usually only takes up a few minutes of the consultation time, or it could be incorporated into the medical clerking process.
2. To apply supportive therapy, the doctor need only keep the following key points in mind:
    - **Assess** the patient's central concerns and needs.
    - **Understand** and **express empathy** about his or her concerns by reflecting the patient's emotions.
    - **Suggest** options for the patient.





Chapter 2

Psychoeducation

"Never give up on someone with a mental illness. When "I" is replaced by "We", illness becomes wellness."

Shannon L. Alder

Josephine, a 35-year-old sales manager, reported recurrent anxiety attacks for the past one year. The frequency of attacks and symptoms caused her distress and impaired her ability to work. After seeing her family doctor at the polyclinic, Dr Tan, she was told she had Panic Disorder and that the treatment included medication as well as therapy. Dr Tan gave her some time to ask him questions about her condition. Initially she was anxious that this diagnosis meant that she was "crazy." Her anxiety diminished as Dr Tan was empathic and conveyed the confidence that she would benefit from treatment.

What is Psychoeducation?

Psychoeducation is about giving information about a certain situation or condition that causes psychological distress. Understanding the condition gives the patient a sense of mastery over it, and is one way to combat psychological stress. It also leads to active participation in self-management and relapse prevention. Increased knowledge

about depression, for example, is associated with better prognosis as well as reduction of the psychosocial burden for the family. It is also effective in improving medication adherence.

The format of psychoeducation can be group-based or individually implemented. Individual psychoeducation has the advantage of being more focused. There usually is some structure so that it stays on track and each psychoeducation session will cover specific content. However some flexibility is useful, in order to answer certain questions about the condition that may trouble the patient.

What Are The Benefits of Psychoeducation?

Even brief passive psychoeducation interventions, such as giving the patient an educational leaflet or online material for his or her condition, can reduce symptoms for depression and psychological distress. It can be applied immediately and is useful as an initial psychosocial intervention in primary care. There are many resources on the internet which are freely available (see References).

Common psychoeducation topics about anxiety, depression and adjustment disorders are:

- Nature of the illness
- Symptoms
- Aetiological factors
- Treatment
- Lifestyle changes
- Recognising early signs of relapse
- Prognosis

How Can Psychoeducation be Performed Effectively?

The following are some useful tips when carrying out psychoeducation, adapted from the book by Silverman, Kurtz, and Draper (1998), on "Skills for Communicating with Patients":

Providing the correct amount and type of information

1. Ask for patient's prior knowledge before giving information and find out extent of patient's wish for information.
2. Give information in manageable chunks, check for understanding and use patient's response as a guide on how to proceed.
3. Ask patient what other information would be helpful e.g. aetiology, prognosis.
4. Give explanation at appropriate times: avoid giving advice, information or reassurance prematurely.

Aiding accurate recall and understanding

1. Organise explanation: divide into discrete sections, develop a logical sequence.
2. Use explicit categorisation or signposting e.g. "There are three important things that I would like to discuss first...", "Now, shall we move on to...".
3. Use repetition and summarising to reinforce information.
4. Use concise, easily understood language; avoid medical jargon.

5. Use visual methods of conveying information: diagrams, models, written information and instructions.
6. Check patient's understanding of information given (or plans made) e.g. by asking patient to restate in own words; clarify when necessary.

Achieving a shared understanding: incorporating the patient's perspective

1. Provide opportunities and encourage patient to contribute: ask questions, seek clarification or express doubts; respond appropriately.
2. Pick up verbal and non-verbal cues e.g. patient's need to contribute information or ask questions, information overload, distress.
3. Elicit patient's beliefs, reactions and feelings regarding information given, terms used; acknowledge and address where necessary.

Explaining treatment

1. Elicit patient's reactions and concerns about plans and treatments including acceptability.
2. Take patient's lifestyle, beliefs, cultural background and abilities into consideration.
3. Encourage patient to be involved in implementing plans, to take responsibility and be self-reliant.
4. Ask about patient's support systems and discuss other support available.

An example of a PSYCHOEDUCATION SESSION

Using the above clinical scenario, Dr Tan proceeded to answer some of the questions Josephine had pertaining to the diagnosis and treatment.

Dr Tan: "Well, based on what you described just now and based on some of your responses on the questionnaire you have completed, it seems that you are suffering from Panic Disorder."

Josephine: [Looks worried] "What is it? Does it mean I'm going crazy?"

Dr Tan: "Don't worry, you're not going crazy. Panic Disorder is a condition where anxiety becomes very strong. Often people experience repeated panic attacks like those you have described and because they are concerned about these attacks, they may avoid certain places or activities that might trigger these attacks."

Josephine: [Still looking worried] "What is causing this? I've been alright all this time!"

Dr Tan: "Well Josephine, there are many possible causes of Panic Disorder; usually several factors are involved, such as abnormality in the serotonin chemical system in the brain, genetic contributions and family history. Panic Disorder can also be associated with major life events or stress like those that you are experiencing now. Does that help to answer your question?"

Josephine: "Yes, now I'm concerned about what can be done about it. Will I get better? Is it long-term? "

Dr Tan: "Treatment often involves a combination of SSRIs and CBT. Let me explain. SSRIs stands for Selective Serotonin Reuptake Inhibitors and help to increase the serotonin in your brain which reduces the anxiety. In the meantime, I also advise patients to go for Cognitive Behavioural Therapy or CBT with a psychologist. This is a form of treatment that enables you to learn better ways to change your anxiety-related thought patterns and behaviours."

Josephine: "Sounds like a lot of commitment."

Dr Tan: "The SSRIs may take a few weeks to take effect and typically, CBT runs for 10 to 12 sessions with the psychologist. Together, these have very good outcome for Panic Disorder."

Josephine: "Will I be cured?"

Dr Tan: "I think it's more about controlling and managing your anxiety. Because anxiety is part of our emotions, we cannot get rid of it, but you can learn skills to keep the anxiety from affecting your life."

APPENDIX

Factsheets on Depression, Anxiety and Adjustment Disorder

KNOWING MORE ABOUT DEPRESSION

What is it?

Disorder that affects your mood where people can experience some or all of the following for two weeks or more with **persistent low mood**:

- Sleep difficulties
- Loss in interest in usual things
- Guilt feelings
- Loss of energy
- Anger
- Poor concentration
- Change in appetite
- Feeling that you are moving slower than before
- Thinking about suicide
- Social withdrawal

Why does it happen?

Different factors can contribute to having depression. Some of these are:

- Genetics
- Brain chemical changes
- Negative thinking patterns
- Loss and grief
- Sense of failure
- Loss of meaning in life
- Insufficient rewarding activities in life
- Loneliness and isolation
- Stressful life situations

What can be done?

Seeing a doctor **for medication and psychotherapy** can be very helpful. Self-help tips include:

- Keeping a consistent daily routine
- Having more pleasurable and rewarding activities in your daily routine
- Talking and reconnecting with other people
- Taking self-care breaks at work

APPENDIX
Factsheets on Depression, Anxiety and Adjustment Disorder

KNOWING MORE ABOUT ANXIETY

What is it?

Anxiety is a normal emotion that warns us about danger. It keeps us safe. However if it becomes too strong or lasts too long, it will affect our lives. Anxiety symptoms include:

- Shortness of breath
- Racing heartbeat
- A lot of worrying or thinking about what can go wrong
- Poor concentration
- Feeling tense
- Always being on alert for danger

Why does it happen?

Different factors can contribute to having anxiety. Some of these are:

- Genetics
- Brain chemical changes
- Thinking patterns about how things may go wrong or worrying about the future
- Avoiding things that triggers the anxiety so that your body doesn't get used to the trigger
- Having overly high standards for yourself
- Stressful lifestyle

What can be done?

Seeing a doctor **for medication and psychotherapy** can be very helpful. Self-help tips include:

- Gradually exposing yourself to the things that made you anxious so that you can get used to it
- Practising mindfulness which will help you to detach from worrying

APPENDIX

Factsheets on Depression, Anxiety and Adjustment Disorder

KNOWING MORE ABOUT ADJUSTMENT DISORDER

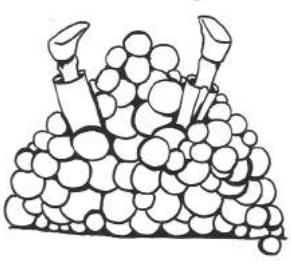
What is it?

We all experience changes in our lives. Sometimes big changes can make us feel that we cannot cope with them and we may experience some of the following symptoms:

- Mood changes (low mood, mood swings)
- Anxiety
- Sense that we cannot cope
- Feeling burnt-out
- Being irritable
- Social withdrawal
- Reduced productivity at work

Why does it happen?

Some of the following can overwhelm us and make us feel that we cannot cope:

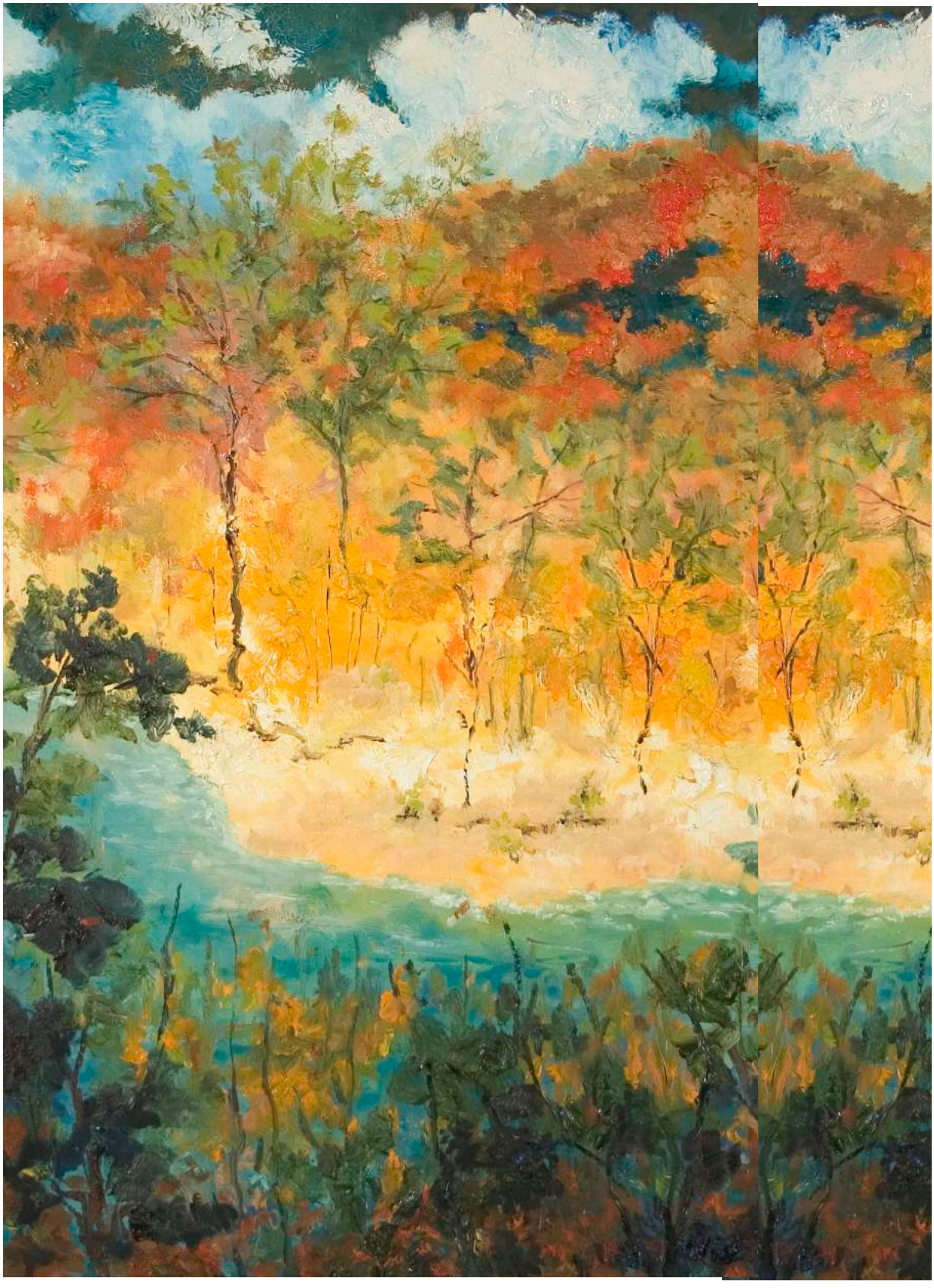


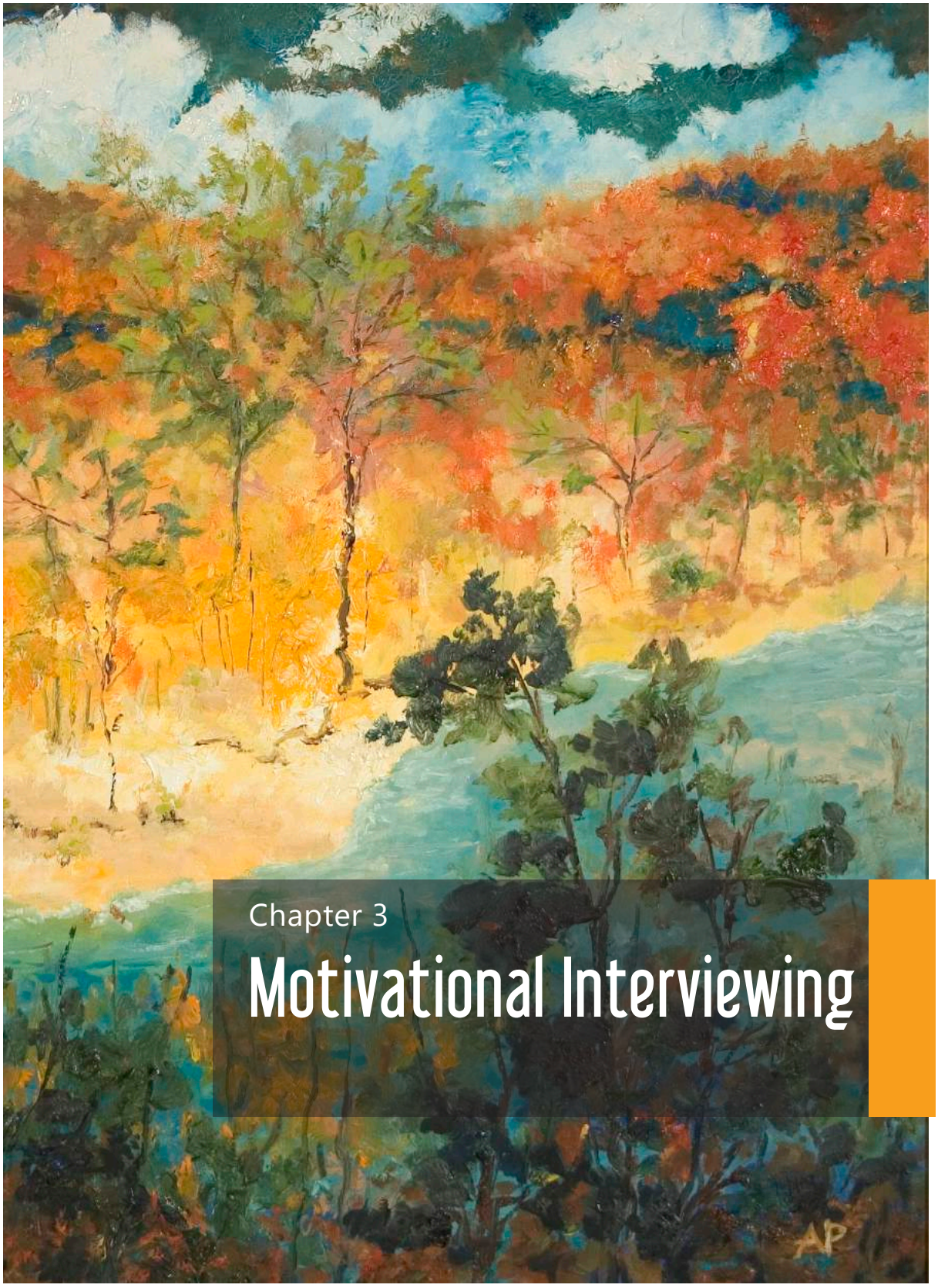
- Too many life changes occurring together
- Life changes that are too big
- Insufficient social support
- Perceiving changes as threats instead of challenges
- Poor problem-solving skills
- Poor emotional management skills
- Unhealthy lifestyle

What can be done?

Seeing a doctor **for medication and psychotherapy** can be very helpful. Self-help tips include:

- Keeping a healthy lifestyle
- Making a list of things that you need to do and solve the easier ones first
- Breaking down big tasks into smaller and more manageable tasks
- Reaching out to others for help
- Learning self-soothing strategies to help manage your mood better





Chapter 3

Motivational Interviewing

Being happy doesn't mean that everything is perfect. It means that you've decided to look beyond the imperfections."

Anonymous

Sally is a 50-year-old woman who is slightly plump. At her recent full-body checkup, her family doctor, Dr Lee, found that Sally had mild hypertension and high cholesterol, and advised her to embark on a healthy lifestyle regime. This included exercise, a balanced diet and managing her stress level. Sally told Dr Lee that it was very difficult for her to exercise or eat healthily. Although she wished to lose some weight, she loved to eat and she felt her body couldn't take it if she exercised. This chapter illustrates how Dr Lee used motivational interviewing strategies to help Sally think about change and take steps towards change.

What is Motivational Interviewing?

Motivational interviewing (MI) is a directive, patient-centered counselling approach that enhances motivation for change by helping the patient clarify and resolve ambivalence about behavioural change.

QUOTE

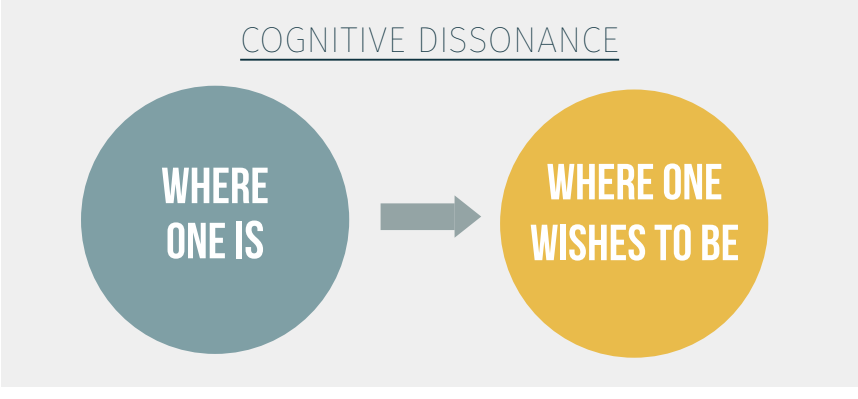
MILLER AND ROLLNICK (1991)

"Motivational interviewing is a way of being with a client, not just a set of techniques for doing counselling."

The concept of MI evolved from experience in the treatment of problem drinkers, and was first described by Miller (1983) in an article published in Behavioural Psychotherapy. These concepts and approaches were later elaborated by Miller and Rollnick (1991) in a detailed description of clinical procedures.

The role of the doctor in MI is directive, and to elicit self-motivational statements and behavioural change from the patient. In addition the doctor tries to create in the patient, a state termed **discrepancy**, in order to enhance motivation for positive change (Davidson, 1994; Miller and Rollnick, 1991). Essentially, MI is believed to activate the capability for beneficial change that everyone possesses (Rollnick and Miller, 1995). Although some people can change on their own, others require more formal intervention and support.

The goal of MI is to amplify discrepancy between present behaviour and broader goals, in order to create **cognitive dissonance**.




THE FRAMEWORK OF MOTIVATIONAL INTERVIEWING (MI)
SPIRIT OF MI
Autonomy
Collaboration
Evocation
PRINCIPLES OF MI
Roll with Resistance
Express Empathy
Develop Discrepancy
Support Self-Efficacy
MICRO-SKILLS IN MI
Open-ended Questions
Reflective Listening
Affirmation
Summaries
CHANGE TALK IN MI
Desire
Ability
Reason
Need
COMMITMENT LANGUAGE OF MI
Commitment
Activation
Taking Steps
BEHAVIOUR CHANGE

What Exactly is the Spirit of Motivational Interviewing?

It is vital for any doctor who practices MI to understand the spirit of MI. The spirit of this method is characterised in a few key points (Rollnick and Miller, 1995):

Motivation to change is elicited from the patient, and not imposed from without

It relies upon identifying and mobilising the patient's intrinsic values and goals to stimulate behavioural change. E.g. the patient may say, "I wish to stop alcohol use because I want to be a responsible father."

The alliance between doctor and patient is collaborative

It uses an empathic, supportive, non-judgmental, non-confrontational, non-adversarial, yet directive style. It provides conditions in which change can occur and builds on the foundation of Carl Rogers' humanistic perspectives (Nelson-Jones, 2006). This is a patient-centered approach which believes that people are capable of change, with the help of appropriate interactions that drive the process of change, especially where motivation is the key factor. To use a metaphor, the patient and doctor are as if working together on a jigsaw puzzle.

The doctor is directive in helping the patient examine and resolve ambivalence

Ambivalence is a common response observed in any change process. It is normal and constitutes an important obstacle to any form of change. It takes the form of conflict between two courses of action, each of which has perceived benefits and costs associated with it. Many patients have never had the opportunity of expressing the

often confusing, contradictory and uniquely personal elements of this conflict. The doctor's task is to facilitate expression of both sides of the ambivalence struggle, and guide the patient toward an acceptable resolution that triggers change. E.g. the patient may say, "I want to start exercising as it is good for my health, but I am too unfit to exercise and I am not sure if I have the time."

Direct persuasion is not used in MI for resolving ambivalence

Persuasion tactics generally increase patient's resistance and diminish the probability of change (Miller, Benefield and Tonigan, 1993; Miller and Rollnick, 1991). E.g. the doctor using direct persuasion may say, "You should change; it is the only way that will work for you."

The counselling approach is generally a gentle and eliciting one

Aggressive confrontation and argumentation are not practiced in MI. To a doctor who is accustomed to confronting and giving advice, MI may appear to be a hopelessly slow and passive process. However the evidence of MI is in the outcome. More aggressive strategies, sometimes guided by a desire to "confront the denial", can easily slip into pushing patients to make changes for which they are not ready. E.g. a confrontational doctor may say, "Stop whining over your problem, just do something about it."

Readiness to change is not a client trait, but a fluctuating product of interpersonal interaction

The doctor is therefore highly attentive and responsive to the patient's motivational signs. Resistance and denial are seen not as the patient traits, but as feedback regarding the doctor's behaviour. Resistance is often a signal that the doctor is assuming greater readiness to change on the part of the patient than is the case, and it is a cue that the doctor needs to modify motivational strategies.

AN ILLUSTRATION OF CONFRONTATIONAL APPROACH VERSUS MI APPROACH

OPPOSITE APPROACH TO MI	FUNDAMENTAL APPROACH OF MI
Confrontation Conversation involves overriding the patient's impaired perspectives by imposing awareness and acceptance of "reality" that the patient cannot see or will not admit.	Collaboration Conversation involves a partnership that honors the patient's expertise and perspectives. The doctor provides an atmosphere that is conducive rather than coercive to change.
Education The patient is presumed to lack the key knowledge, insight, and/or skills that are necessary for change to occur. The patient seeks to address these key deficits by providing information.	Evocation The resources and motivation for change are presumed to reside within the patient. The intrinsic motivation for change is enhanced by drawing on the patient's own perceptions, goals, and values.
Authority The doctor tells the patient what he or she must do.	Autonomy The doctor affirms the patient's right and capacity for self-direction and facilitates informed choice.

Which Micro-skills (or Fundamental Interaction Techniques) are useful in MI?

Successful MI always starts with the building of a strong therapeutic alliance with the patient. The basic approach to interactions in MI is summarised in the acronym OARS (Miller and Rollnick, 1991; Miller, Zweben, DiClemente & Rychtarik, 1992):

These techniques can be used comfortably, regularly and consistently, as part of a basic foundation of forming interpersonal relationships with your patient in every session.

Open-ended Questions

- Asking open-ended questions helps you understand your patient's point of view and elicits his or her feelings about a given topic or situation.
- Open-ended questions facilitate dialogue; they cannot be answered with a single word or phrase and do not require any particular response. They are a means to solicit additional information in a neutral way.
- Open-ended questions encourage the patient to do most of the talking, prevent the doctor from making premature judgments and keep communication moving forward.

- Examples of open-ended questions: “What brings you here today?”, “Tell me what’s been happening since we last met”, “What makes you feel that it might be time for a change?”

TIP

HOW TO ASK OPEN-ENDED QUESTIONS

Close-ended Questions	Open-ended Questions
• So you are here because you are concerned about your high blood pressure?	• Tell me, what brings you here today?
• Do you have children?	• Tell me about your family.
• Do you agree that it would be a good idea for you to see a counsellor?	• What do you think about the possibility of going to see a counsellor?
• Do you like to smoke?	• What are some of the things you enjoy about smoking?
• Does your behaviour affect your family?	• How does your behaviour affect your family?
• Do you think you drink too often?	• In what ways are you concerned about your drinking?

Affirmations

- Affirmations are positive reinforcements, or statements of a patient's behaviour that deserves recognition. When a particular behaviour is acknowledged, the pride that the patient feels from its recognition can lead to repetition of that positive behaviour.

- Affirming the patient can encourage, empower and support him or her through the change process. Affirmation builds self-confidence in the patient's belief that he or she can change, hence reinforcing self-efficacy.
- For affirmation to be meaningful, it must be genuine, congruent and appropriate to the positive behaviour.
- An example of affirmation: "It takes great courage to share your story and to be so open and honest to a stranger."

EXAMPLES OF AFFIRMING RESPONSES

- I appreciate that you are willing to meet me today.
- You are clearly a resourceful person.
- You handled yourself really well in that situation.
- That's a good suggestion.
- If I were in your shoes, I don't know if I could have managed nearly so well.

Reflective Listening

- Reflective listening is an essential practice in building rapport. It is a fundamental component of motivational interviewing in which the doctor demonstrates accurate understanding of the patient's communication by restating it.
- Reflective listening is a way of checking rather than assuming that one knows what is meant (Miller & Rollnick, 2002). It strengthens the empathic relationship between doctor and patient, and also encourages exploration of deeper problems and feelings.

- Some examples are listed in Appendix A on reflective listening, how to roll with resistance, reframing and more complex reflection techniques in different circumstances.

SOME STANDARD PHRASES IN REFLECTIVE LISTENING

- So you feel...
- It sounds like you...
- You're wondering if...
- So what I hear you saying is...
- This is what I am hearing; please correct me if I am wrong...

Summarising

- Summaries are a form of reflective listening where the doctor reflects to the patient what he or she has been saying.
- Summaries can be used throughout a conversation but are particularly helpful at transition points. E.g. if you are in a lengthy conversation with a patient, you may summarise at some point to ensure you are on track with where the patient is going, and then continue with the conversation.
- Summarising enhances building of rapport, or call for attention or direction towards an important point. Doing it frequently is helpful, as too much information from the patient can be unwieldy for the doctor to digest and feedback. If the interaction is going in an unproductive or problematic direction, for instance when encountering resistance, the summary can be used to shift focus of the interaction.

TIP

EXAMPLES OF SUMMARIES

(You can begin with a statement indicating you are making a summary):

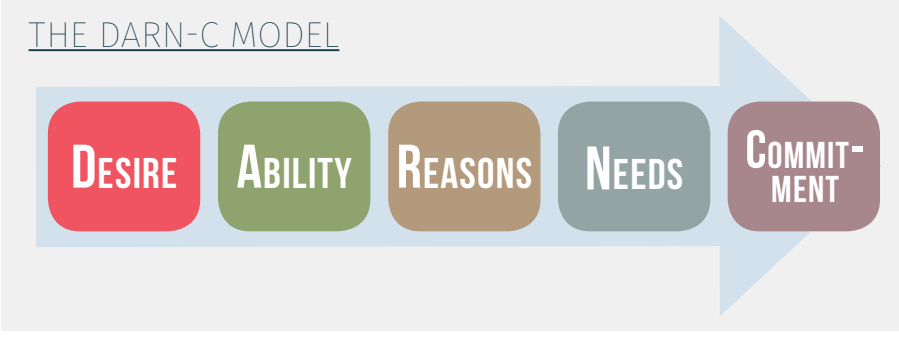
- Let me see if I understand so far...
- Here is what I've heard. Tell me if I've missed anything.
- What you've said is important. Let me re-cap.Here are the salient points that you have just shared.

An illustration on the application of OARS is provided in Appendix A on how Dr Lee used the reflection techniques and summarising to facilitate her change talk with Sally.

How Does the Clinician Identify *Change Talk* in MI?

The goal of using OARS is to move the patient forward by eliciting change talk, or self-motivational statements.

Change talk refers to the doctor's ability to recognise the patient's response and discussion of his or her '**desire**', '**ability**', '**reason**', and '**need**' to change behaviour and what will give rise to a **commitment to change – in the acronym DARN-C.** (Amrhein, Miller, Yahne, Palmer & Fulcher, 2003; Sciacca, 2009). Examples are given in Appendix D.



Change talk involves statements or affective communications that indicate the patient is considering the possibility of change. The doctor actively listens for:

- Change talk in its various strengths (from weak to strong or committed)
- Whether the patient talks about commitment to change (intention, decision)
- Activation to change (readiness and preparation)
- Whether the patient is taking steps to change (plans and actions)

Miller and Rollnick (1991, 2002) organised this change talk process in four categories. Sample questions on Evoking Change Talk (Miller and Rollnick, 1991) are listed in Appendix B:

- Client's ability to recognise the problem
- Client's concern of the problem
- Client's commitment to change
- Client's belief that change is possible

Essentially, any statement oriented towards the present or future, either in the cognitive or emotional realm, may represent a self-motivational statement. E.g. "I think that smoking may be causing problems" (present-cognitive); "I'm kind of worried that things may be getting out of control" (present-emotional); "I'm definitely going to do something about that" (future-cognitive); "You know, I'm starting to feel like this just might work out" (future-emotional).

How Can *Change Talk* Be Mobilised to Commitment and Activation?

Mobilising change talk signals movement towards resolution of the ambivalence in favor of change. It means that change talk – wants to, can, has reasons to or must change – is not the same as saying one will change. The doctor's observation of the patient's commitment language can give a good gauge on the patient's readiness to put action on change.

The commitment to change language (Miller and Rollnick, 2013) is described as follows:

COMMITMENT

- Committing language signals the likelihood of action. Commitment language is when the patient says, "I will, I promise, I guarantee, I give my word..."
- "I want to, I could, I have good reasons to, I need to..." may not be commitment language.

ACTIVATION

- Activation language indicates movement towards action, yet is not quite a commitment to do it. It signals that the patient is leaning in the direction of action – "I'm willing to...I am ready to...I am prepared to..."
- The doctor can respond to such talk with questions such as: "When will you do it?" or "What exactly are you prepared to do?"
- Activation language is a sign of the patient being "almost there" and implies a commitment without actually stating it.

TAKING STEPS

- This is also an activation language that indicates that the patient has already done something in the direction of change. E.g. "I bought a pair of running shoes for exercising" or "I started a food diary" or "I went to see a dietician to plan a healthy diet for me".
- Taking steps does not necessarily indicate a commitment to change, but the key is to listen for language that signals movement towards change.

How Can the Principle of Motivational Interviewing be Used to Deal With Ambivalence?

Ambivalence is observed to be one of the key barriers in motivation to change. It is a common thought and behavioural process observed in every patient when he or she thinks about change.

The doctor needs to identify the ambivalence when it is presented by the patient. E.g. the patient may say, "If I start to watch what I eat, I may feel better about myself, but I may also feel unhappy that I cannot choose to eat the food I like."

AMBIVALENCE

Having opposite feelings and emotions at the same time.

The doctor could adopt the five key strategies to address ambivalence in thought and behaviour. It is summarised in the acronym '**DEARS**' (Miller and Rollnick, 1991):

Develop discrepancy between the patient's goal or values and current behaviour

This is a strategy that uses comparison on the positives and negatives of the behaviour. This process develops the patient's awareness of the consequences, and helps client examine the need for change. The doctor uses pros and cons discussion to develop discrepancies between the patient's goals and his or her current behaviour. Often the patient will present arguments for change and doctor's task is to acknowledge and empower self-motivational statements.

Express empathy through reflective listening

Expressing empathy is one of the essential and defining characteristics of MI. It is a specifiable and learnable skill the doctor uses to demonstrate understanding of the patient's meaning through reflective listening (as discussed in OARS). An empathic style involves communicating respect and acceptance of the patient and his or her feelings. The doctor encourages a supportive, trusting, non-judgmental and collaborative relationship. In some instances, the doctor is seen as a knowledgeable

consultant; sincerely complimenting instead of denigrating the patient. The doctor tends to listen more, instead of giving direct advice, hence establishing a safe and open environment that is conducive to examining issues and eliciting personal reasons and methods for change. A key component of MI is an accurate understanding of the patient's unique perspective, feelings and values.

Avoid argumentation and direct confrontation

It is tempting to argue with a patient who is unsure about change or unwilling to change, especially if the patient is hostile, defiant or provocative. However, trying to convince a patient that a problem exists or that change is needed could precipitate even more resistance. Arguments with the patient can rapidly degenerate into power struggle and do not enhance motivation; instead, they are counterproductive to change process. The doctor needs to observe cues of the patient's defensiveness in the conversation. Resistance is a signal to change strategies or directions. The doctor should avoid imposing and pushing for change or unnecessary labeling e.g. telling the patient "You are in denial." MI advocates starting with wherever your patient is, and altering self-perceptions not by arguing or confronting, but through substantially more effective means of change talk.

Rolling with resistance is adjusting to the patient's resistance rather than opposing the patient directly

Resistance is an important concern for the doctor because it is predictive of poor treatment outcomes and lack of involvement in the therapeutic process (Miller, Zweben, DiClemente, & Rychtarik, 1992). Resistance is a signal that the patient views the situation differently. Hence this requires the doctor to put effort to understand the patient's perspective and proceed from where they are. It is a signal to change direction or listen more carefully. It offers the doctor an opportunity to

respond in a new way and to take advantage of the situation without being confrontational. Adjusting to resistance is similar to avoiding argumentation; it offers another opportunity to express empathy by remaining non-judgmental and respectful, encouraging the patient to talk and stay involved.

There are four common types of resistance highlighted by Miller and colleagues (see Appendix D). These are:

- Arguing
- Interrupting
- Denying
- Ignoring

The doctor can use reflective listening techniques to react appropriately to resistance (examples shown in Appendix A).

Support self-efficacy and optimism

Many patients do not have a well-developed sense of self-efficacy and find it difficult to believe that they can begin or maintain behavioural change. Reinforcing self-efficacy requires eliciting and supporting hope, optimism and the feasibility of accompanying change (Sobell & Sobell, 2003). This requires the doctor to recognise the patient's strengths and bring these into conversation whenever possible. Unless a patient believes change is possible, the perceived discrepancy between the desire for change and feelings of hopelessness about accomplishing change is likely to result in rationalisation or denial, in order to reduce discomfort. Because self-efficacy is a critical component of behaviour change, it is crucial that as a doctor you also believe in the patient's capacity to reach his or her goals. Education can increase the patient's sense of self-efficacy. Credible, understandable, and accurate information helps the patient understand more about his or her situation.

More examples on the use of “DEARS” are illustrated in Appendix E (Source: Sobell & Sobell, 2003).

APPENDIX A-I

Other Complex Reflection Techniques:

In dealing with the patient's resistance, here are some strategies using different reflection techniques:

1. **Simple Reflection–** One way to reduce resistance is simply to repeat or rephrase what the patient has said. This communicates that you have heard the person, and that it is not your intention to get into an argument with the person.

Sally: "But I can't exercise. My body is so heavy, I cannot take it."

Dr Lee: "Exercising seems nearly impossible because you feel your body is too weak and unfit."

Sally: "That's right, but I think what you say is true too, that I should start exercising."

2. **Amplified Reflection–** The doctor can amplify or exaggerate the reflection points, where the patient may disavow or disagree with it. It is important that the doctor does not overdo it, because if the patient feels mocked or patronised, it may provoke an angry response.

Sally: "But I can't change my diet. As I really like sweets and desserts."

Dr Lee: "Hmmm, I see. So you really can't change your diet because you feel the sweets and desserts are the main meals that your body needs and you may not survive without them."

Sally: "Well, they are not really the main meals needed by my body, they are just indulgence, I don't think my body needs it to survive."

APPENDIX A-II

3. **Double-sided Reflection–** The doctor reflects both current resistance statement, and a previous contradictory statement that the patient has made.

Sally: "But I can't exercise. My body is so heavy, I cannot take it."

Dr Lee: "You can't imagine exercising, and at the same time you're concerned about how your weight is affecting your physical health."

Sally: "Yes, I guess you are right, I do have mixed feelings about it."

4. **Shifting Focus with Reflection–** This is another way to reduce resistance. It is often not productive to address resistant or counter-motivational statements; instead goals may be better achieved by simply not responding to the resistant statement.

Sally: "But I can't change my diet. I really like sweets and desserts.

Dr Lee: "You are getting way ahead of the topic here. I'm not talking about quitting your sweets completely. We are talking about healthier diet choices."

APPENDIX A-III

5. **Shifting Focus with Reflection–** is a way to avoid argument that is counter-productive to change talk. There is a paradoxical element in this, which often will bring the patient back to a balanced or opposite perspective. This strategy can be particularly useful with patients who present in a highly oppositional manner and who seem to reject every idea or suggestion.

Sally: "But I can't exercise. My body is so heavy, I cannot take it."

Dr Lee: "Well, after our discussion, you may decide that exercise might not be the best option for you, as it may be too difficult to start doing it."

6. **Reframing–** a reflection strategy in which the doctor invites the patient to examine his or her views in a new perspective. By doing this, new meaning is given to what has been said.

Sally mentioned her mother did not understand and nagged at her a lot about her health and weight. Sally may view her mother as "always telling me what to do."

Dr Lee reframed this as: "Your mother must care a lot about you to tell you something she feels is important to you, even knowing that you will likely get angry with her."

APPENDIX A-IV

TIP

EXAMPLES OF SUMMARIES FOR APPENDIX A

Examples of Summaries

(Begin with a statement indicating you are making a summary):

- Let me see if I understand so far...
- Here is what I've heard. Tell me if I've missed anything.
- What you've said is important. Let me re-cap.
- Here are the salient points that you have just shared.

Dr Lee's summary to Sally:

> *"Let's stop for a moment and summarise what we've just talked about. You are saying you are not sure that you want to change your lifestyle because there are a lot of adjustments to make. At the same time, you have some concerns about the worsening of physical and mental health. Did I miss anything?"*

The goal is not to acquire ammunition, which will then be turned on Sally's defenses in an overwhelming manner. Instead, it should be to reflect what Sally had said and encourage Sally to supply the meaning. This is an area where it requires the doctor's attentive listening to the patient's understanding of the problem. It is this understanding that will guide the patient's effort to change or maintain status quo.

APPENDIX B

Evoking Change Talk

(Source: Miller and Rollnick, 1991)

PROBLEM RECOGNITION

- What makes you think that this is a problem?
- What difficulties did you encounter in relation to your current behaviour?
- In what ways have other people been affected by your behaviour?
- In what ways has this behaviour been a problem for you?
- How has this behaviour prevented you from doing what you want to do?

CONCERN

- What is there about your behaviour that you or other people might see as reasons for concern?
- What worries you about your current behaviour?
- What can you imagine happening to you?
- How much does this concern you?
- In what ways does this concern you?
- What do you think will happen if you don't make a change?

OPTIMISM

- What makes you think that if you decide to make a change, you could do it?
- What encourages you that you can change if you want to?
- What do you think would work for you, if you needed to change?

INTENTION TO CHANGE

- The fact that you're here indicates that at least part of you think it's time to do something.
- What are the reasons you see for making a change?
- What makes you think that you may need to make a change?
- If you were 100 per cent successful and things worked out exactly as you would like, what would be different?
- What makes you think that you should keep this behaviour the way as it is? What makes you think it's time for a change?
- I can see that you're feeling stuck at the moment. What's going to have to change?

APPENDIX C-I

Listening to Change Talk

(Source: Miller and Rollnick, 2013)

Change talk can be classified into five categories **- Desire, Ability, Reason, Need, and Commitment (DARN-C)**. Learning to listen for the subtleties of meaning in the patient's conversation in these five categories is a very important practice in MI, as it will help the doctor to decide which strategies work best for the patient.

These questions are additional resources to elicit change talk focusing on DARN-C categories:

DESIRE: Why would you want to make this change?

ABILITY: How would you do it if you decide to change?

REASON: What are the three best reasons?

NEED: How and why is it important?

COMMITMENT: What do you think you'll do?

Here are some examples of how conversations might go with Sally:

DESIRE

"If you were going to change your lifestyle, why would you do it?"

Doctor

"Well, my mother has been nagging me, and I'm beginning to think she is right. I've got to do something or my health just won't take it anymore, since now I have hypertension and high cholesterol. Besides, my stamina is very poor, I get breathless just by taking a few flight of steps."

Sally

"So, you're thinking your mother might be right about your unhealthy lifestyle and it is affecting your health."

APPENDIX C-II

ABILITY

"I know you are not ready to stop your desserts and sweets, but if you were, what are some things you would do?"

Doctor

"It would be very hard for me, because I love my desserts and sweets. I'd have to start by cutting back to just take them on weekend."

Sally

"While it would be hard for you to cut back, it seems like just eating your sweets and desserts only on weekend might be a place to start."

REASON

"Can you give me three good reasons why you might consider changing your lifestyle?"

Doctor

"Oh, if you talked to my mother, she'd tell you more than three reasons! She has been nagging again. She says I'm so unfit that I will just collapse with stroke or heart attack at a young age. Now knowing my blood pressure and cholesterol is high, she will sure nag non-stop. But I guess she is right about it, as my health is suffering now."

Sally

"It seems that your mother is very concerned about you and your health."

APPENDIX C-III

NEED

Doctor

"How important would you say changing your lifestyle is right now?"

"Maybe...not very important yet."

"Why do you say that?"

"I have so many other worries such as work

"It seems to you that your lifestyle is not the most important thing right now. What would have to happen to make it more important?"

Sally

"I think if I had a life-threatening health condition, or an illness which affects my job, it might get my attention."

COMMITMENT

Doctor

"I'm not sure. I could try what my best friend is doing, which is to sign up for a gym membership, just to see what it's like."

"What do you think you'll do about changing your lifestyle? What ideas do you have for yourself?"

Sally

In each of these conversations, the doctor responded with reflective statements, which summarise the change talk statements the patient made. This is an additional technique which the doctor can use in conjunction with the practice of OARS presented in Appendix A. It is important to understand that the doctor would acknowledge the statements that are on the "no change" side of the ambivalence, but reinforce the change talk.

APPENDIX D-I

4 Types of Resistance

(Source: Miller and Rollnick, 1991)

ARGUING (The patient contests the accuracy, expertise, or integrity of the doctor.)

- **Challenging** — The patient directly challenges the accuracy of what the doctor has said.
- **Discounting** — The patient questions the doctor's personal authority and expertise.
- **Hostility** — The patient expresses direct hostility towards the doctor.

INTERRUPTING (The patient breaks in and interrupts the doctor in a defensive manner.)

- **Talking over** — The patient speaks while the doctor is still talking, without waiting for an appropriate pause or silence.
- **Cutting off** — The patient breaks in with words obviously intended to cut the doctor off.

DENYING (The patient expresses unwillingness to recognise problems, cooperate, accept responsibility, or take advice.)

- **Blaming** — The patient blames other people for problems.
- **Disagreeing** — The patient disagrees with a suggestion that the doctor has made, offering no constructive alternative. This includes the familiar "Yes, but...," which explains what is wrong with suggestions that are made.

APPENDIX D-II

- **Excusing** — The patient makes excuses for his or her behaviour.
- **Claiming impunity** — The patient claims that he or she is not in any danger from continuing in that behaviour.
- **Minimising** — The patient suggests that the doctor is exaggerating risks or dangers and that it really isn't so bad.
- **Pessimism** — The patient makes statements about himself or herself or others that are pessimistic, defeatist, or negative in tone.
- **Reluctance** — The patient expresses reservations and reluctance about information or advice given.
- **Unwillingness to change** — The patient expresses a lack of desire or an unwillingness to change.

IGNORING (The patient shows evidence of ignoring or not following the doctor.)

- **Inattention** — The patient's response indicates that he or she has not been paying attention to the doctor.
- **Non-answer** — In answering a doctor's query, the patient gives a response that is not an answer to the question.
- **No response** — The patient gives no audible verbal or clear nonverbal reply to the doctor's query.
- **Side-tracking** — The patient changes the direction of the conversation that the doctor has been pursuing.

APPENDIX E-I

Examples of "DEARS"

(Source: Sobell & Sobell, 2003)

I Developing Discrepancy through DECISIONAL BALANCING

Decisional balancing strategies can be used anytime throughout session. A good strategy is to give the patient a written Decisional Balance (DB) exercise at the beginning of the session and ask the patient to bring the completed exercise on the subsequent session. The DB exercise asks the patient to evaluate his or her current behaviour by simultaneously looking at the good and not so good things about his or her actions.

The goal for the patient is twofold: to realise that (a) there are some benefits from the problem behaviour and (b) there will be some costs if the patient decides to change that behaviour.

Talking with patients about the good and not so good things they have written down on their DB can be used to help them understand their ambivalence about changing and to move them further toward wanting to change. The doctor can do a DB exercise with the patient by simply asking in an open-ended fashion about the good and not so good things regarding the problem behaviour and what it would take to change that behaviour (a sample of DB worksheet is attached below).

The doctor could say:

- Tell us some good things and not so good things about your behaviour?
- How do you think your life would be different if you were to change?
- What do you see your life to be if you don't make changes and continue the same behaviour?

APPENDIX E-II

- How does your _____ fit in with your goals?
- On one hand, you say that your _____ are important to you, yet you continue to _____, help me to understand...
- What do you feel you need to change to obtain your goals?
- How will things be for you a year from now if you continue to _____?
- Hypothetically speaking, if you were to make a change in any area of your life, what would it be?

A SAMPLE OF DECISIONAL BALANCE WORKSHEET

When we think about making changes, most of us don't really consider all "sides" in a complete way. Instead, we often do what we think we "should" do, avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we have fully considered a possible change. This can help us to "hang on" to our plan in times of stress or temptation.

Below, write in the reasons that you can think of in each of the boxes. For most people, "making a change" will probably mean quitting / stopping _____(behaviour), but it is important that you consider what specific change you might make, which may be something else.

(Refer to the worksheet on the next page)

APPENDIX E-III

Decisional Balance Worksheet

	BENEFITS/PROS	COSTS/CONS
Making A Change		
Not Changing		

II Expressing EMPATHY

The doctor could say:

- I understand how difficult this is...
- Yes, making changes is hard work...it is VERY hard work!
- I know where you're at with this.
- That must have been hard on you.

APPENDIX E-IV

III Amplifying AMBIVALENCE

The doctor could say:

- How has your behaviour been a problem to you? How has it been a problem for others?
- What was your life before you started having problems with _____?
- If you keep heading down the road you're on, what do you see happening?

IV Rolling with RESISTANCE

The doctor could say:

- That is OK if you don't want to change...it is your choice.
- Maybe you aren't ready to change.
- What do you want to do? How do you want to proceed?
- Where do you want to go from here?

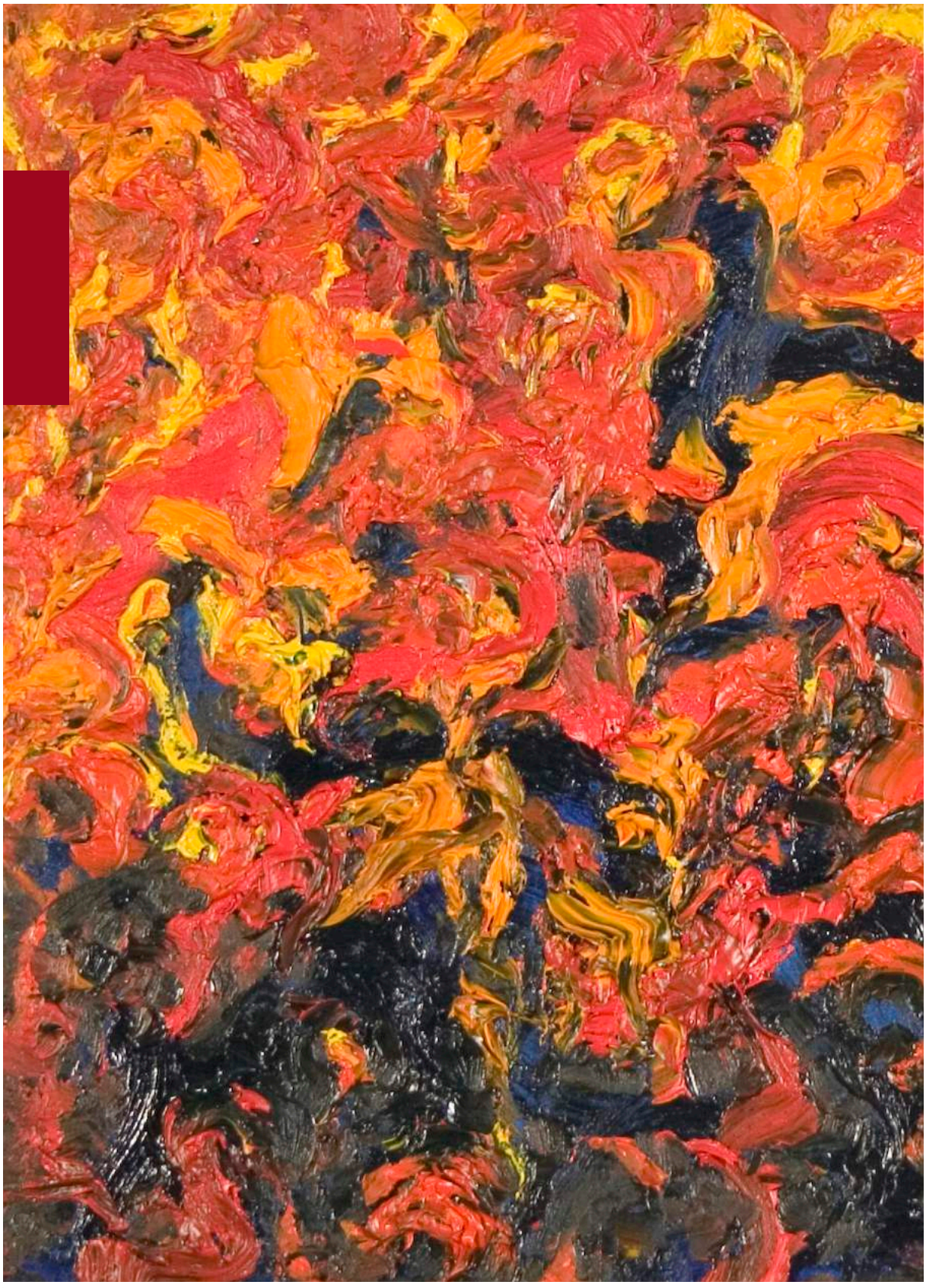
V Supporting SELF-EFFICACY

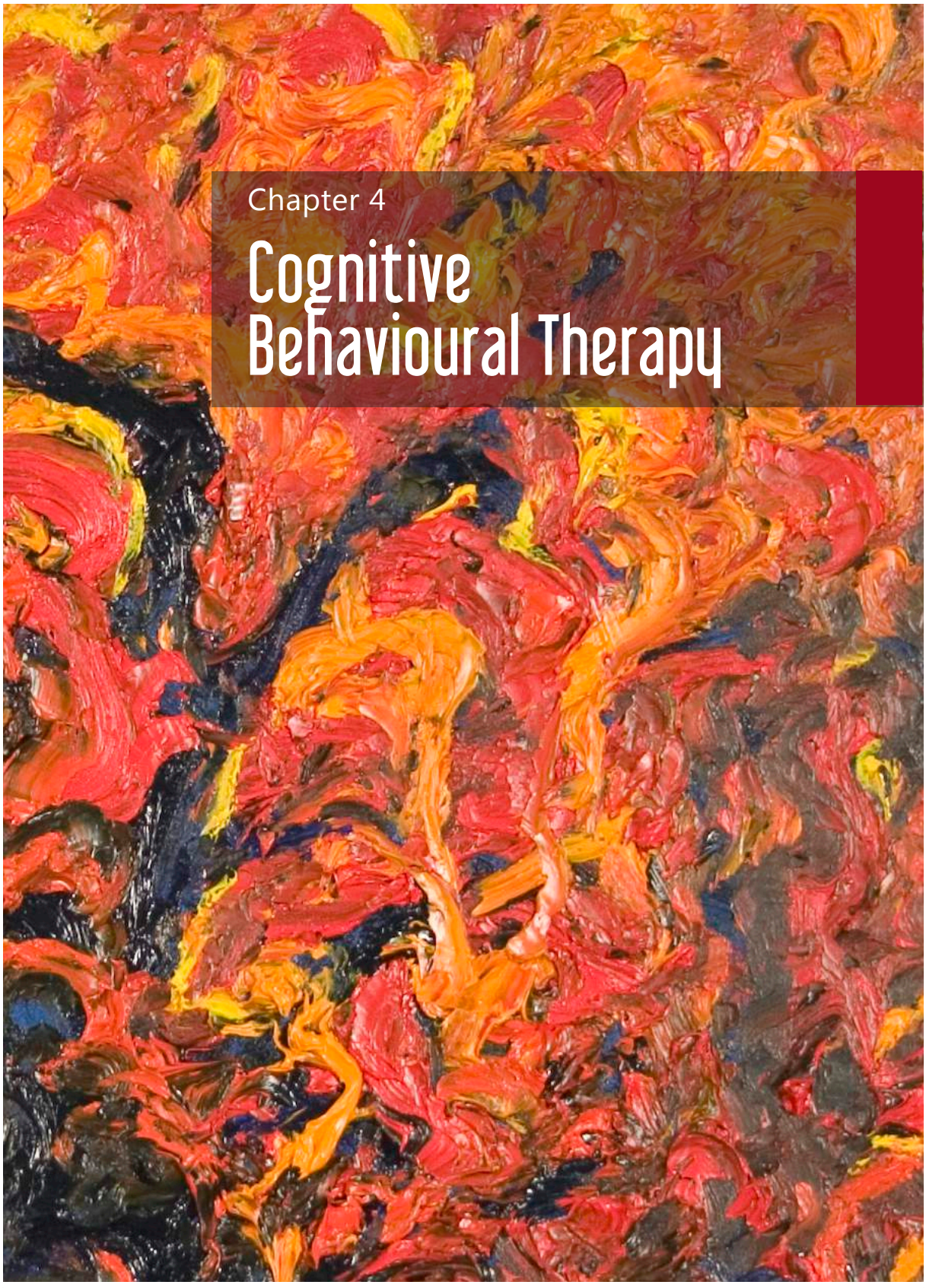
The doctor could say:

- It seems as though you have put a lot of thought into your goals...
- You have a good plan of action...
- It sounds like you are still struggling with making these changes, but you have had some success at making some.
- It sounds like you have made real progress. How does that make you feel?

Key Points at a Glance

1. MI is a technique in which the doctor can take on a more directive role, and become the enabler in the change process.
2. The doctor's goal is to elicit self-motivational statements from the patient in addition to creating discrepancy, in order to enhance motivation for positive change.
3. It is a collaborative relationship between the doctor and the patient.
4. MI can be used to resolve the ambivalence that prevents the patient from realising his or her goals.
5. MI builds on Carl Rogers' optimistic and humanistic theories about believing people's capabilities for exercising free choice and changing through a process of self-actualisation.
6. MI seeks to understand the patient's frame of reference, particularly through reflective listening, expressing acceptance and affirmation.
7. The doctor closely monitors the patient's degree of readiness to change, ensuring that resistance is not generated by jumping ahead of the patient.
8. Even for patients with low readiness or lack of motivation, MI can serve as a prelude to therapeutic work.





Chapter 4

Cognitive Behavioural Therapy

"It's not what happens to you but how you react to it that matters."

Epictetus

John visited his family doctor for the fourth time in a fortnight, each time presenting with different and vague symptoms and requesting a medical certificate to excuse him from work. Having treated him more than 10 years, his doctor noticed that John looked quite downcast and low-spirited recently. Upon further probing, he learnt that John had ended a long-term relationship a few months ago. He lost interest in activities he used to enjoy, and expressed that he felt "useless" and undeserving of love.

Emily had always seemed quite anxious and tended to worry a lot about things. At her visit to the doctor, she shared that she had been having a number of things on her plate, including her son's upcoming school examinations, her mother's ill-health, and a new project at work. As a result, she had been experiencing palpitations and nervous tension. Besides referring her for further investigations, her family doctor also thought she might need help in managing her anxiety.

This chapter will apply the concepts and framework of Cognitive Behavioural Therapy to understand John's and Emily's problems. Brief interventions suitable for primary care will also be introduced.

What is Cognitive Behavioural Therapy?

Cognitive behavioural therapy, or CBT for short, is a form of therapy originally developed to treat depression. It has since been extended and used for a wide range of other psychological problems including anxiety, eating disorders, and obsessive compulsive disorder. Extensive research has shown that combining CBT with pharmacotherapy is more efficacious that either form of therapy alone for the treatment of psychological conditions such as depression and anxiety.

The Power of Perception

CBT combines concepts from both behavioural therapy and cognitive therapy. The fundamental theory in CBT argues that emotional and psychological problems arise from negatively-biased thinking i.e. emotions do not occur because of an event; rather, they come about from our perception and interpretation of an event. The resulting emotions influence our actions and behaviours, which in turn further impact on our emotions. In this way, thoughts, emotions, behaviours, and physiology influence each other in a unified system. This is illustrated in Figures 1 and 2. The goals of CBT are, therefore, to change unhelpful and biased thoughts and behaviours in order to change emotions.

QUOTE

WILLIAM JAMES

"The greatest weapon against stress is our ability to choose one thought over another."

FIGURE 1 - CBT MODEL (I)

Thoughts, behaviours, emotions and physiology mutually influence and interact with each other

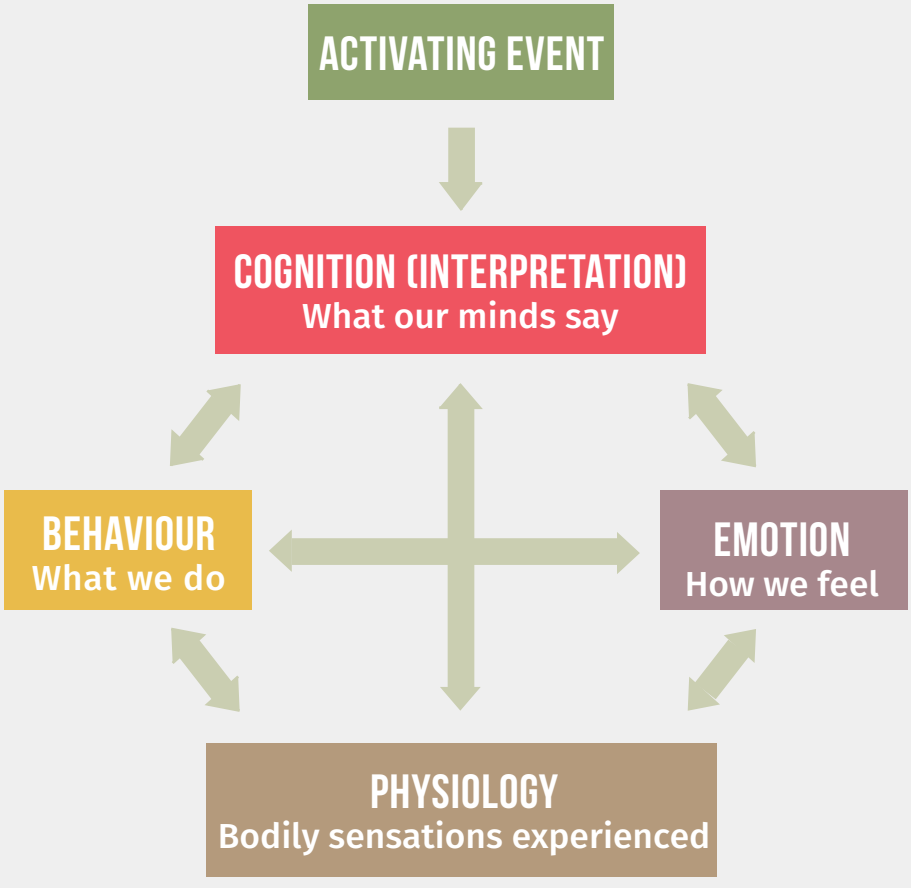
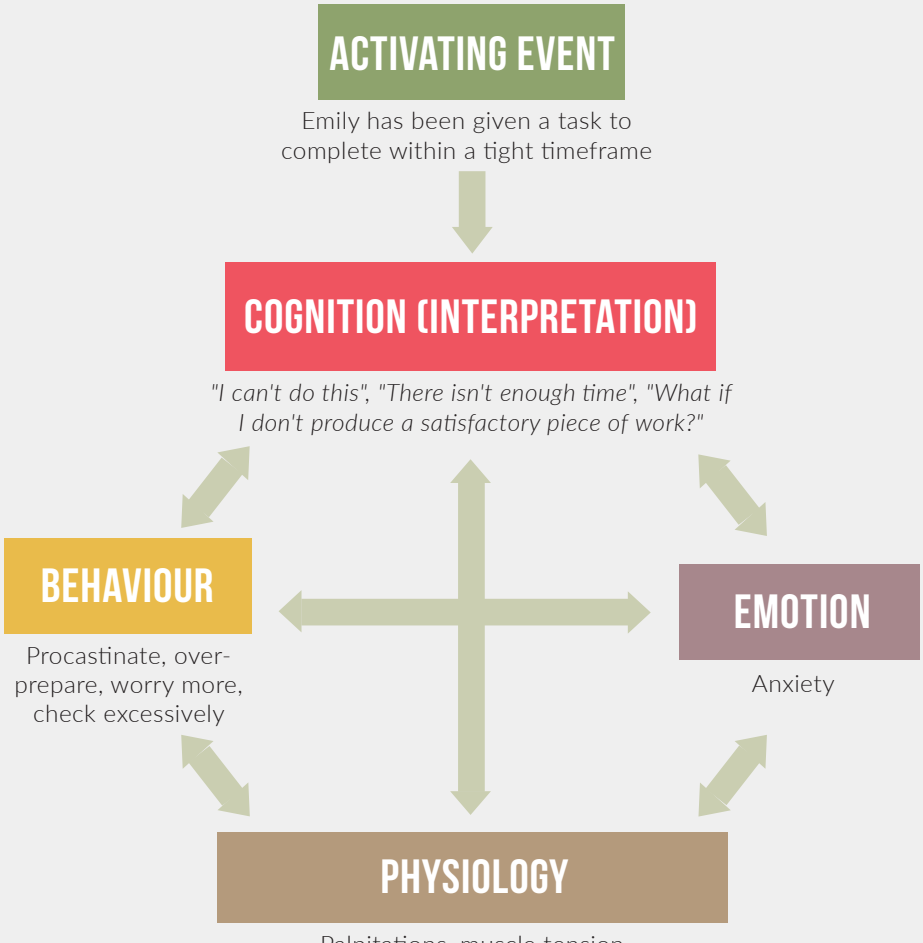


FIGURE 2 - CBT MODEL (II)

Case example of the CBT model. Emily's automatic thoughts that arise from the activating event cause her to feel anxious and trigger physiological reactions in her body. The thoughts also cause her to engage in unhelpful behaviours that perpetuate her problem and result in more worrying. The palpitations may also bring on more anxiety, and hence more palpitations. In this way, various components of the model have reciprocal influences on each other.



Principles and Characteristics of CBT

Therapeutic work in CBT is based on a shared formulation, or case conceptualisation. The doctor uses the CBT framework to understand what causes and maintains the patient's problems, and shares this with the patient. This is made possible through good therapeutic alliance and a collaborative approach between doctor and patient. At the core of CBT, the unhelpful thinking is examined and questioned through techniques that guide the patient to self-discovery, rather than lecturing, persuading, or debating. A range of behavioural and cognitive strategies are used, depending on the patient's presenting issues. Throughout this, the doctor explains the rationale and process of each exercise, to teach the patient to become his own therapist.

How will CBT be useful for my Family Practice?

CBT has been adapted for use in primary care with promising results. Given its time-limited nature, it is possible to use CBT as a brief intervention. The wide range of behavioural and cognitive techniques allows the doctor to pick and choose interventions. Often, patients may resist being referred to mental health specialists, have to face with long waiting times for specialist treatment, or are limited by resources e.g. money, time, accessibility. The psychoeducation components of therapy can build insight in the patient that may encourage further help-seeking behaviours. The collaborative nature empowers the patient to start taking small steps for self-help, rather than rely entirely on the doctor for a "cure".

What are some Prerequistes and Contraindications for CBT?

In order to engage in the CBT techniques, patients need to have some accessibility to their thoughts and be able to identify and report them. Some level of emotional awareness is also required e.g. ability to recognise, differentiate, and name emotions. If these are not present, it is recommended that patients first build up such skills through monitoring records such as a mood diary. CBT should also be used only when the doctor has reasonable rapport with the patient to be able to trust and engage with the doctor. CBT is also most suitable for patients with mild to moderate levels of emotional and psychological disturbances. If patients are acutely unwell to the extent that they are unable to engage, pharmacotherapy or other forms of therapy should be considered first.

What about the Case Formulation?

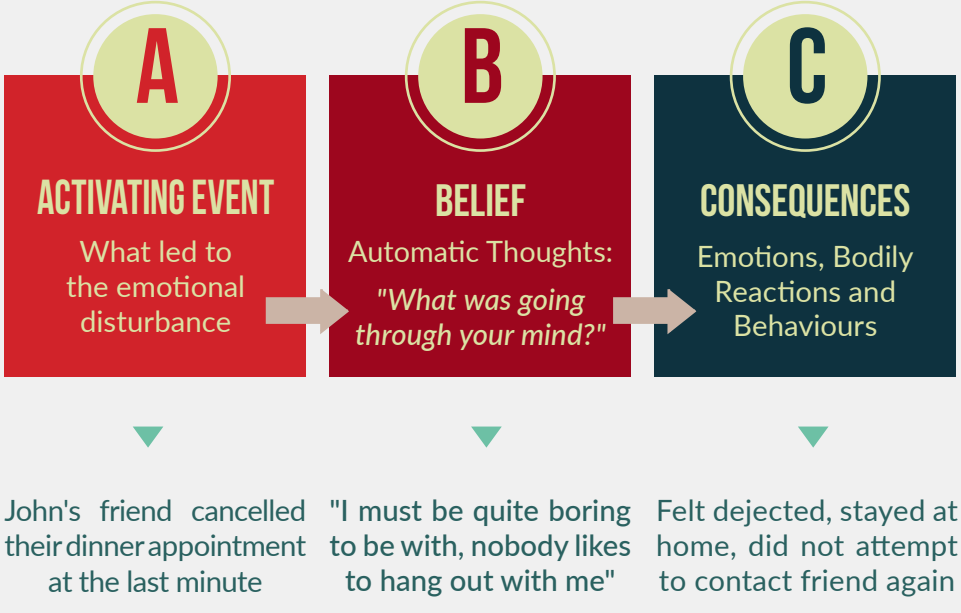
The case formulation helps us make sense of the problem. Information is collected by carrying out a thorough and focused interview with the patient. The doctor identifies factors that make the patient vulnerable to experiencing this problem (background and predisposing factors), what triggered the problem (precipitating factors), what processes and issues are maintaining the problem (perpetuating factors), and what positive aspects can be harnessed upon in treatment (protecting factors).

The main focus in CBT is usually on the perpetuating factors and these are usually targeted in therapy by selecting appropriate interventions to overcome them. The formulation is also shared with the patient without using jargon (see section on Psychoeducation).

The ABC's of CBT

The ABC framework helps the doctor and patient identify triggers, thoughts, emotions, and behaviours. These can be elicited either through direct questioning (see section on socratic questioning) or monitoring diaries (see Figure 3). This also provides an opportunity for the doctor to educate the patient on the link between thoughts and feelings and present the rationale for challenging and changing thoughts. The doctor may first use an everyday example that is easily identifiable to the patient, before applying the model to the patient's own problems. This is illustrated in Box 1.

FIGURE 3 - AN EXAMPLE OF JOHN'S THOUGHT DIARY



BOX 1 - EXPLAINING THE THOUGHT-FEELING LINK

using an everyday example with the help of a diagram

Doctor: Imagine this person, A, is walking in a mall and happened to see his colleague from another department, a few metres away from him. As his colleague looks over, A smiles and waves at him. But his colleague doesn't wave back - what do you think would be going on in A's mind?

John: Maybe this colleague doesn't like me, or maybe I'm so insignificant that he doesn't remember or recognise me.

Doctor: And how would A feel if he thought that way?

John: Sad.

Doctor: Now imagine A thought something else, like "Wow this guy is rude and arrogant". How would A feel?

John: He would probably feel angry.

Doctor: And now, imagine A thought "Oh, maybe he was deep in thought and didn't see me". How would he feel?

John: He wouldn't feel anything. Just normal.

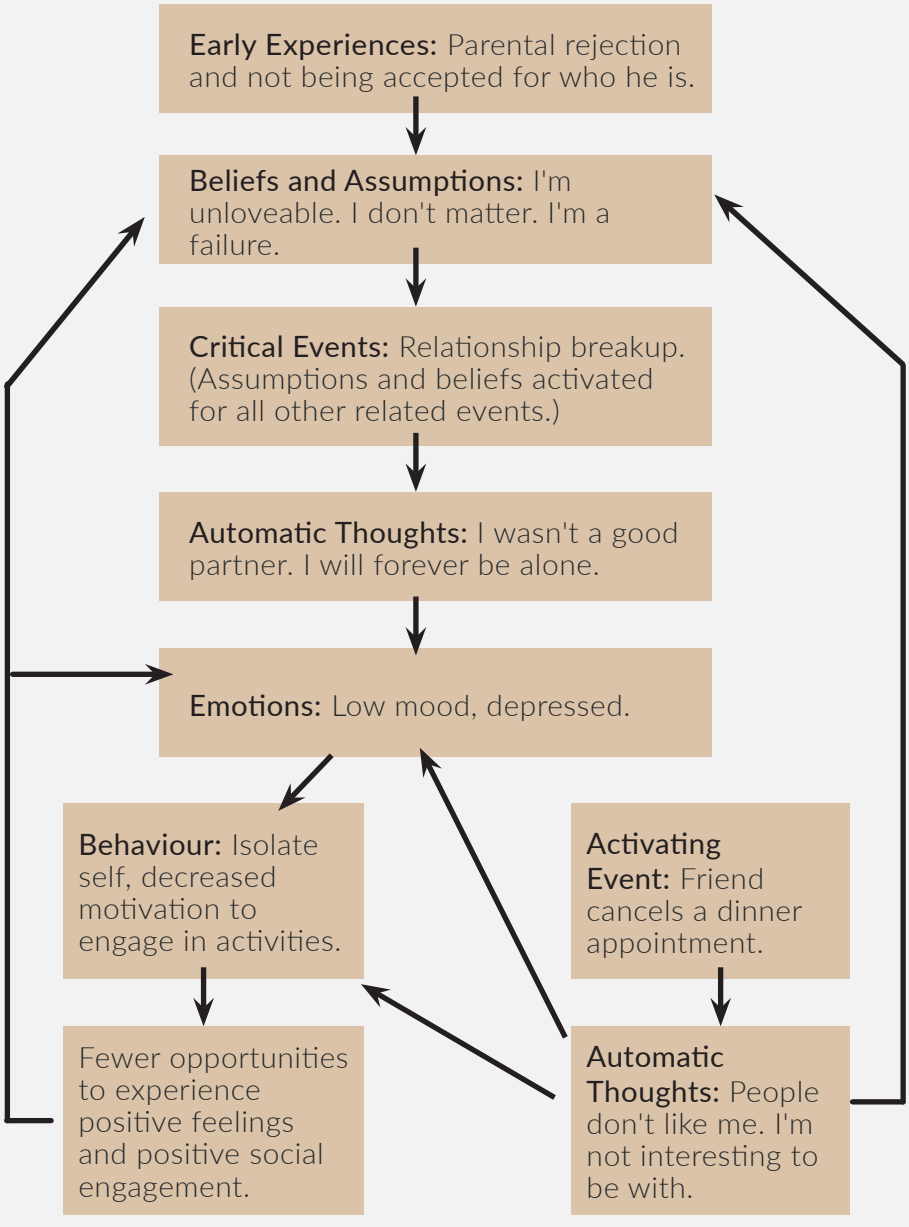
Doctor: So you see how different thoughts and interpretations can arise from one single event, and depending on how we think, we will feel differently, and subsequently act differently.

The Origins of Automatic Thoughts

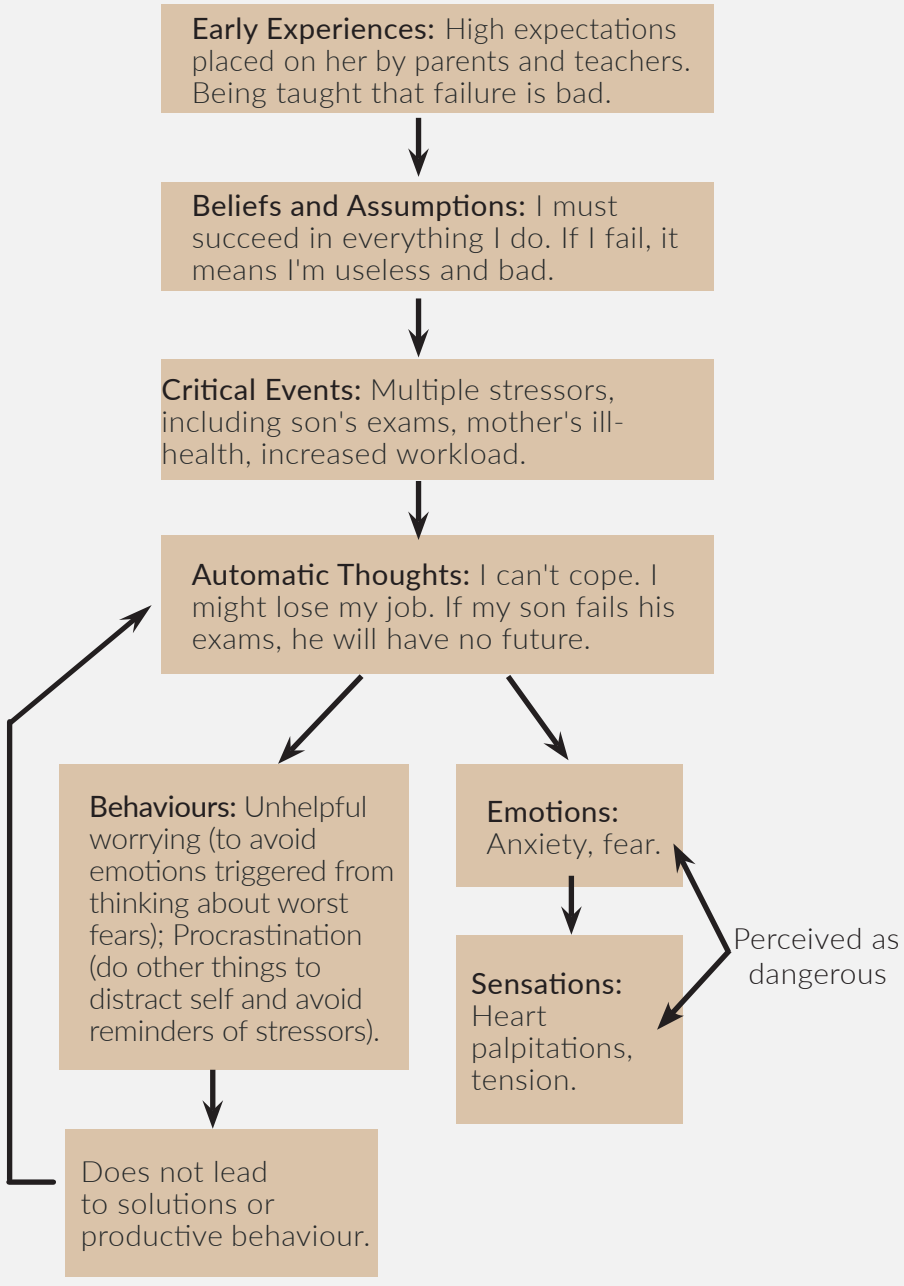
Automatic thoughts are what we call self-talk, things we say to ourselves, or self-statements. These are distinguished from underlying beliefs and assumptions, or which are overarching beliefs about oneself, others, and the world. Underlying beliefs guide information processing, help us organise the world, and shape how we think, feel, and behave. They are formed from early childhood and mostly remain dormant until activated by significant events and triggers e.g. a relationship breakup. When these beliefs are activated, our interpretations of (i.e. automatic thoughts) and responses to other related situations will be influenced by these beliefs.

This is illustrated in Boxes 2 and 3 for both John and Emily. Underlying beliefs are more difficult to elicit and not always obvious. Sometimes, working on the level of automatic thoughts is sufficient and it is not always necessary to work with underlying beliefs. When necessary, further examination and careful questioning of the activating event and automatic thoughts can shine light on the underlying beliefs.

BOX 2 - CASE FORMULATION FOR JOHN



BOX 3 - CASE FORMULATION FOR EMILY



Maintaining Process

As the main focus of CBT is on the present, perpetuating factors (or maintaining processes) form a crucial component of the formulation. These are usually understood as vicious cycles in which automatic thoughts, influenced by activated underlying beliefs, trigger emotions and sensations, and guide actions and behaviours, that further feedback to the external event, thoughts and underlying beliefs, thereby maintaining the emotion and symptoms.

Below is a list of a few common maintaining processes applied to case examples in Boxes 2 and 3.

1. Reduction of Activity and the Lethargy Cycle
2. Escape and Avoidance
3. Scanning and Hypervigilance
4. Fear of Physiological Sensations of Anxiety
5. Cognitive Distortions

REDUCTION OF ACTIVITY AND THE LETHARGY CYCLE

This is a common maintaining process in depression. Low mood leads to decreased motivation and energy, and thus a reduction in activity. Inactivity can have an opposite effect of increasing feelings of lethargy. In addition, reduction in activities that used to produce positive feelings (such as social activities and hobbies) leads to fewer opportunities to experience these emotions like enjoyment, satisfaction, achievement, and joy. As a result, the low mood is maintained.

ESCAPE AND AVOIDANCE

This is a common maintaining factor in anxiety. Situations or places that bring on anxiety are avoided or escaped from in order to avoid experiencing anxiety. E.g. someone who gets anxious and experiences feelings of panic on public transport might avoid taking public transport. Someone who fears being judged by others might avoid going to crowded places. This maintains the problem because the person does not learn that 1) the symptoms may not come on, 2) the feared consequences may not happen, and 3) if they do happen, he or she will be able to cope and gain confidence from the experience. Worrying is viewed as a form of cognitive avoidance, as it allows one to avoid the somatic experience of anxiety and avoid thinking about core and deeper fears.

SCANNING AND HYPERVIGILANCE

Often seen in people with anxiety, scanning or being hypervigilant to feared events or symptoms can have the very effect of making them happen (a form of self-fulfilling prophecy). E.g. someone who worries about pain in his leg might subconsciously rub, pinch, or press on it from time to time to monitor for pain sensations. These actions might inadvertently bring on pain. Someone who fears attracting attention in public may constantly scan the environment for anyone who might be staring at her. These actions might in turn make her stand out and attract stares.

FEAR OF PHYSIOLOGICAL SENSATIONS OF ANXIETY

Common bodily changes brought on by the sympathetic nervous system when one experiences anxiety include increased heart rate, sweating, and muscle tension (which can lead to trembling). Some people can develop a fear of such sensation and perceive them as dangerous or threatening (e.g. "I'm having a heart attack"). These fears can be so intense that they bring on anxiety, which then makes the sensations stronger, leading to an upward spiral of increasing anxiety.

COGNITIVE DISTORTIONS

Cognitive distortions are also known as thinking errors, or unhelpful thinking styles. Often, the automatic thoughts that bring about distressing emotions tend to seem believable and true at that point in time, but upon further examination, these are usually biased, irrational, unhelpful, and lead to negative emotions. Most people make thinking errors from time to time. Problems occur when people are unable to recognise them, regulate them, and consider alternative ways of thinking. Therefore, a major component of CBT is to help the patient identify and recognise these thinking errors, understand how they influence emotions, question or challenge them, and derive more balanced thoughts.

A list of common cognitive distortions can be found in Table 1.

TABLE 1 - EXAMPLES OF COGNITIVE DISORDERS OR THINKING ERRORS

Cognitive Distortion and Explanation	Example
All-or-nothing/ black-and-white thinking Looking at things at the extremes rather than on a continuum.	"If I don't do this perfectly, it means I have failed."
Ultimatums Using absolute terms like always, never, everyone, no one.	"I never do well at anything", or "Everyone thinks I'm weird".
Personalisation and self-blame Holding oneself fully responsible for something that one had only partial responsibility (and not full control) for.	Someone who thinks, "It's all my fault, I pulled everyone down with me", when his team loses in a competition.
Catastrophising Believing that the worst outcome will happen.	"If I say something wrong, he will not like me, and he will tell everyone what a bad person I am. Then I will not have any friends."
Mental Filter Focusing on the negatives and ignoring or minimising the positive aspects; not taking into account the whole picture.	Making a conclusion that one did not do well in one's presentation based on a colleague's statement, while discounting positive feedback from others.

TABLE 1 - EXAMPLES OF COGNITIVE DISORDERS OR THINKING ERRORS (CONTINUED)

Cognitive Distortion and Explanation	Example
Overgeneralisation Using one piece of evidence to make generalised conclusions.	Saying that one is a failure in all aspects of his life because he made a mistake in one piece of work.
Labelling Making generalised, all-or-nothing statements about oneself or others.	"I'm a loser" or "She's heartless".
Mind Reading Making predictions about and believing that one knows what others are thinking.	"She must think I'm incompetent."
Fortune Telling/ Predicting the Future Predicting and believing that things will go badly even before it happens.	"I know I'm going to fail this test."
Double Standards Expecting of oneself what one would not expect of others.	Being harsh on oneself for making mistakes, but pardoning others for making the same mistakes.

What are the Various Interventions and Techniques used in CBT?

Socratic Questioning

This is a form of questioning that derives from the Greek philosopher, Socrates, who taught his students by asking questions that would lead them to arrive at the answers and conclusions themselves. In CBT, socratic questioning refers to the technique of asking questions that 1) the patient knows the answer to, and 2) draw the patient's attention to relevant information that he has not considered. Instead of suggesting these to the patient directly, this form of gentle and curious questioning encourages the patient to use what he or she already knows to discover alternative viewpoints (refer to Box 4).

The aim is guided discovery, rather than changing minds. Questions are phrased in an inquisitive manner that encourages reflection, rather than to engage in a debate or point out that the patient is wrong. An empathic stance should be maintained at all times. Socratic questioning is used in various stages and techniques in CBT (see examples in Table 2).

BOX 4 - THE DIFFERENCE BETWEEN

(a) Socratic Questioning and (b) Direct Persuasion or Suggestion

(A) Socratic Questioning

Emily: "I get so worried about making mistakes at work, that I spend so much time checking and re-checking my work."

Doctor: "And what happens when you do that?"

Emily: "I take even longer to finish the work, have less time for other work so I have to rush, and it makes me more stressed.

Doctor: "And what happens when you're stressed?"

Emily: "I get more flustered and I make more mistakes."

Doctor: "So what does this tell you about how checking and re-checking helps your work?"

Emily: "It actually doesn't help me. Maybe if I spent less time checking, I will have more time to do my work and be less stressed and won't make so many mistakes."

Doctor: "How can we test that out?"

Emily: "I could check my work only once for the next one week, and record my stress levels and how many mistakes I actually make."

(B) Direct Persuasion or Suggestion

Emily: "I get so worried about making mistakes at work, that I spend so much time checking and re-checking my work."

Doctor: "But Emily, do you realise that when you spend too much time checking, you will take longer to finish your work and have less time for other work, so you will have to rush to finish the rest of the work. And this can make you more stressed and flustered, and so you'll actually be more likely to make mistakes. So maybe if you can try to check your work only once through, you might free up more time for other work, and be less stressed, and in turn make fewer mistakes."

TABLE 2 - EXAMPLES OF THE USE OF SOCRATIC QUESTIONING IN VARIOUS STAGES AND TECHNIQUES OF CBT

CBT Stage / Intervention	Examples of Questions
Assessment and Psychoeducation	• What was going on in your mind? • What happened when you did that? • When that happens, how do you feel? • What do you mean when you say that? • If that were true, what would it mean? • What does this tell you about _____?
Behavioural Techniques	• What could you do to test that thought? • How would we know if this were true? • What would be the first easiest step to take? • How can we start? • What's the worst that can happen? How can you prepare for it? What could you do if it happened? • What did you learn from this experiment?
Cognitive Therapy	• What is the evidence that this is true? • Were there times in the past that this was not true? • Were there times in the past that someone said something different to you? • What would you say to a friend in this situation? • How does thinking this way help you? • Now that we have considered other viewpoints, how likely do you think this will happen?

Psychoeducation

Psychoeducation is the first stage of therapy proceeding from the assessment phase, and continues to be an ongoing process throughout therapy.

As CBT is collaborative in nature, the aim of psychoeducation would be to get the patient "on board" in the treatment process, help the patient understand the problem and the maintaining factors, and thereby present a rationale for intervention strategies. The process comprises a balance of didactic teaching and guided discovery through socratic questioning.

The following steps are covered in psychoeducation (see Box 5 for an example):

1. Share information on the problem.
   - E.g. What is depression, common symptoms, prevalence, likely causes (genes-environment or diathesis-stress model).
2. Frame the problem as an exaggeration of normal processes.
   - E.g. Fear and worry as a normal process and reaction, but in anxiety disorders these are exaggerated and become unhelpful.
3. Discuss the maintaining factors.
   - The use of diagrams and arrows helps the patient visualise these vicious cycles better.
4. Explain what to expect in therapy, how therapy will address the problem and maintaining factors.

BOX 5 - EXAMPLE OF PSYCHOEDUCATION ABOUT THE LETHARGY CYCLE AND EXPLAINING THE RATIONALE FOR BEHAVIOURAL ACTIVATION.

(Refer to Box 1 as well for example of psychoeducation on thoughts and feelings)

Doctor: "John, you told me that you have been feeling quite down lately, and as a result you have been staying at home more."

John: "Yes, exactly. I just can't work up the energy to do anything. I just lie on the couch all day, staring at the television but not really watching any show in particular. My room is in a mess, but I don't have any motivation to tidy it."

Doctor: "It's common for people to feel unmotivated and lethargic when they are depressed. Tell me, John, how do you feel after lying on the couch for the whole day?"

John: "I feel worse- like I have just wasted another day."

Doctor: "So despite resting on the couch and not doing anything, you are not feeling more energetic but actually feel worse."

John: "Yes, you're right."

Doctor: (drawing a diagram as he speaks) "Actually, many people who are depressed go through this too. When they feel down, they feel tired and unmotivated, and lose interest in things they used to enjoy. So naturally, they stop doing these things and stay at home more, thinking if they get more rest, they will feel better. However, over time, what happens is they miss out on all the opportunities to experience joy and satisfaction from engaging in meaningful activities. They might even start to blame themselves for being "lazy". And how do you think this would make them feel?"

John: "They feel more depressed. Just like me. But what should I do then?"

Doctor: "First, in order to break this vicious cycle, we will get you to start doing something, even if you don't feel like it. I know this is going to be hard, so we will move slowly, in a step-by-step manner. Secondly, we will look more closely at some of the things you say to yourself, and test out whether these are helpful, realistic, and true."

Behavioural Techniques

The behavioural component of CBT targets unhelpful behaviours that maintain the problem.

Behavioural Activation

As explained in Box 4, the lethargy cycle is broken by encouraging the patient to schedule and engage in meaningful activities. The patient is told to do them "even if you don't feel like it". Activities suitable for behavioural activation are those that increase positive emotions like pleasure, satisfaction, and mastery. Examples include exercising, social activities, previous hobbies, or even mundane tasks (such as paying bills and doing the laundry) that when completed, will bring about a sense of achievement.

Some guidelines for behavioural activation include:

1. Start small. Breaking tasks down into smaller steps makes them seem easier and more achievable.
    - Start with doing a 10-minute walk every day, or start with tidying just one part of the room (e.g. throwing dirty laundry into the laundry bin).

2. Be specific and schedule it into the calendar. Patients are more likely to do it if they have planned for it.
    - Specify the activity as much as possible (e.g. what, how long, when, where).
    - Engage the patient in this process by asking (rather than telling) the patient what to do (*"When will you do it?"*).
    - I will go for a 10-minute walk to the nearest supermarket every evening before dinner.

3. Anticipate barriers.
    - Discuss what negative thoughts might get in the way (e.g. *"I'm not going to enjoy this"*, *"This is going to fail again"*) and come up with coping statements to overcome them.

4. For resistant or sceptical patients, this can be framed as an experiment (*"Try it out and see what happens to your mood"*).

Graded Exposure

In exposure, the patient faces his fears, usually in a gradual manner, and learns that 1) he can cope with it, and 2) the consequences might not be as bad as expected. E.g. someone with social anxiety might be asked to approach someone at the store for help; or someone who avoids crowded places due to a fear of experiencing panic attacks might be asked to start going out to nearby places and work towards going to crowded places during peak hours.

The aim is for the patient to experience a moderate level of anxiety, but to stay in the situation instead of escaping. Through this, the patient learns that his anxiety level peaks and drops if he stays long enough in the situation (instead of spiralling out of control which is what patients usually expect); in other words, the patient habituates to it.

A graded approach to exposure is recommended, in which mildly-feared stimuli are targeted first, followed by more strongly-feared stimuli. This approach involves constructing an exposure hierarchy in which feared stimuli are ranked according to their anticipated fear reaction (like steps in a ladder). Generally, higher-level exposures are not attempted until the patient's fear subsides for the lower-level exposure.

Graded exposure can be carried out in the following steps:

1. Present the rationale for exposure.
    - A metaphor can be used to illustrate this. "Imagine you were going to teach a child how to swim. This child is afraid of the water. What would you do?" Patients are usually able to say that they would first let the child sit by the pool, then take him knee-deep into the water, and gradually progress to dipping his entire body and head in the water. The patient can also be asked to consider what would happen if the child was allowed to come out of the water every time he got afraid.
    - Parallels are then drawn to the patient's situation and problem.

2. Create an exposure hierarchy (or ladder). An example is shown in Table 3.
    - Introduce the patient to the term Subjective Units of Distress (SUDS), a way to rate anxiety from 0 (very relaxed) to 100 (extremely anxious).
    - Elicit the most anxiety provoking situation (highest level; SUDS = 100).
    - Ask the patient what would constitute an activity that brings about a SUDS level of 50. This will be the first step.
    - Brainstorm and list other activities between the first and last step.
    - Emphasise that these can be changed later on to make it easier or harder.

3. Start from the first step. Prepare the patient by specifying the task, planning for it, anticipating barriers, and discussing ways to cope (much like in behavioural activation).

4. Patient to do exposure on his own.

5. Patient returns and debrief is conducted. Difficulties will be discussed. The therapist encourages the patient to reflect on what he has learnt from the exercise.

TABLE 3 - SAMPLE EXPOSURE HIERARCHY

for Emily, who avoids taking public transport as she fears that a panic attack might come on and she will not be able to cope.

Steps	Task Description	SUDS Level
1	Take the train one stop down	50
2	Take the train to the gym (3 stops down, 7-minute ride)	60
3	Take the bus to the library (20-minute ride)	70
4	Take the train to best friend's house (20-minute ride)	80
5	Take the train to/from work during non-peak hour (30-minute ride)	85
6	Take the bus to/from work during non-peak hour (30-minute ride)	90
7	Take the train to/from work during peak hour (30-minute ride)	95
8	Take the bus to/from work during peak hour (45-minute ride)	100

How are Cognitive Interventions Carried Out?

Cognitive interventions target maladaptive thoughts, beliefs and assumptions held by the patient, and attempt to replace them with more balanced and adaptive beliefs. The use of socratic questioning is crucial here. Thoughts are framed as hypotheses, rather than truths, and the patient is encouraged to test these hypotheses to evaluate their validity. The process consists of the following steps:

1. Identify the thought or belief.
2. Apply cognitive techniques to test the thought or belief.
3. Encourage the patient to generate an alternative, more balanced thought or belief.

Identifying Thoughts

In order to work with thoughts, we first need to recognise the thought. Hence, the first step in cognitive therapy is for the patient to identify and verbalise the thought. The easiest and most common method is to ask the patient during the session, "What was going through your mind?", or "What were you saying to yourself?" The patient can also record his thoughts in a thought diary outside of session. A sample template of a thought diary can be found in the Appendix. When patients are unable to verbalise these thoughts, the doctor can aid the process by suggesting or guessing what might be going on for the patient:

e.g. *"Were you thinking that no woman would ever be interested in you?"*

"Were you thinking that your boss would think you are incompetent if you asked for more time?"

Cognitive Distortions and Thinking Errors

As cognitive distortions and unhelpful thinking styles can perpetuate the problem, it is important to teach patients to recognise them. This can be done by providing them with a list of common thinking errors (see Table 1) and having a discussion about which ones sound familiar to the patient.

The patient can then start to identify the types of thinking errors in their thought records (see sample in Appendix), and ask themselves some questions to test these thoughts. E.g. Someone who thinks "*It's my fault, I never do anything right"* is using ultimatums and blaming himself. This person can be encouraged to ask himself *"Have there been other times when I have done well or other people have complimented me?"* or *"Am I claiming responsibility for things that are not within my control?"*

A list of such questions can be found in Box 6 and Table 2.

BOX 6 - EXAMPLES OF QUESTIONS PATIENTS CAN ASK THEMSELVES IN RESPONSE TO THINKING ERRORS

- What would I say to a friend or loved one in the same situation?
- What would I say if this happened to a friend or loved one?
- What's the worst that will happen? How could I deal with it?
- What's the likelihood that the worst will happen? What else might happen instead?
- Has a similar situation happened before? How did it turn out?
- Based on what I know from past experience, what is the evidence that this will (or will not) happen?
- How does thinking this way help me?
- What are some other ways to look at this issue?

Alternative Explanations

The patient can be asked, "Could there be an alternative explanation for what happened?"

> John: He must've thought that having dinner with me would be boring, so he cancelled the appointment.
>
> Doctor: Could there be an alternative explanation for why he cancelled the dinner?
>
> John: I don't know. Maybe something else cropped up. I know work has been hectic for him.

Examining the Evidence

The patient is asked to imagine himself as a detective and through a series of socratic questions, he searches for evidence for and against an automatic thought or belief. An example is shown in Box 7.

BOX 7 - EXAMPLE OF A THERAPIST EXAMINING THE EVIDENCE WITH JOHN

John:	"He must have thought having dinner with me would be boring, so he did not turn up."
Doctor:	"You think he cancelled on you because he didn't think it was worth meeting you.'
John:	"Yes, I'm a boring person to be with."
Doctor:	"That's an interesting thought, John. Let's examine it a little more. What is the evidence to support that thought?"
John:	"Well, my ex-girlfriend said it when we broke up."
Doctor:	(takes out a piece of paper) "Ok, let's put it here. What other evidence do you have?"

John: "I'm quite a quiet person. I don't say much when I'm with people."

Doctor: "Ok, what else?"

John: "Nothing else I can think of."

Doctor: "Ok, now let's look at the other side of the table. I wonder if there is any evidence to show that you are not a boring person to be with?"

John: "Not that I can think of."

Doctor: "Has anyone ever said they enjoy your company?"

John: "I guess so. My nephew loves to play with me when he comes over. Yeah, I guess he wouldn't think I'm boring."

Doctor: "Ok, let's put that down. Any other evidence?"

John: "Well, I have other friends who have been trying to get me out, saying they miss me, but I haven't had the mood to meet them."

Doctor: "And what does that mean - when they say they miss you and want to meet you?"

John: "I guess it means I'm not that boring after all - there are at least a few people who do enjoy my company."

Thought: I'm a boring person to be with	
Evidence for this thought	**Evidence against this thought**
Girlfriend said this. I'm quiet and don't talk much.	Nephew loves to play with me. Friends miss me and want to meet me.

Pie Chart

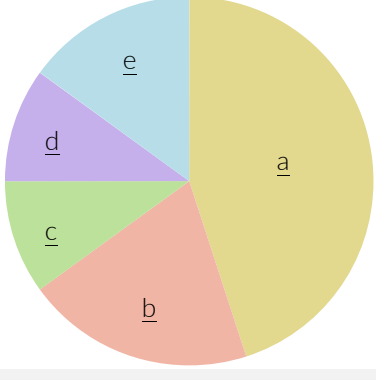
The pie chart is particularly useful for patients who tend to assume personal responsibility for things. The biased thought is identified, and the patient is asked to list all alternative explanations that may have contributed to the event happening. He or she is then asked to assign a level of importance (out of 100%) to each of these explanations on the list. Finally, he or she assigns the remaining percentage to the original thought. This is drawn out in a pie chart (see Box 8).

BOX 8 - EXAMPLE OF EMILY'S PIE CHART

Thought/belief: "*My son failed his recent test because I wasn't there to revise with him the night before. It's all my fault.*"

List all possible reasons and rate contribution:

a. My son did not start studying for it earlier despite my reminders (45%)
b. The test was hard (20%)
c. Unlucky - the topics he put more focus on did not come out (10%)
d. He was still recovering from the flu that day (10%)



Contribution of original thought (e):
100 - (45+20+10+10) = 15%

New balanced thought: *"He might have done better if I had revised with him the night before, but this was only one of the many reasons why he did not do well. It's not entirely because of me."*

This exercise encourages patients to consider other reasons for the occurrence of an undesirable event and through this, realise that their role in it is actually smaller than what they had originally perceived it to be. An alternative, more balanced, thought is then constructed. For some patients who continue to place an unrealistic proportion of blame on themselves relative to other factors, further socratic questioning can be used to examine and test these beliefs.

Behavioural Experiments

Behavioural experiments are exercises in which information is gathered to test the validity of the one's beliefs. Both the doctor and patient can take on a curious approach, and the exercise is framed in a way that there is no loss to the patient for trying it out i.e. if it goes as expected, the patient's beliefs can be confirmed, but if it turns out to be different, new beliefs can be constructed.

The following steps can be used:

1. The patient's belief is expressed in the form of a statement, which is the hypothesis to be tested.
   - *"If I stumble on my words in a presentation, people will notice and laugh at me."*
2. An experiment is designed to test out this belief.
   - Stumble on a word during a presentation or meeting on purpose. Get a trusted colleague to record how many people laugh. Later, ask colleagues if they noticed me stumbling on the word.
3. The patient carries out the experiment, collects data, and records the outcome.
4. A conclusion is made from the experiment. The patient discusses with the therapist what this means for the original belief. An alternative, more adaptive, belief is constructed.
   - *"If I stumble on my words in a presentation, most people will not notice. Those who notice tend not to laugh."*

APPENDIX A

ABC Thought Diary

Activating Event	Describe the event or situation leading to unpleasant feelings.	
Belief	What thoughts were going through your mind?	
Consequence (Emotions)	How did you feel? Name the emotion, including any physical sensations.	
Consequence (Behaviours)	What did you do? Describe your actions and behaviour.	

APPENDIX B

Thought Diary: Thoughts As Hypotheses, Not Truths

A- Activating Event

Describe the event or situation, leading to unpleasant feelings.

B- Belief

What thoughts were going through your mind? Choose the "hottest" thought.

C- Consequences

Describe physical sensations, label emotions, and describe your behaviours.

D- Disputation

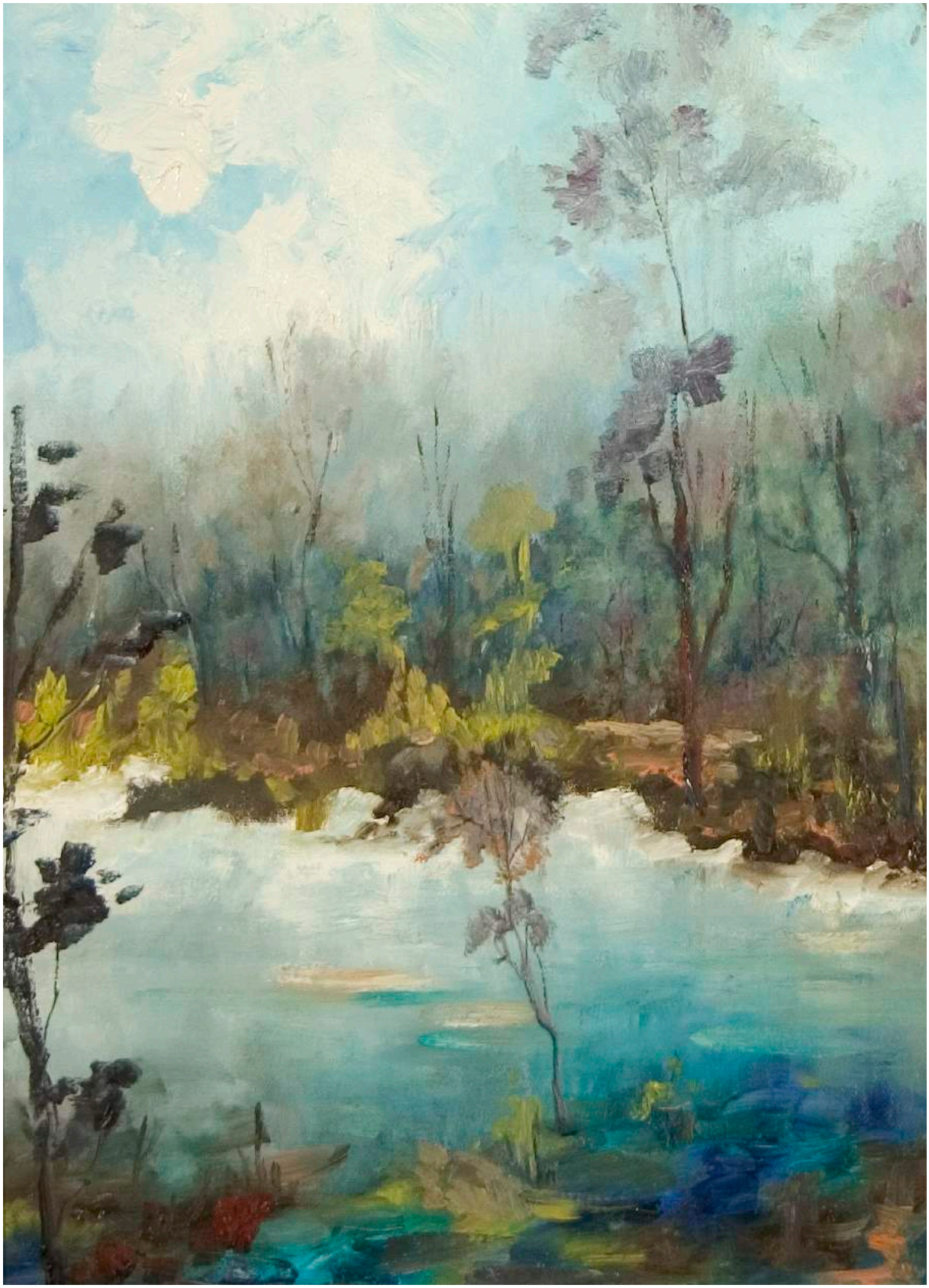
1. Am I making any thinking errors?
2. What is the evidence for/against this thought?
3. Has this situation happened before? What was the outcome?
4. What would I say to a friend or loved one who was having this thought?
5. What is the worst that could happen? How would I cope?

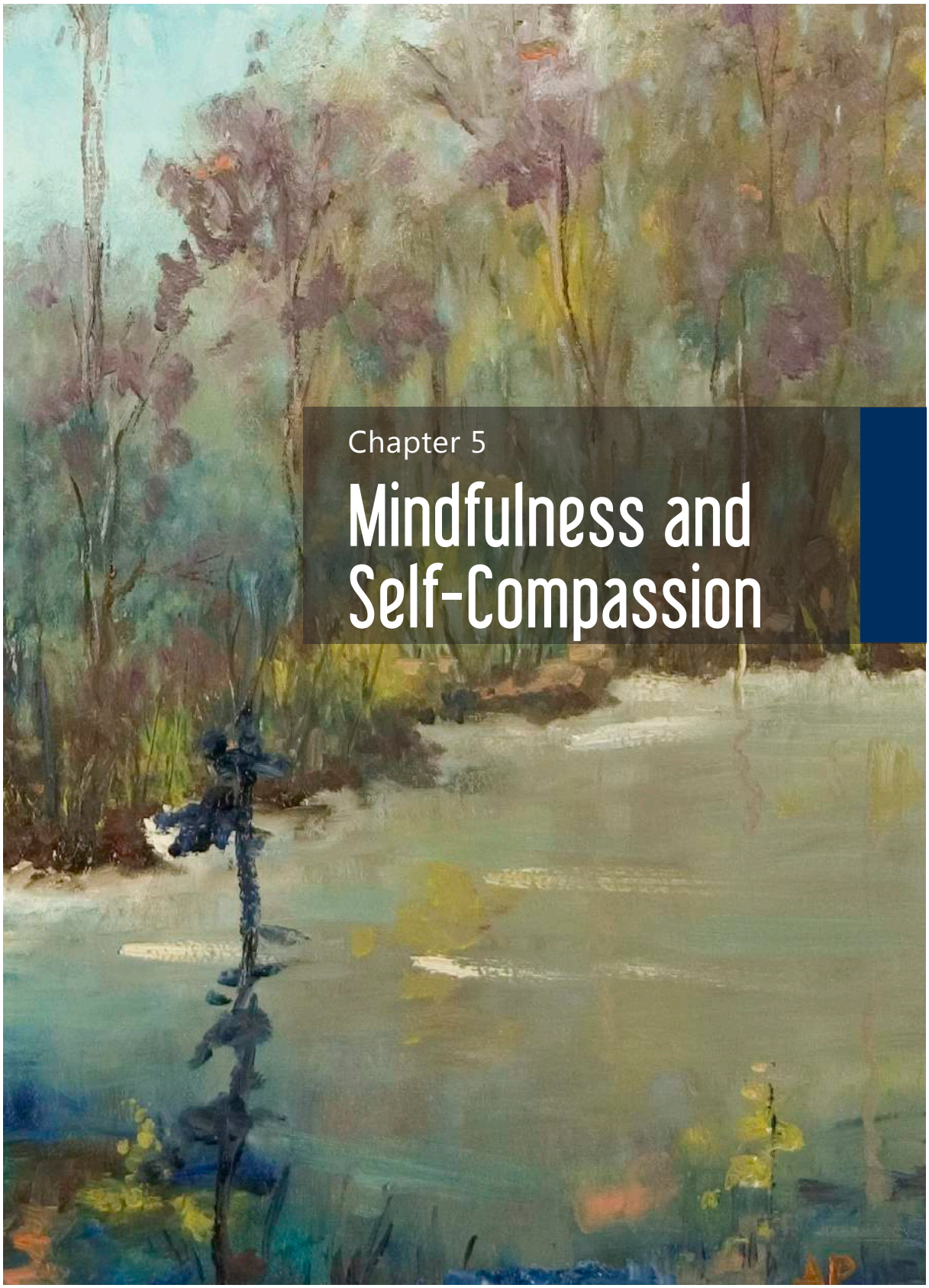
E- Energise

What is an alternative way of thinking?
What is a more realistic outcome?
What should I do?

Key Points at a Glance

1. Cognitive behavioural therapy looks at changing unhelpful thoughts and behaviours that contribute to emotional problems.
2. One's perception and interpretation of an event determines how one feels about the event.
3. A CBT formulation helps the doctor understand the factors that maintain the problem and which areas to target in treatment.
4. As CBT is collaborative in nature, the doctor shares the formulation with the patient and provides psychoeducation on the problem and its maintaining factors.
5. Socratic questioning is used to guide discovery, rather than debating and persuading.
6. Both behavioural and cognitive techniques are employed in CBT to change biased thoughts and unhelpful behaviours, and to replace them with more balanced thoughts and helpful behaviours.





Chapter 5

Mindfulness and Self-Compassion

The moment one gives close attention to anything, even a blade of grass, it becomes a mysterious, awesome, indescribably magnificent world in itself."

Henry Miller

From previous consults, Dr Quek knew that Amy tended to be highly strung and anxious. However, despite repeated exploration, Amy was unable to identify what made her so tense. All she knew was that she was extremely anxious and that this anxiety made her physically uncomfortable. She also felt that she was a "loser" and a "weakling" for experiencing anxiety. Despite such suffering, Amy refused to take any medication that Dr Quek wished to prescribe for her condition. Dr Quek offered to coach Amy in some mindfulness and self-compassion skills, so that Amy had some way to manage herself whenever her anxiety became too distressing.

Mindfulness in Context

Family doctors would sometimes encounter patients whom they sense require more than medical interventions. These patients usually present with acute but intense emotional responses. Some of these patients would be able to verbalise their emotional turmoil whilst others might express them more in terms of physical

complaints such as insomnia, headaches, or indigestion. At other times, it is the patients' physical illnesses that are stress-provoking, causing strong emotional responses that threaten to overwhelm the patient. Intense emotional turmoil can have a debilitating effect on physical health, regardless of whether they are the contributor or result of physical symptoms. Furthermore, sufferers of chronic physical illnesses would often report a sense of self-blame, negative self-perception or reduced self-worth, which aggravates their emotional turmoil.

Janet Christie-Seely (1995) argued that doctors not only take care of the physical aspect of healing, they also take care of the emotional aspects associated with physical wellness. Indeed, if the emotional aspects of health and the emotional contributors to ill-health are addressed, then it is likely that medical interventions would become effective and enhanced. This is because the doctor is treating the patient more holistically, not just addressing the physical aspects of medicine, but also the emotional and mental aspects.

In the presence of patient emotional turmoil, interventions such as mindfulness and self-compassion techniques might increase the doctor's treatment repertoire. When explained and delivered appropriately, mindfulness and self-compassion training can also serve to empower the patient to do something about his or her uncomfortable emotional and physical state.

Benefits of mindfulness

When we make the effort to be regularly and consistently mindful, then we might experience several benefits. For instance,

mindfulness-based therapy has been associated with reduction of depression and anxiety symptoms, as well as those linked to physical health problems. Participation in mindfulness-based stress reduction training (a comprehensive mindfulness training programme) is associated with reduction in stress symptoms, ruminative thinking tendencies, and increased empathy and self-compassion. Furthermore, mindfulness practices have been related to improvement in functional somatic symptoms, immune functioning, reduction in blood pressure and cortisol levels and improvement in chronic pain experiences. Mindfulness brings about these benefits because it enhances our capacity to relate constructively to our physical and emotional differences – as opposed to our usual symptom-perpetuating style of responding.

Benefits of self-compassion

Likewise, being compassionate towards ourselves and our shortcomings has been shown to be beneficial. For instance, being self-compassionate is associated with a reduced likelihood of having a mental illness, an increased likelihood of being optimistic, socially connected and psychologically well, and better physical and mental health. Meredith Terry and Mark Leary (2011) suggested that self-compassion could improve coping as well as self-regulation, which in turn positively affects health-improving behaviour and subsequently physical health status.

Before the doctor can coach patients in mindfulness and self-compassion practices, he or she needs to understand what these are both at a conceptual level and a personally experienced level.

So What is Mindfulness (And What is Not)?

Before you read on, take a moment to notice:

- The position of your body, and the sensations that go along with this position – what are you aware of?
- The movement and sensations of your breathing as it moves through your nose, down your chest and into your abdomen.
- The sensation of your hands as they hold this book – what does the texture and weight of the book feel like?
- Any thoughts, images, impressions, emotions, memories or even judgments about what you are doing now, come up in your mind – allowing anything and everything to come up for the moment.
- Any sounds happening around you at the moment – simply noticing whatever sounds come to your awareness.

How was this brief experience like for you? Was it in some way:

- **A deliberate/ purposeful** exercise of your attention? – You had to make the conscious effort to pay attention to your body, breathing, the book, your internal experiences and the sounds surrounding you.
- **Open and accepting? –** You are allowing yourself to be aware of all internal and external experiences without censoring anything.
- **Free of judging or attempts** to control any of these experiences? – You are simply aware of everything, even any judgments or evaluations about your awareness; and any urge control your experiences
- **Happening in real time? –** Your awareness of all of the experiences above was concrete and as they were happening. You were present in your body.

Congratulations and welcome! You have just had a brief taste of being mindful. From your experience, mindfulness is simply:

"Purposefully acting to be aware of all of one's internal and external experiences happening in any moment, without any attempts to change these experiences."

Now, think of a time earlier today or even several days before when you:

- Daydreamed during a meeting, an interaction or while doing some other activity.
- Ate a meal without tasting it or remembering what you actually ate.
- Met a new person and instantaneously forgot his or her name.
- Heard what someone said to you and immediately forgot about it.
- Got overwhelmed by upset or disgust or had some negative emotion towards someone or something then tried to suppress

such negative emotions.

What was your state of mind during these moments? Was it in some way:

- **Dazed, forgetful, tranced-out and diffused –** You were unaware of the details of an experience?
- **Conflictual and judgmental –** You had some emotions and you were being judgmental about these emotions? You felt as if you were struggling against your own emotions?
- **Out-of-body –** You were somewhere else and definitely quite unaware of your body?
- **Automatic reaction –** Your reactions tend to happen without much deliberation or seemingly lack control?

How often have you felt like this? This state of mind is called **mindlessness**, the opposite to being mindful. It is made up of the automatic and almost knee-jerk reactions to situations and our internal experiences. Mindlessness is characterised by being absorbed into the mental narratives of the past and/or the future with an underlying wish to avoid the unpleasant experiences. Often this leads to the mistaken attempts at controlling what is outside one's sphere of control which only results in failure and further frustration.

How About Self-Compassion?

Self-compassion is another healthy response to our experiences. It is the fraternal twin of mindfulness. Kristen Neff (2011) argued that it involves having a kinder, more balanced relationship with ourselves (our emotions, thought, actions, and experiences) in the face of hardship or perceived shortcomings.

Think back to a time when you made mistake at work or in your personal life. Were you:

- **Highly critical toward yourself**
  - Beating yourself up about what you should have done or could have done? Perhaps you even ran a story telling how bad a person or doctor you are, going into detail the string of catastrophes you just barely managed to avoid due to no fault of yours.
- **Feel like you are the only, single most inadequate person or doctor in the world**
  - No one could make such a blunder as you? Surely competent human beings or doctors do not make mistakes of this magnitude?
- **Become very caught-up with the idea of being unworthy**
  - This idea colours your day, and makes you recall every single time you have made a mistake? Do you think along these lines: "If I've made this mistake, then I must be a failure"?

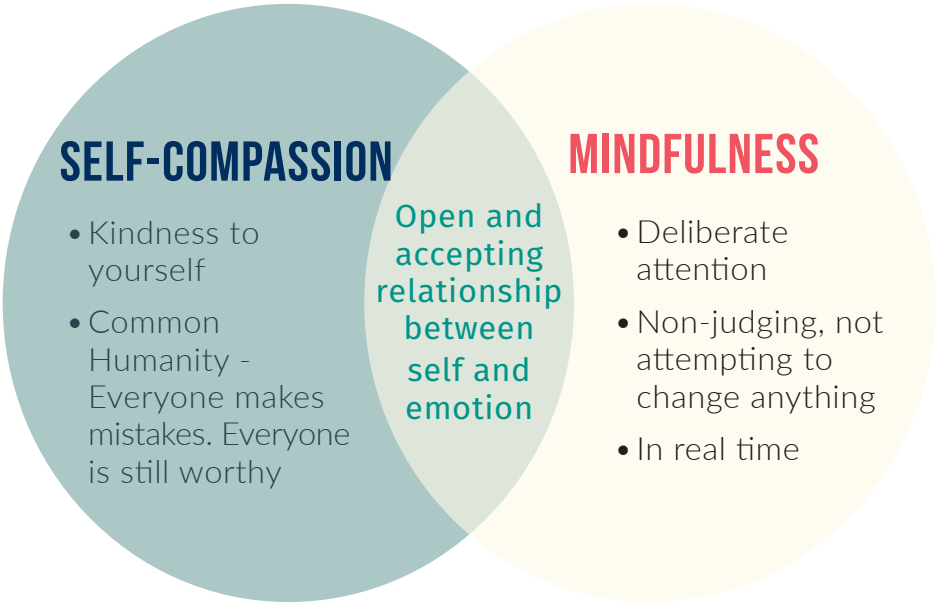
This is self-hatred. It is the opposite of self-compassion. Now, think back to a time when you made a mistake but (even for a little bit) you:

- **Were kind to yourself**
  - You tell yourself that despite the mistake, you are still a worthwhile human being. You show your emotions empathy, much like you would show empathy to a friend in pain.

- **Put things in perspective**
  - You are aware somehow that you are not the only person who makes mistakes. Instead, you understand that being human means we make mistakes, and that everyone has made a mistake before. You are not alone in this.

- **Were mindful**
  - You are able to relate to your emotions (even the critical ones) at a comfortable distance. You are aware that there is a YOU in which emotions are occurring, like clouds occurring in the sky.

If you have managed this even for a little bit, then congratulations! You were being self-compassionate. Kornfield (2008) put it this way: you were in a place where "(your) love meets (your) pain". How are mindfulness and self-compassionate related? Put simply:



Some Ways of Being Mindful

Here are some simple exercises you and your patients can practice on a regular basis to foster a more mindful living condition. Choose the one that best fits you.

EXERCISE 1: CURIOSITY

Curiosity is one part of the antidote to being overwhelmed by fear and other strong emotions.

- Sit or stand comfortably upright, with your eyes looking downwards and relaxed.
- Be aware of any experiences that are happening inside you right now – they could be thoughts, images, emotions or sensations.
- Considering the flow of these experiences as a whole, can you describe what it is like?
  - Where do you feel this flow of experiences the most?
  - What shapes or forms does it have?
  - Does its shape change?
  - What colours best describe this flow of experience?
  - What are its movements like?
  - Does it change with time?
  - What other features does it have?

EXERCISE 2: LABELLING

This exercise helps you be aware of experiences happening in real-time. It also helps you have a more realistic and objective understanding of these experiences. It helps create a distance between the person and his or her experiences.

- Sit or stand comfortably upright, with your eyes looking downwards and relaxed.
- Be aware of any experiences that are happening inside you right now – they could be thoughts, images, emotions or sensations.
- Whenever you notice a prominent experience, mentally label it "thinking", or "feeling" or "sensations" or "images".
- Keep labeling prominent experiences moment-by-moment.
- Do so for two to five minutes.

EXERCISE 3: BREATHING AS ANCHOR

This exercise is helpful for patients who need to stabilise their strong emotions. It grounds the attention on something concrete (the breath), bringing the person's awareness out from the depths of their emotions to their present physical reality. Note: the breathing is natural, and there is no deliberate attempt to make it deep or slow.

- Sit or stand comfortably upright, with your eyes looking downward and relaxed.
- Be aware of the natural rhythm of your breathing in your body.
- As you breathe in, mentally trace this breath in your mind. Silently say: "Innnnnnn", for the duration of this breath.
- As you breathe out, mentally trace this breath in your mind. Silently say: "Ouuuuut", for the duration of this breath.
- Leave everything else such as your thoughts, emotions, sensations, impressions and memories in the background of your awareness.
- Whenever your mind drifts to the background of your awareness, gently bring it back to the current breath.

EXERCISE 4: MINDFUL ACTIONS

This exercise has the same effect as Exercise 3. However, it can be applied more flexibly on-the-go. It is essentially turning all your routine activities into mindfulness practices.

- Think of a task that you will be doing later. For instance, you might be brushing your teeth.
- When you do brush your teeth, be aware of the physical action and sensations of brushing your teeth.
- Make your actions deliberate, and also be curious about noticing as many sensations as you can (both in your mouth, and in your brushing arm).
- Be aware of the how these movements and sensations change as you go about brushing your teeth.
- Repeatedly bring your awareness back to the motion and sensations of brushing, leaving all other experiences in the background.

Here is another common activity most take for granted.

- As you walk from place to place, be aware of the movement of your legs and feet. Also be curious about how your feet feel as they contact the ground and then lift off from the ground.
- Notice the changes in movement and the sensations that follow as you walk.
- Leave all other experiences in the background of your awareness, always returning attention to your current foot-step.

The main principle for this exercise is to be fully aware of the motions and sensations of your routine activity, while you leave all other experiences in the background of your awareness. Choose some activities that you do daily and plan to apply this principle to them. You will get a lot of mindfulness practice that way!

EXERCISE 5: BEING AWARE OF THE URGE TO CHANGE EXPERIENCES

While we can be aware that we should not attempt to change any of our experiences, we will undoubtedly experience the urge to do so. This exercise helps put things in perspective. It can also be used in conjunction with any of the other exercises in this chapter.

- Whenever you encounter something you dislike.
- Whenever you encounter an experience you wish would be different.
- Be aware of where you feel this desire to change your experiences.
- Take a moment to mentally and kindly say to this desire (in whatever way you can imagine it): "Hi, it's okay that you are here." Repeat this acknowledgement a few times if needed.
- Then return to the activity you were engaging in.

The principle here is to treat the desire to change experiences as another experience in itself.

Some Ways of Being Self-Compassionate

Here are some simple exercises you and your patients can practice on a regular basis to develop greater self-compassion. Choose the one that best fits you.

EXERCISE 6: KIND WISHES

- Set aside two to five minutes.
- Sit comfortably upright with your eyes closed or looking at the ground.
- Be aware of the natural movement of your breathing in your nose, throat, chest or belly.
  - When you breathe in, mentally wish yourself: "May I be well."
  - When you breathe out, mentally wish yourself: "May I be safe."
  - For the next in-breath, mentally wish yourself: "May I be loved."
  - For the next out-breath, mentally remind yourself: "I am worthy."
- Repeat these four wishes, really meaning them to the best of your ability, as you follow your breathing.

It might feel awkward initially, but you will likely feel more natural as you continue this practice. This practice is particularly useful after a hard day, an altercation or after you've made mistakes. Notice when you are starting to beat yourself up after these incidents, and quickly respond with positive wishes.

EXERCISE 7: BALANCED SELF-TALK

On the topic of mistakes, we all make them. We make errors in the tasks we do. We might treat other people badly. When you make such mistakes, you might start giving yourself a hard time. At other times, you might simply feel bad about yourself for some other reason. At moments like this, take a moment to reflect in this manner:

A. Be aware and acknowledge your suffering

- Start by reflecting on this mistake or simply focusing on the sense of feeling bad about yourself
  - What emotions do you notice?
  - What are you saying about yourself, in your mind?
- Mentally acknowledge these emotions by telling yourself "There's pain there." Other variations include: "This hurts", "Ouch", "It's uncomfortable".
- Mentally acknowledge the things you are saying about yourself.
  - You could tell yourself "These thoughts are here." (Other variations include: "Yes, I'm thinking about myself in this way").

B. Remember common humanity - everyone feels like this sometimes

- Next, reflect on how everyone feels like this sometimes – "I'm not alone in feeling and thinking this way", "Others feel this way about themselves too", "We all struggle in our lives".
- You could also reflect like this: if it was a person dear to you who feels and thinks this way, what would be a compassionate response to them?
- Reflect about treating yourself with a similar compassionate response.
- Finally, reflect on this: "Even though I have made a mistake/ feel bad about myself for some reason, I'm still basically a worthy person."

Please note:

This exercise is NOT an excuse for the mistake! One still has to acknowledge the mistake and make amends where possible. Rather, it is about expanding awareness so that the practitioner comes to appreciate that everyone feels similarly at some point in their lives. It normalises the experience of self-blame and suffering, and enables a more self-compassionate attitude. Self-compassion is the first step towards making healthy amends.

EXERCISE 8: INNER RELATIONSHIP WORK

We are sometimes bombarded by negative self-talk and emotions. It is as if we have a gremlin inside blaming us, criticising aspects of ourselves, and whispering harsh judgments to us. These whispers can lead us to dislike or even hate ourselves. Here is a more healthy way of treating ourselves.

Whenever you notice self-criticism or negative feelings towards yourself.

- Be aware of where you feel it the most.
- Breathing in, gently say to the self-critical voice or negative feelings (in your imagination): "You are here".
- Breathing out, gently say to yourself: "I am here too."
- Repeat this sequence to the natural rhythm of your breathing.

This exercise creates a kind of mental distance between your sense of self and the emotions or thoughts that are floating within it. It reduces the impact of these emotions and thoughts, by practicing a kind response towards them. It is also a powerful mindfulness exercise.

EXERCISE 9: QUICK COMBINATION SELF-COMPASSION

While the first three exercises can be used independently, when combined they can have a potent effect. We can do the combination exercise at any time, regardless of whether we are experiencing negative emotions towards ourselves or not.

A. **Inner relationship:** Take a moment to be aware of what emotions and thoughts are floating around in your awareness. Gently and kindly acknowledge them in some way.

B. **Common humanity:** For the self-critical thoughts and negative emotions you carry, gently remind yourself that everyone struggles with these feelings. You are not alone in this experience.

C. **Kind wishes:** Mentally wish yourself well.

- "Regardless of my feelings and thoughts.
- May I be well and may I be loved. I am worthy."

EXERCISE 10: SITTING WITH SELF-CRITICISM

This is an adaptation from Paul Gilbert's (2010) exercise for patients who are overly self-critical. Self-criticism can heighten negative emotions, and sometimes, people can become highly self-critical at themselves for having negative emotions.

- Whenever you start to blame yourself or otherwise criticise yourself in some way, take a moment to be aware of this critical part and what it is saying about you.
- Next, with a gentle and soft breathing rhythm, start imagining a compassionate person (this can be someone you really know or simply imagine) who is treating you compassionately. This person could simply be smiling at you or could be speaking well wishes to you. Stay with this image, allowing more details of it to arise.
- Whenever you drift back to the self-critical part, imagine this compassionate person also treating the self-critical part with compassion.
- Then return to imagining the compassionate person treating you with compassion. Repeat the last two steps as many times as needed.

An example of
COACHING MINDFULNESS & SELF-COMPASSION

Skills Coaching Protocol

Notice that Dr Quek uses the following protocol or steps to coach Amy:

STEP 1.

Offer and explain why – Dr Quek offers the technique and explains why and how it is useful. When offering these interventions, start by explaining why and how they can be useful.

- He relates the technique or practice to Amy's experience, making it relevant

Dr Quek: "Would you like to try something that can help with your anxiety?"

Amy: [looks doubtful and a bit anxious] "I don't know. Will it really help?"

Dr Quek: "Well, I'm going to show you a non-medical method that can decrease your anxiety. You've told me that your mind is very active and this keeps the anxiety going. Is that right?"

Amy: [replies] "Yes!"

Dr Quek: "You've also told me that you tend to be very critical towards yourself when you feel anxious?"

Amy: [nods vigorously] "I just feel so useless! I can't even overcome something like this! It's not like I've got cancer or anything."

Dr Quek: "Aha! You're being harsh towards yourself right now! So, this method will help you manage your anxious mind, and also the harshness towards yourself."

Amy: [looks interested]

STEP 2.

Demonstrate – Dr Quek proceeds to demonstrate the technique. He uses simple language in his demonstration.

- Dr Quek has chosen to coach Amy using Exercise 9: Quick Combination Self-compassion.
- Amy suffers from both intense anxiety and self-criticism ("harshness") so this practice is suitable for her.
- It is useful to provide a summary of the technique.

Dr Quek: "So this method has three steps you can do over and over again, in sequence. Let me demonstrate. It is usually done silently in your mind but I'll talk you through it out-loud."

Dr Quek: "So, I close my eyes and sit or stand upright comfortably. I become aware of the natural rhythm of my breathing.

"Now, I'm aware of my anxious thoughts and also my harshness. As I breathe in, I say to these thoughts and harshness in my imagination, 'You are here.' As I breathe out, I remind myself that, 'I am here.' I do this for a few breaths."

"Step 2, I remind myself as I breathe, 'I am not alone in experiencing this anxiety and this harshness. Other people also have similar experiences.'"

"For the third step, I wish myself well. I might say something like: 'Even though I am anxious and have harshness, may I be well and be loved. I am worthy.'"

"So I'll summarise the three steps. First I become aware of my emotions and I acknowledge them. Then I remind myself that I am not alone in experiencing these emotions. Next I wish myself well. I can repeat these three steps as many times as I need."

Amy: [when asked to try, she says] "I can't remember the steps."

Dr Quek: "That's alright. I'll guide you. Later I'll give you a printout of the steps."

Amy: [closes her eyes and listens to Dr Quek's instructions]

STEP 3.

Patient practice – Dr Quek asks Amy to try the technique, allowing her to have an experience of it.

- Notice that Dr Quek is correcting Amy as she goes along.
- Amy must try the technique. (It also allows Dr Quek to correct any errors and Amy can raise her concerns about the technique.
- Always check in with the patient about the experience of the practice.

Dr Quek: "Now Amy, just be aware of the natural rhythm of your breathing. No need to control your breathing, let it be natural."

"Now, be aware of your anxiety and harshness, wherever these experiences are inside you. As you breathe in, say to them 'you are here'. As you breathe out, say to yourself 'I am here'. Do this for a few breaths. Good."

"Next Amy, as you breathe, remind yourself that 'I am not alone in experiencing these feelings. Other people also have similar experiences.' Again repeat this mentally a few times. Good."

"Now, as you continue breathing naturally, mentally wish yourself well. Really mean your well wishes. 'Even though I have these feelings, may I be well and be loved. I am worthy.' Repeat this a few times."

Dr Quek: "Now Amy, do these three steps on your own a few more times and continue for two more minutes."

"Now you can slowly open your eyes. How was that for you?"

Amy: [blinks a few times rapidly] "It was calming, but..."

Dr Quek: "Yes?"

Amy: "I don't feel that I can wish myself well. It feels awkward."

STEP 4.

Clarification – Dr Quek answers any questions and addresses any confusion Amy has about the technique.

- It would be good if possible to have a follow-up consult to check how Amy is doing with the technique.

Dr Quek: "Yes, I agree that it can feel awkward and artificial initially but as you keep doing it, it will likely become more natural. This part is very important as it reduces your harshness towards yourself."

Amy "Do I have to say these exact words?"

Dr Quek: "Nope. You can use any words for these three steps as long as they are kind words and acknowledge your experiences. You might want to come up with your own phrases beforehand."

Amy: "Ok."

Dr Quek: "Here is a handout for you to remember the three steps. If it's ok, can I see you again sometime next week so that I can check in with you on how you are doing with the practice?"

Amy: [nods] "Sure."

TIP

A WORD ABOUT ALL MINDFULNESS AND SELF-COMPASSION EXERCISES

They have to be practiced regularly to have any benefits. They are exactly like any physical conditioning exercises, which will only be useful when done regularly and consistently. Another important point is this: the benefits of these exercises are gradual and might not be immediately noticeable. The physician is reminded to explain this to the patient.

When are Mindfulness and Self-Compassionate Practices Appropriate to Use?

Generally, mindfulness and self-compassion practices are beneficial for most people. This is regardless of what medical or emotional problems they have. They could be used during the consult with the patient to calm them down if they are agitated. They also empower patients between consults to manage their emotional turmoil.

However, there are some clinical conditions for which the doctor needs to be cautious about recommending mindfulness or self-compassion practices:

1. **Psychotic patients –** it is best not to recommend these practices for psychotic patients as they might further aggravate the confused internal state of these patients. This is because these practices require the patient to turn inwards to be aware of their internal state, and to engage in different internal responses. They effectively ask psychotic patients to be aware of and come into close contact with their psychotic states.

2. **Anxious patients presenting with avoidance behaviours –** this constitutes a caution rather than a contraindication. Anxious patients tend to engage in unhelpful avoidance behaviours in their bid to quickly reduce the discomfort of their anxiety symptoms. These behaviours provide immediate relief for patients but perpetuate the anxiety in the long term. Hence, the doctor needs to be mindful that mindfulness and self-compassion practices are not used as avoidance behaviours.

SETTING EXPECTATIONS

It helps if the doctor explains at the outset when introducing the practices that they are not meant to reduce emotional symptoms. They are meant to help patients **relate differently** to these symptoms. The doctor can further explain that any intention to use these practices to improve symptoms would actually aggravate them, for the expectation that they "work" or are "effective" would form an additional stressor (e.g. the patient might say, "I've been noticing my breathing for 20 minutes already, so why isn't it working?").

BEING MINDFUL WITH EXPECTATIONS

The doctor can also refer patients to Exercise 5: Being aware of the urge to change experiences. The expectation that these practices "work" is actually an urge by patients to change their emotional experiences. The doctor could coach patients to practise Exercise 5.

Before You Teach... You Have to Practise

It is important for doctors to have some personal experience of some mindfulness and self-compassion practices before they attempt to coach patients in them. This is unlike medical procedures where the doctor does not need to be on the receiving end.

By having some personal experience in mindfulness and self-compassion, doctors can describe the experience of being mindful and self-compassionate to patients, have an understanding of the struggles of doing so, and have some familiarity with the possible obstacles to practise that patients might encounter. This not only allows them to coach these practices convincingly and knowledgeably, it also allows them to be able to modify these practices according to the patients' needs.

Finally, these practices are beneficial for the busy family doctor and can reduce burnout. Do give some of the exercises above a try, modifying them to suit your personal needs.

Key Points at a Glance

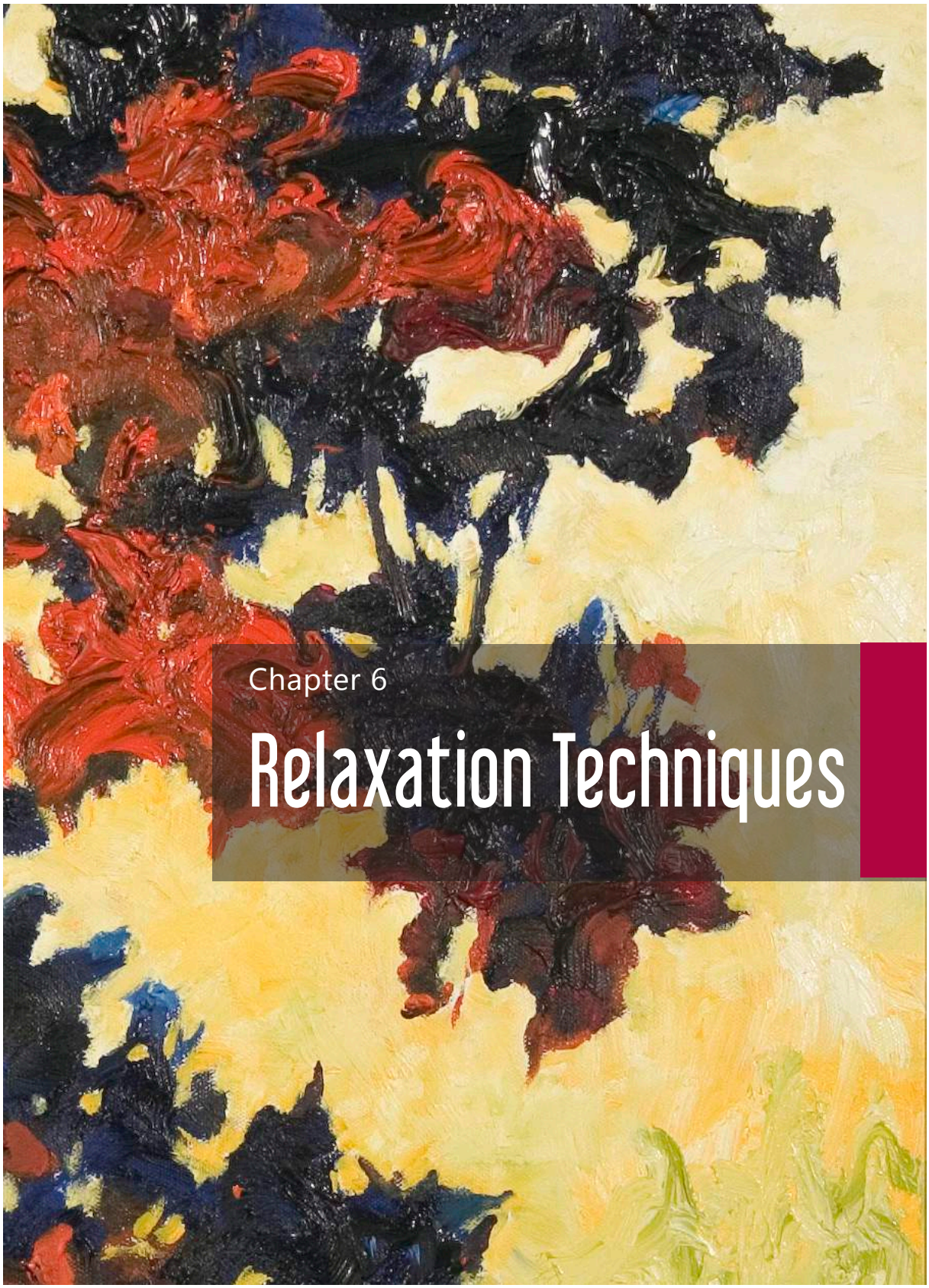
1. Chronic physical health problems can result in emotional turmoil, and emotional turmoil can aggravate physical health problems.

2. Mindfulness and self-compassion practices are beneficial for regulating emotional turmoil.

3. The basis of mindfulness and self-compassion is having a direct, accepting and compassionate relationship with all of one's own experiences.

4. Discuss with your patient and select one or at most two ways of mindfulness and self-compassion for him or her to practise regularly.

5. Doctors should practise mindfulness and self-compassion before attempting to coach patients in these practices.



Chapter 6

Relaxation Techniques

"Nothing can bring you peace but yourself."

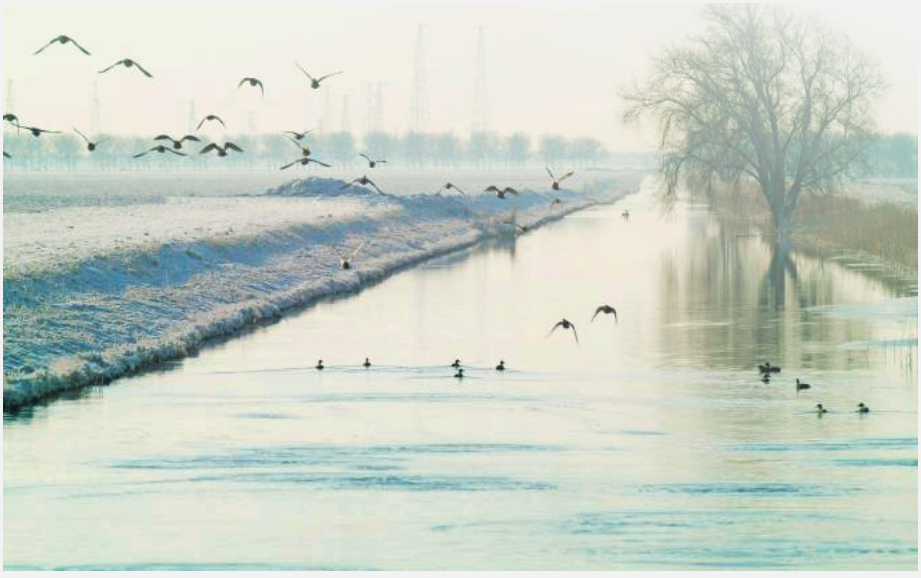
Ralph Waldo Emerson

Mr Tan is a 38-year-old man who was recently diagnosed with hypertension. He felt stressed at work as there had been a change in his reporting officer. This new officer frequently sent him text messages and called him for updates. This caused him much anxiety. His wife, although understanding, had to deal with his irritability and occasional outbursts, leading to frequent arguments. Mr Tan's family doctor suggested that he may benefit from relaxation interventions to reduce his stress symptoms.

How does relaxation help reduce stress?

"Fight or flight" is a term referring to the body's **stress response.** It is what the body does as it prepares to confront or avoid danger. When appropriately invoked, the stress response helps us rise to many challenges. But trouble starts when this response is constantly provoked by less momentous day-to-day events, such as money woes, traffic jams, job worries, or relationship problems.

Prolonged stress may result in health problems. A prime example is high blood pressure, a major risk factor for heart disease. This is similar to what Mr Tan is suffering from. The stress response suppresses



the immune system, thereby increasing susceptibility to colds and other illnesses. Moreover, the build-up of stress can contribute to anxiety and depression. We cannot avoid all sources of stress in our lives (nor would we want to), but we can develop healthier ways of responding to them. One way to invoke the relaxation response is through a technique first developed in the 1970s at Harvard Medical School by a cardiologist, Dr Herbert Benson. The relaxation response is a state of profound rest that can be elicited in many ways.

The relaxation response is perhaps one of the most important skills you can use to gain control over your body. Inducing a relaxation response has broad health benefits, including the reduction of pain and restoration of sleep.

In addition, research on the relaxation response has shown that this simple technique can increase energy, decrease fatigue, as well as increase arousal from a drowsy state. It can increase motivation, productivity, and improve decision-making ability. The relaxation response lowers both stress hormone levels and blood pressure.

What is the Relaxation Response?

The relaxation response is defined as your personal ability to make your body release chemicals and brain signals in order to make your muscles and organs slow down and increases blood flow to your brain. Drugs can do some of these for you; however, they often have unwanted side effects. You can get your body to relax without drugs while remaining conscious and aware at the same time. To be physically relaxed and mentally alert is the goal of the relaxation response.

The Relaxation Response is not:

- Laying on the couch
- Sleeping
- Not doing anything

The Relaxation Response is:

- A mentally active process that leaves the body relaxed
- Done in an awake state
- Trainable and more achievable with practise

There are many ways of achieving the relaxation response. Some of these techniques are:

- Abdominal Breathing
- Counting Your Breath
- Progressive Muscle Relaxation
- Visual Imagery

Which is the best relaxation techniques?

To date, there is no data supporting the idea that one method is better than another. What does matter is your willingness to use a particular technique for your own health and your ability to gain relaxation through that method.

The various relaxation exercises and their benefits are described below. These relaxation exercises can be incorporated by family doctors to teach their patients.

A) Abdominal Breathing

"Mr Tan, it sounds like your current day-to-day living involves a lot of tension. I wonder whether you find yourself holding your breath at some points, or breathing rapidly without realising it. The way that we breathe has a very strong effect on our physical wellbeing because it encourages a full oxygen exchange where we trade the incoming oxygen for outgoing carbon dioxide. This deliberate method of breathing can slow the heartbeat and lower or stabilise blood pressure, and also be a quick and effective way of reducing our immediate stress. Would you be willing to try and practise a simple deep breathing exercise?"

PURPOSE

Relax your body without the use of drugs

GOAL

Concentrate on slow, deep breathing and aid in disengaging from distracting thoughts and sensations

STEPS:

1. Sit comfortably in the chair.
2. Place your hands over your belly button. The movement of your hands will tell you if you are moving your abdomen as you breathe.
3. When you breathe in, imagine the air flowing into your stomach and filling it up. As you do that, allow your abdomen to rise up away from your spine.
4. When you breathe out, imagine air flowing out of your stomach like a balloon emptying itself. As you do that, allow your abdomen to fall back towards your spine.
5. Now breathe this way, letting your abdomen rise and fall without straining. Let your hands tell you if your abdomen is rising and falling.
6. Breathe this way slowly and as you do it, say "In … out … in … out" (repeat 10 to 20 times).

TIP

NOTE FOR ABDOMINAL BREATHING

When you have learned to relax using abdominal breathing, you can use it to lower your tension level whenever you (i) anticipate a stressful situation, (ii) experience a stressful situation, and (iii) after the stressful situation ends. Most patients report that abdominal breathing helps them get through difficult situations more easily.

Not every patient will be able to do this unless you spend some time coaching them to breathe using their diaphragm. If the patient still cannot do it following coaching, it is better to use another relaxation exercise.

B) Counting Your Breath

"Mr Tan, it is quite common for our minds to wander to many different things such as our bodily sensations, noises, daydreams, plans, worries and so forth, such that we find it difficult to be fully present at what we are doing or to the person in front of us. When we can't let go, we cannot relax, leading to long term consequences on our physical and emotional health.

Mindful breathing is a way to help you slow down your mind and become more present, simply by observing your breathing. It helps you to observe your experiences rather than react to them. As a result, it can help you to calm your mind and relax your body. Would you like to give it a go?"

PURPOSE

Relax your body without the use of drugs

GOAL

To use breathing to increase awareness, calm the mind, relieve stress and relax

STEPS:

1. Sit comfortably in the chair.
2. Close your eyes or keep your eyes half-closed and gaze gently at the ground in front of you. This helps to relax your eyes.

3. Start by noticing your breathing. Some people notice it at their nose as air moving in and out. Some people notice it as movement in their chest or stomach. Pay attention to the part that is most obvious.
4. Inhale and exhale slowly. Every time your exhale, count the exhalation moving from 1 to 2 to 3 and so on.
5. Try to gently concentrate on your breathing.
6. Every time your mind wanders away and you forget to count your breathing, just re-focus on your breathing and start counting from 1 again.

NOTE FOR "COUNTING YOUR BREATH"

This breathing exercise can be easier than the abdominal breathing for some patients.

C) Progressive Muscle Relaxation (Tense & Relax Technique)

"Mr Tan, everyone's muscles have their moments of tension and also a baseline resting level. Some people have a great amount of tension at rest, others less. When people are under acute stress, their muscles tend to have higher levels of baseline resting tension that can be painful and exhausting. Over time, they may forget how to let their muscles relax. Progressive muscle relaxation is a way to achieve a lower body relaxation. Through tensing and relaxing your muscles, the tension level not only returns to the original level, but will automatically drop below the original level, producing even greater relaxation to the muscles. This can help induce the feelings of bodily muscle relaxation that promote a sense of relief and rest."

PURPOSE

Relax your body without the use of drugs

GOAL

To tense and relax various muscle groups of the body to produce relaxation

STEPS for the Tense & Relax Exercise 1 (Preparation):

1. Make yourself as comfortable as possible in a seated position.
2. Try to sit up straight (with good posture) with your hands resting on your lap.
3. You can keep your eyes open or shut. Most people prefer to close their eyes. Remove your glasses if you wear them, some people prefer to remove their contact lenses.
4. As you perform this exercise, you will tense different muscle groups above their normal level of tension. When tensing, you need not tense to the point of pain – simple tensing for two seconds is generally sufficient. Focus on how the tension feels. Then, let the tension go. Focus on the sensations of relaxation.

5. Continue to breathe deeply and regularly throughout the exercise.

6. After you have become skilled at using this technique, you can repeat parts of it in a shorter format when you need a quick relaxation break. E.g. when sitting in a car during a traffic jam, you can tense the muscles in your shoulders and upper back and then relax them to get a nice burst of relaxation.

Let's get ready to learn the tense and relax technique:

STEPS for the Tense & Relax Exercise II (Tensing and Relaxing Specific Muscle Groups)

1. Relaxation of the feet and calves
   - Flex your feet (pull toes toward the knees)
   - Contract calf muscles and muscles of lower leg
   - Feel the tension build up and hold the tension
   - Take a deep breath
   - As you exhale say the word "RELAX" and let the tension go

2. Relaxation of the knees and upper thighs
   - Straighten your knees and squeeze your legs together
   - Contract your thigh muscles and all the muscles of your legs
   - Feel the tension build up and hold the tension
   - Take a deep breath
   - As you exhale say the word "RELAX" and let the tension go

3. Relaxation of the hips and buttocks
    - Tense the buttock muscles by squeezing them inward and upward
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

4. Relaxation of the abdomen
    - Observe your abdomen rising and falling with each breath
    - Inhale and press your navel toward the spine then tense the abdomen
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

5. Relaxation of the upper back
    - Draw the shoulder blades together to the midline of the body
    - Contract the muscles across the upper back
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

6. Relaxation of the arms and palms of the hands
    - Turn palms face down and make a tight fist in each hand
    - Raise and stretch both arms with fists
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

7. Relaxation of the chin, neck, and shoulders
    - Drop your chin to your chest
    - Draw your shoulders up towards your ears
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

8. Relaxation of the jaw and facial muscles
    - Clench your teeth together
    - Tense the muscles in the back of your jaw
    - Turn the corners of your mouth into a tight smile
    - Wrinkle the bridge of your nose and squeeze your eyes shut
    - Tense all facial muscles in towards the centre of your face
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

9. Relaxation of the forehead
    - Raise eyebrows upwards and tense the muscles across the forehead and scalp
    - Feel the tension build up and hold the tension
    - Take a deep breath
    - As you exhale say the word “RELAX” and let the tension go

10. Intensification of relaxation throughout the body
    - Focus on relaxation flowing
      - From the crown of your head over your face down the back of your neck and shoulders
      - Down your body through your arms and hands
      - Over your chest and abdomen
      - Flowing through your hips and buttocks
      - Into your thighs, your knees and calves
      - And finally into your ankles and feet
    - Continue to breathe deeply for several minutes

11. Finishing the tense & relax exercise
    - Count backwards in your head from 3 to 1
    - 3 – Become aware of your surroundings (location, people, noises)
    - 2 – Move your feet, legs, hands, arms, rotate your head
    - 1 – Open your eyes feeling re-energised, refreshed, and relaxed

NOTE FOR THE "TENSE & RELAX" EXERCISE

This strategy is useful for patients who experience stress as increased physical tension or for those who tend to freeze and stiffen when stressed. It is useful to demonstrate to patients how to tense and relax each part of the body.

D) Visual Imagery

"Mr Tan, some people find physical activities relaxing, while others may be more relaxed through visual imagery, such as by imagining a beautiful place. Visual imagery taps into the power of your mind to not only distract yourself from pain, tension, or problems, but to also increase images in your mind that are so captivating and rich in detail that they produce feelings of relaxation, calmness, and peace. Would you like to see if this is a technique you find useful?"

NOTE FOR VISUAL IMAGERY

This exercise is particularly useful for patients with very active imagination. You may wish to test patients by asking them if they tend to daydream or can see vivid images in their minds if they wanted to.

Imagery is an acceptable way of obtaining the relaxation response, but there are some guidelines on how to gain the most benefit from this strategy.

How is visualisation carried out?

Start the exercise by sitting or lying in a comfortable position and deep breathing. Unlike the tense-relax technique, the focus is not on your body but on a pleasant image.

You will want to decide where you want to go in your image before starting. Some people like to have several destinations in mind since it may be difficult to stay interested in any one image for very long, at least initially.

You can leave your eyes open or close. Most people prefer to close their eyes when creating a mental image.

Your image can take you anywhere of your choice. It could be a beach, a mountain retreat, a hiking trail, your own back yard, a fishing pond, a clean kitchen with tasty cinnamon buns baking, a favourite restaurant, a computer-generated virtual reality, or a psychedelic '60's-like landscape. Whatever you choose, try to make it peaceful, and calming.

In creating your image, try to USE ALL OF YOUR SENSES. E.g. if imagining a forest or woods, try to imagine:

- Vision: the moss, trees, animals, sun, soil and leaves
- Smell: smell the moist earth, the heavy scent of green vegetation
- Sounds: hear the birds, sticks cracking, animals moving, creeks
- Feel: the cool moist air, cool soil, warm sun in a clearing
- Taste: the fresh water from a creek, a ripe berry, a sweet apple

Start off with five minutes then gradually expand your imagery time to about 15-20 minutes per day.

This technique takes practice in order to fully master concentrating on your image and not being distracted by internal bodily discomfort or external noises. After you have become skilled at using this technique, you can repeat parts of it in a shorter format (i.e. a few seconds or a few minutes) when you need a quick relaxation break.

Now let's focus on the steps to relaxation through visualisation.

PURPOSE

Relax your body without the use of drugs

GOAL

To use visualisation and all your senses to produce relaxation

Your imagery experience will have four parts: Entering the image, the journey to a private place in the image, experiencing the private place, and finally returning and ending the imagery.

STEPS for Visualisation

1: Enter Your Image

- As you enter your image notice the view.
- What is in the distance?
- What do you hear?
- Are there any immediate smells or tastes?
- Reach out and touch the things in your immediate environment.
- How do these things feel?

- What is under your feet? How does this feel?
- Are there any new smells or sounds?
- What is the temperature? Make it comfortable.
- Look above you. What do you see?
- What do you hear now?
- Identify a path along which you will travel as you journey through this place.

2: The Journey

- As you begin your journey take several additional deep breaths.
- Your journey should take you deeper and deeper into your image.
- As you travel, be keenly aware of the sights passing by you.
- As you travel, be aware of new sounds that occur.
- As you travel, be aware of the temperature, and feelings under your feet.
- As you travel, be aware of the things you can touch and examine their texture.
- As you travel, be aware of smells and tastes that enter your image.
- Continue on your journey until you find a place of rich sensory experiences. This is your private place.

3: The Private Place

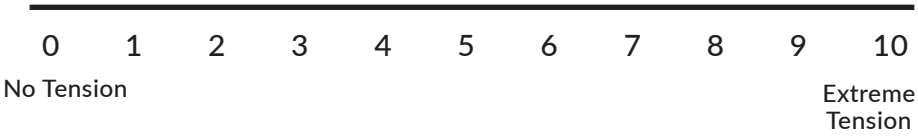
- Once you reach your private place take several additional deep breaths.
- Your private place should make you feel calm, peaceful, and filled with sensory pleasure.
- In your private place, be keenly aware of the sights around you.
- In your private place, be aware of new sounds that occur.
- In your private place, be aware of the temperature, and feelings under your feet.
- In your private place, be aware of the things you can touch and examine their texture.
- In your private place, be aware of smells and tastes that enter your image.
- Stay in your private place for several minutes allowing your imagination to run free with pleasurable images.

4: The Return Home

- Before you start to return home, notice how your body feels. (You will want to return to this feeling in the future.)
- Try and recall the best aspects of your journey and of your private place. (You will want to return to these in the future.)
- Prepare to leave by counting backwards from 3 to 1.
  - 3 : Become aware of your surroundings (location, people, noises).
  - 2 : Move your feet, legs, hands, rotate your head.
  - 1 : Open your eyes feeling re-energized, refreshed, and relaxed.

Exercise:

As you prescribe relaxation technique(s) for Mr Tan, you may teach him to use the table below to monitor and chart his own tension levels daily, before and after the exercise to monitor his progress.



Rate tension levels	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Tension level before ___ **Progressive Muscle Relaxation** (3 days) Tension level after ___							
Tension level before ___ **Visual imagery** (3 days) Tension level after ___							

Creating a Routine

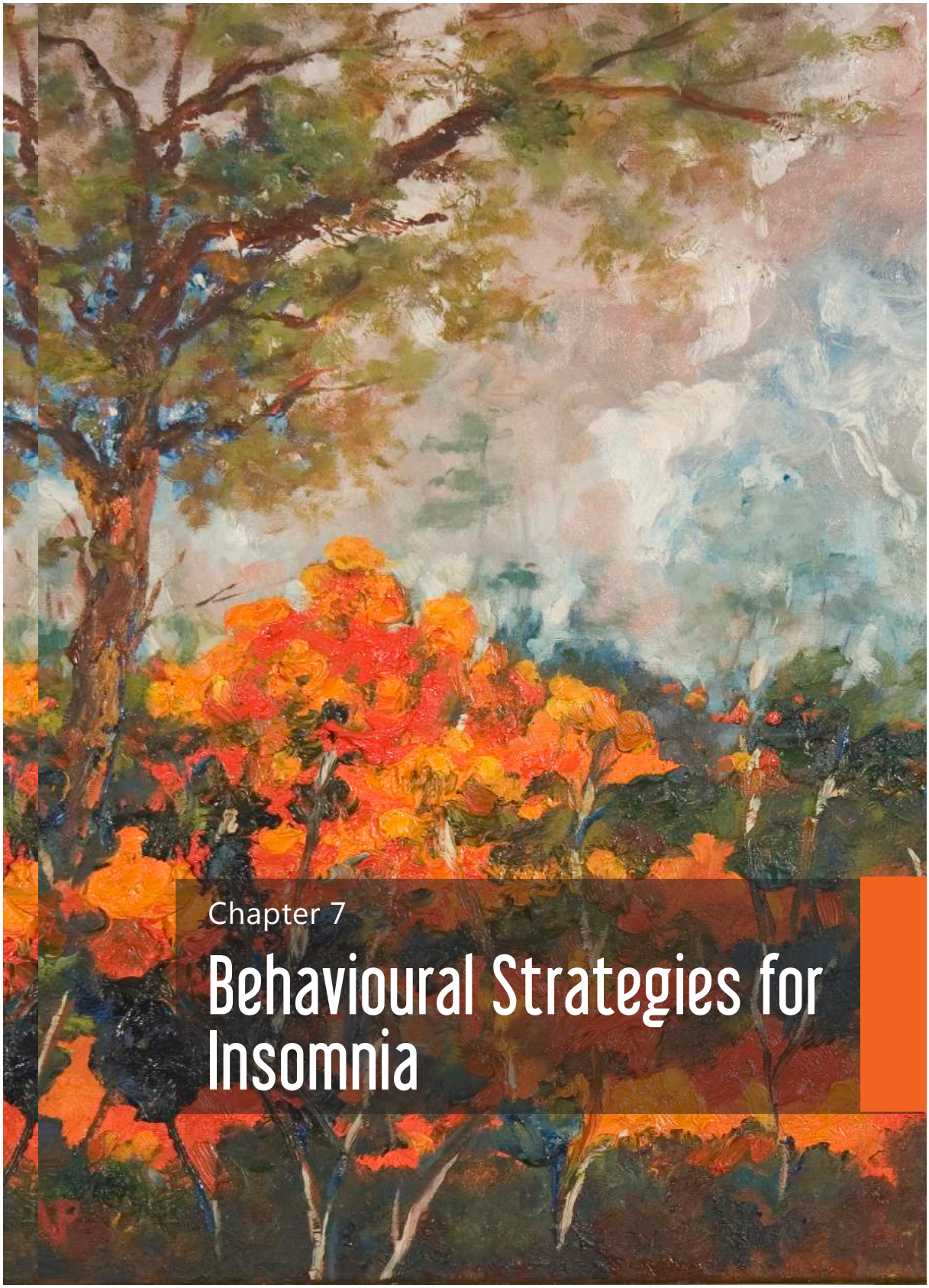
You may also find the following tips helpful:

- Choose a special place where you can sit or lie down comfortably and quietly.
- Don't try too hard. That may just cause you to tense up.
- Don't be too passive, either. The key to eliciting the relaxation response lies in shifting your focus from stressors to deeper, calmer rhythms. Having a focal point is essential.
- Try to practise once or twice a day, always at the same time, in order to enhance the sense of ritual and establish a habit.
- Try to practise at least 10 – 20 minutes each day.

Key Points at a Glance

1. The relaxation response can significantly:
   - Decrease pain
   - Increase energy
   - Decrease muscle tension
   - Increase motivation
   - Decrease irritability
   - Improve sleep
   - Enhance productivity
   - Lower blood pressure
   - Lower stress hormone levels
   - Increase arousal from the drowsy state
   - Improve decision-making ability
   - Reduce fatigue
   - Decrease anxiety

2. Over time, as patients use a relaxation exercise on a daily basis, they can expect to get better at the skill.



Chapter 7

Behavioural Strategies for Insomnia

"A well-spent day brings happy sleep."

Leonardo da Vinci

David Sng had been suffering from insomnia for 10 years since he started to work shifts at his job in the airport. He tried various medications on and off for years, but had not found significant relief for his sleep difficulties. The 35-year-old bachelor recently changed jobs and now works office hours. He often complained to his family doctor about difficulties falling asleep and feeling that his sleep was too light. David's difficulties will be used to illustrate the concepts and strategies in this chapter.

What is the Prevalence of Sleep Difficulties?

Sleep is a quintessential part of human survival. Although its actual function is still unclear, sleep deprivation studies have indicated that sleep impacts on our memory and the restoration of our body systems. Despite the importance of good sleep, sleep problems continue to be prevalent and under-diagnosed in most societies including Singapore and are often co-morbid with other physical and mental health conditions. One Singapore study by Yeo (1996) placed the prevalence of sleep problems in Singapore for people aged between 15 and 55 years old to be 15.3%. A recent

newspaper article reporting on a world-wide survey suggested that Singaporeans are the third most sleep-deprived people in the world. Of the different types of sleep disorders, insomnia can affect up to more than 30% of populations in developed countries.

Can the Family Doctor Effectively Treat Insomnia?

Given that family doctors often serve as the first point of contact for patients who are feeling unwell, they are well positioned to notice, treat and triage patients with sleep difficulties. Often however, medication is their choice of intervention whereas patients would prefer that their doctor provide more of a supportive role, be more active in assessing their unique needs and offer different treatment options.

These options include pharmacological, behavioural therapies or a combination of therapies. Research has also demonstrated that even brief behavioural interventions comprising 25-minute sessions delivered twice a month in a primary care setting was sufficient to improve sleep. This chapter provides family doctors with a set of tools to quickly assess for sleep difficulties amongst their patients

DEFINITION OF INSOMNIA (DSM-V)

(Cunnington, Junge & Fernando, 2013)

Symptoms (can involve more than 1):

- Difficulties initiating sleep
- Difficulties staying asleep
- Adequate sleep duration that does not feel restorative

Duration: ≥ 4 weeks

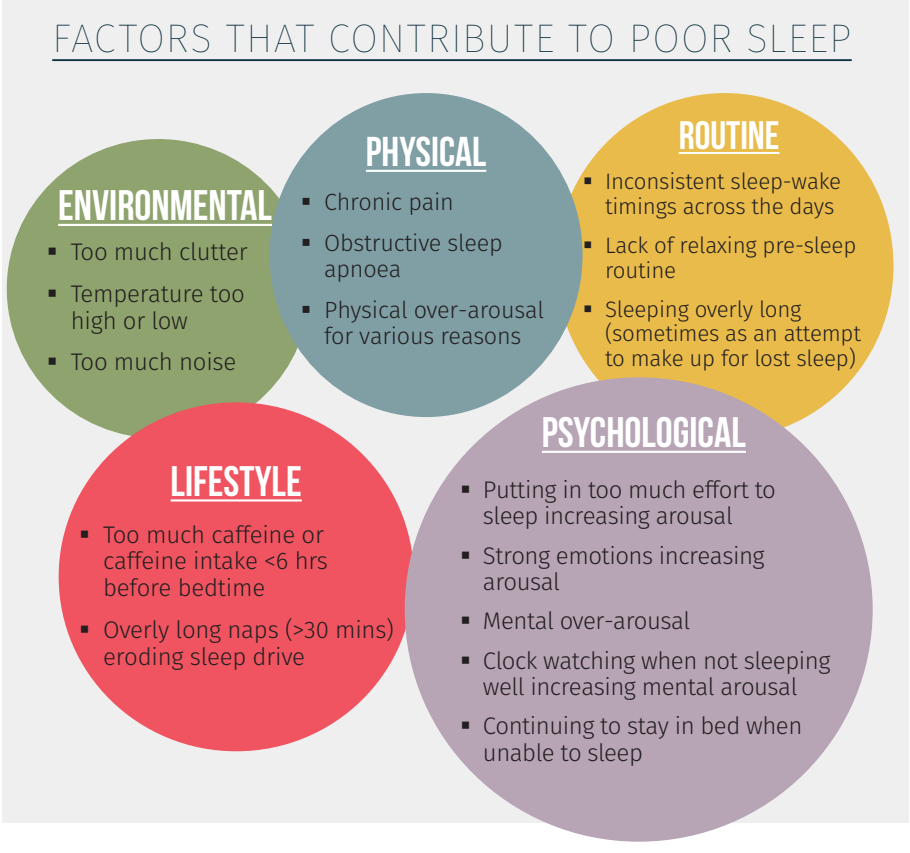
Functioning: impacted daily functioning. Daytime sleepiness experienced.

and also serves as a guide on how to deliver brief behavioural sleep interventions in their busy clinics.

What Are Some Common Causes of Insomnia?

Multiple factors contribute to insomnia and specific behavioural interventions are designed to address these different factors. Factors that can affect sleep can be broadly grouped into environmental factors, lifestyle factors, psychological factors, physical factors and routine factors.

These factors are summarised in the diagram below (Figure 1).



Overall, a lack of a consistent sleep-wake routine result in disruption to one's circadian rhythm. Over-compensating for poor sleep erodes sleep drive required for deeper sleep. Other than these, mental and emotional over-arousal also contributes to difficulties initiating sleep.

How is Assessment of Insomnia Carried Out?

Assessment of sleep difficulties typically involves identifying the types of insomnia the patient is suffering from and also the aetiology of these problems. A simple assessment worksheet can be found in the Appendix at the end of this chapter.

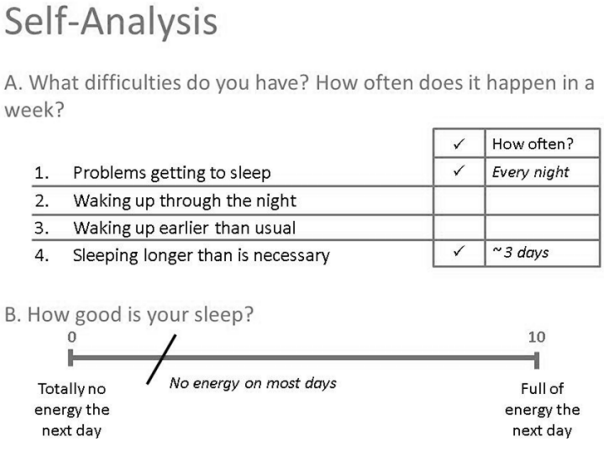
Assessment worksheet for sleep difficulties and aetiology

Assessment is not only for the doctor to obtain clinically relevant information. It also serves as an awareness-raising and educational tool for patients.

Introducing the assessment to patient

"So David, as you are facing some difficulties sleeping, I've got a simple questionnaire (refer to diagram below) here to help us figure out the type of difficulties you have and find out what might cause these difficulties. Let's do this together."

An example of the questionnaire that the doctor can administer on David to rate his sleep quality



Self-Analysis

A. What difficulties do you have? How often does it happen in a week?

		✓	How often?
1.	Problems getting to sleep	✓	*Every night*
2.	Waking up through the night		
3.	Waking up earlier than usual		
4.	Sleeping longer than is necessary	✓	*~3 days*

B. How good is your sleep?

0 — 10

Totally no energy the next day

No energy on most days

Full of energy the next day

A self-analysis questionnaire that allows the doctor to determine the type of behavioural strategies to use on David

INSTRUCTIONS

1. Tick the factors that feature in your life that affects your sleep

2. Choose the strategies that address the top few factors

NB: Mindfulness and relaxation are covered in the other chapters of this book

Factors	Yes? (✓)	Strategies
Environmental Factors		
▪ Too much clutter?		Environmental Control
▪ Too cold / too hot?		
▪ Too noisy?		
Lifestyle Factors		
▪ Caffeine overload / caffeine <6 hrs before bedtime	✓	Lifestyle Control
▪ Overly long naps (>30 mins)	✓ *Weekends*	
Psychological Factors		
▪ "Force" self to sleep / put in too much effort to sleep	✓	Mindfulness
▪ Strong emotions	✓ *Frustration, irritation, active mind, no specific topic*	
▪ Thinking a lot / worrying / planning / regretting	✓	
▪ Clock watching when cannot sleep	✓	
▪ Continue staying in bed if cannot sleep	✓	Stimulus Control
Physical Factors		
▪ (Chronic) pain		Physical Health Management
▪ Obstructive sleep apnoea		
▪ Physical over-arousal (e.g., exercise too late)		Relaxation
Routine Factors		
▪ Inconsistent sleep-wake time across days		Consistent Sleep Wake
▪ Lack of relaxing / winding down pre-sleep routine		Relaxation
▪ Sleeping overly long (sometimes to make up for poor sleep)	✓ *On weekends 10 hrs*	Sleep Restriction

Summarising the assessment findings and proposing interventions

"So to summarise, your sleep difficulties include difficulties falling asleep, sleeping longer than necessary, and having no energy the next day. Based on the questionnaire, some of the things that might affect your sleep include some lifestyle, some psychological and some routine factors. I've got a few techniques that can help you deal with these things which might help you sleep better."

What Behavioural Strategies Are There for Treating Insomnia?

Some of the behavioural strategies to improve sleep are self-explanatory and straight-forward, whereas others such as stimulus control and sleep restriction are counter-intuitive and require patient buy-in for effective execution. **It is also important to remind patients that these interventions need to be practised daily for two to three weeks for new habit formation to occur.**

A summary of various behavioural strategies is provided in the table below.

Behavioural Strategies for Sleep

Strategy	Description	Best Used For
Relaxation	Various mental or physical activities that elicit the relaxation response. Patient are often advised to use these strategies to help with sleep initiation or as part of their pre-sleep relaxation routine	Physical and mental over-arousal; sleep initiation problems

Strategy	Description	Best Used For
Mindful-ness	Exercises designed to help patients to accept their internal experiences (e.g., emotions, thoughts) in a detached manner	Strong emotions, mental over-arousal; sleep initiation problems
Sleep Hygiene	Education about how environmental, physical and habit factors can contribute to poor sleep. Involves discussing with patients on how to change these in view of their current lifestyle	Addressing environmental factors, physiological and habit factors that affect sleep
Stimulus Control	Conditions the patient's mind and body to the sleep environment. Usually involves instructing patients to go to bed only when they experience sleepiness. Patients are also advised to restrict the bed to sleep and sex.	Conditioned wakefulness
Sleep Restriction	Involves reducing the amount of time spent in bed to approximate the actual amount of sleep that patients naturally need. Often involves starting with a much reduced sleep duration and slowly increasing this duration across the weeks.	Poor quality of sleep, sleep that is too light; frequent night-time wakening

The following sections provide a more detailed explanation on how to deliver each strategy. A possible educational script is also provided for the doctors to explain the treatment rationale to their patients.

Relaxation and Mindfulness

Relaxation exercises and mindfulness are covered in other chapters in this book. These are methods to address physical and mental over-arousal which often affects sleep initiation. A possible way of introducing relaxation and/or mindfulness to patients is as follows:

> *"From the (assessment) worksheet, we can see that you try to force yourself to sleep, you get frustrated when you cannot sleep and your mind is very active. All these emotions and mental activity make it challenging for you to sleep.*
>
> *Relaxation exercises help to train our body to slow down and switch off. Mindfulness exercises help us become less bothered by strong emotions and thoughts which quiet the mind. Let us try some of these now."*

Mindfulness and relaxation exercises can often be combined together. For instance, abdominal breathing can be used as a form of mental focus i.e. a two-step mindfulness exercise. If time permits, it is useful to spend 10 minutes practising these techniques with patients during your consult.

If there is insufficient time, provide patients with a list of CDs or websites where they can listen to mindfulness and guided relaxation audiovisual tracks. (Please see Appendix in Chapter 5 and 6 for a list of these resources available online).

Sleep Hygiene

Sleep hygiene education often involves making practical changes to the patients' lifestyle, habits, environment and physical states. A simple handout for patients can be found in the Appendix at the end of this chapter.

> *"David, some of your lifestyle practices might also make it more difficult for you to sleep at night. Currently you take four cups of coffee to boost your energy in the day and also nap on weekends to make up for lost sleep.*
>
> *It may be tough for you to stop drinking coffee all at once. How about if you start by reducing to two cups and stopping by around 3 pm?*
>
> *Also, you currently nap for two hours on weekends. Try not to nap more than 30 minutes during the day because it makes you more awake at night"*

Although educating patients on sleep hygiene is often straight-forward, challenges arise when patients are not ready to make these changes for their own reasons. Common struggles for patients include inability or lacking motivation to reduce substance intake such as caffeine, alcohol or cigarettes. Other patients would reject the idea of using eye masks or ear plugs because they feel uncomfortable.

In these instances, the doctor needs to think of creative ways to address these factors which patients are more receptive. Examples of creatively working around patients who are not very receptive include suggesting double-layered curtains that occlude light maximally in place of eye masks, use of "door snakes" to occlude noise coming from the gap under the door for people who are averse to using the ear plugs etc.

Stimulus Control

Stimulus control is based on the idea that repeated pairing between a stimulus and an internal state can result in a conditioned response where the stimulus will automatically trigger that internal state. For sleep, most people who struggle to sleep would force themselves to stay in bed and try hard to sleep only to become frustrated and mentally over-aroused. With repeated pairings between the bed and feelings of frustration, the bed will come to automatically trigger wakefulness and frustration instead of sleep (i.e. BED = FRUSTRATION + WAKEFULNESS).

Stimulus control generally involves advising patients to go to bed only when they are very sleepy and to get out of bed when they are awake, when they start to struggle with sleep or when they are doing non-sleep related activities (e.g. using the internet, eating, talking on the phone etc.). With repeated disciplined pairings of sleepiness with the bed, the bed will come to trigger sleepiness and relaxation (i.e. BED = SLEEPINESS + RELAXATION). A simple handout for patients can be found in the Appendix at the end of this chapter.

"Like most people, you try to stay in bed and force yourself to sleep when you are struggling to sleep. You told me that you can spend up to two hours in bed before you fall asleep, is that right?

When you become frustrated trying to sleep you become more and more awake, and our bodies form a habit such that every time you sleep in your bed or get into your bed, you are automatically reminded of your frustration and being awake.

What you want for good sleep is for your bed to trigger sleepiness when you lie down on it. So to do this, only go to bed when you are very sleepy. If you start struggling to sleep, get out of bed and do relaxation exercises until you start falling asleep. Then go to bed again. Keep repeating this because you want the bed to be constantly paired with feeling very sleepy. Also restrict your bed to sleep and sex only. What do you think? Is this do-able?"

Less intensive versions of stimulus control can involve the following:

- Changing one's sleep position and orientation
- Changing one's bed, changing the bedsheets
- Changing the positioning of one's bed
- Changing the sleep environment by removing or adding things
- Changing to another room to sleep

Less intensive stimulus control strategies work on the idea that the bed-wakefulness pairing has not generalised to other possible sleep environments. Often it is worthwhile introducing less intensive strategies to patients who are not as receptive to the standard stimulus control intervention.

Sleep Restriction

Sleep restriction intervention is often experienced as the most intensive and intrusive intervention used to improve sleep. It is often used to "reset" one's sleep-wake pattern, to increase the depth of sleep and to reduce frequent night-time wakening. The rationale behind this intervention is that humans have limited sleep drive which is often determined by the amount of melatonin that is secreted. Excessive sleeping in the form of prolonged sleep beyond what one

needs or excessive daytime napping erodes and dilutes this limited sleep drive. This in turn results in long, but very shallow sleep and predisposes the person to be easily aroused by external stimulation such as sound and light.

Sleep restriction typically involves advising patients to map their daily sleep for two weeks and finding out the average time required and then implementing the restricted sleep time based on this average time. However, most patients would struggle to complete the sleep monitoring. Doctors have therefore suggested five hours to be the starting (and most restrictive) sleep duration. The steps for sleep restriction are:

1. Determine the average sleep time required / using five hours as the lowest limit.
2. Determine the time that the patient needs to wake up (e.g. 6 am).
3. The restricted sleep time would be wake time – average sleep time. If 5 hours is used, the sleep time would be 1 am (i.e. 1 am to 6 am).
4. Advise the patient to adhere to this sleep-wake time strictly for one week on a daily basis.
5. In the second week, the sleep time is advanced by 30 minutes (i.e. 12.30 am to 6 am).
6. Every week, the sleep time is advanced by 30 minutes until poor / light sleep starts to appear again. The sleep duration in the week before poor / light sleep re-appears is the optimal sleep duration.

A simple worksheet can be found in the Appendix at the end of this chapter to help doctors and patients work out their sleep restriction duration.

Explaining the sleep restriction rationale to patients is necessary because of the intensity of the intervention. Here is a possible way to explain it to patients (use handout on explaining sleep restriction that can be found in the Appendix):

> *"So when you cannot sleep, like most people, you try to sleep longer to make you feel more energised during the day. However, this only makes your sleep very shallow and you end up not feeling very rested. Am I right?*
>
> *This is because all of us have limited sleep drive to spend every day. This comes from how much melatonin our bodies can produce. We need sleep drive to sleep deeply, but when we sleep longer, we are diluting the sleep drive.*
>
> *Sleep restriction is a powerful way to reset your body's sleep system and to maximize the use of your sleep drive so that every hour you are asleep is as deep as possible. Here is how we do it [Worksheet is presented to patient]."*
>
> *"Here is how sleep restriction is done. It will require around one month of daily effort to reset your sleep pattern. We start of by setting what time you want to wake up, then the sleep time is five hours before. We'll keep to this sleep-wake time for one week , then make the sleep time ½-hour earlier in the second week and another ½-hour earlier in the third and so on. Slowly, we'll be able to find your optimal sleep time that is not too long. Here's a worksheet to show how it is done"*
>
> *"It is important to note that you will be more tired than normal when you start the sleep restriction. It is useful to rearrange meetings or important things to a later date if possible."*

Putting Various Strategies Together

For the time-strapped family doctor, various sleep interventions including stimulus control, sleep hygiene, relaxation and mindfulness can be put together into a general handout for patients. See the Appendix at the end of this chapter for the handout titled “Simple Sleep Tips”.

APPENDIX

Self-Analysis

A. What difficulties do you have? How often does it happen in a week?

	✓	How often?
1. Problems getting to sleep		
2. Waking up through the night		
3. Waking up earlier than usual		
4. Sleeping longer than is necessary		

B. How good is your sleep?

APPENDIX

Self-Analysis

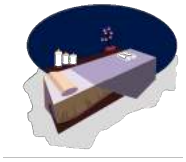
Factors	Yes? (✓)	Strategies
Environmental Factors		
▪ Too much clutter?		Environmental Control
▪ Too cold / too hot?		
▪ Too noisy?		
Lifestyle Factors		
▪ Caffeine overload / caffeine <6 hrs before bedtime		Lifestyle Control
▪ Overly long naps (>30 mins)		
Psychological Factors		
▪ "Force" self to sleep / put in too much effort to sleep		Mindfulness
▪ Strong emotions		
▪ Thinking a lot / worrying / planning / regretting		
▪ Clock watching when cannot sleep		
▪ Continue staying in bed if cannot sleep		Stimulus Control
Physical Factors		
▪ (Chronic) pain		Physical Health Management
▪ Obstructive sleep apnoea		
▪ Physical over-arousal (e.g., exercise too late)		Relaxation
Routine Factors		
▪ Inconsistent sleep-wake time across days		Consistent Sleep Wake
▪ Lack of relaxing / winding down pre-sleep routine		Relaxation
▪ Sleeping overly long (sometimes to make up for poor sleep)		Sleep Restriction

Instructions

1. Tick (✓) the factors that feature in your life that affects your sleep
2. Choose the strategies that address the top few factors

NB: Mindfulness and relaxation are covered in other chapters in this book.

APPENDIX



Environmental Control

Make your room like a spa

- De-clutter your room, adjust the temperature, use ear plugs / eye masks
- Use aromatherapy / light music

Lifestyle Control

- Reduce caffeine intake if possible; if not, restrict caffeine to the mornings
- Try not to nap during the day; if needed, nap for no longer than 30 mins as sleeping too long reduces night-time sleep drive

Consistent Sleep-Wake Time

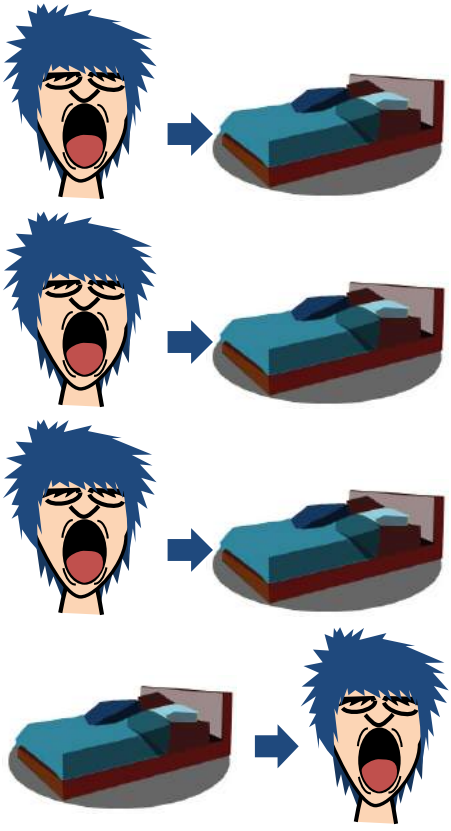
- Sleep is a bodily habit so set a consistent daily sleep and wake time
- The sleep and wake time should not vary by more than one hour on weekends

Physical Health Management

- Engage in aerobic exercise to deepen sleep
- Manage sleep apnoea by seeing an ENT specialist or through postural changes
- Manage chronic pain through medication and behavioural strategies

APPENDIX

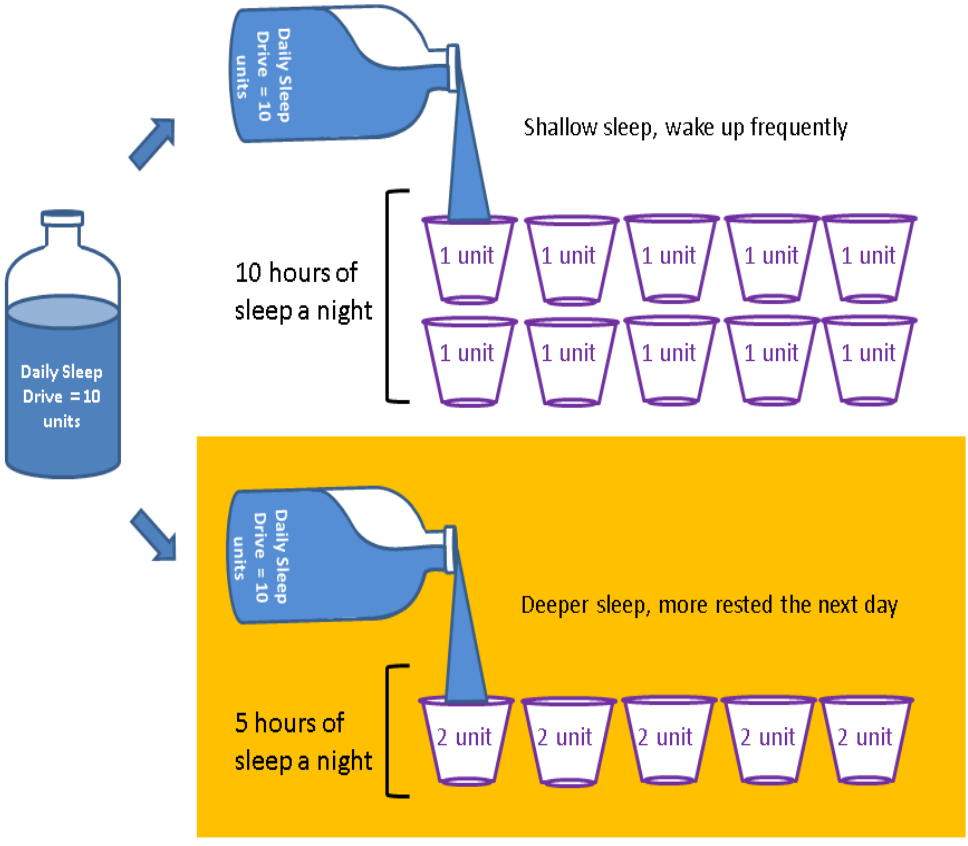
Stimulus Control (BED = SLEEP + RELAXATION)



- Go to sleep only when you feel sleepy. If you are struggling in bed, get out and do something relaxing until you are sleepy before going back to bed
- Use your bed only for sleeping and sex
- The goal is to pair up sleepiness with the bedroom so that your bedroom will immediately trigger a sense of sleepiness

APPENDIX

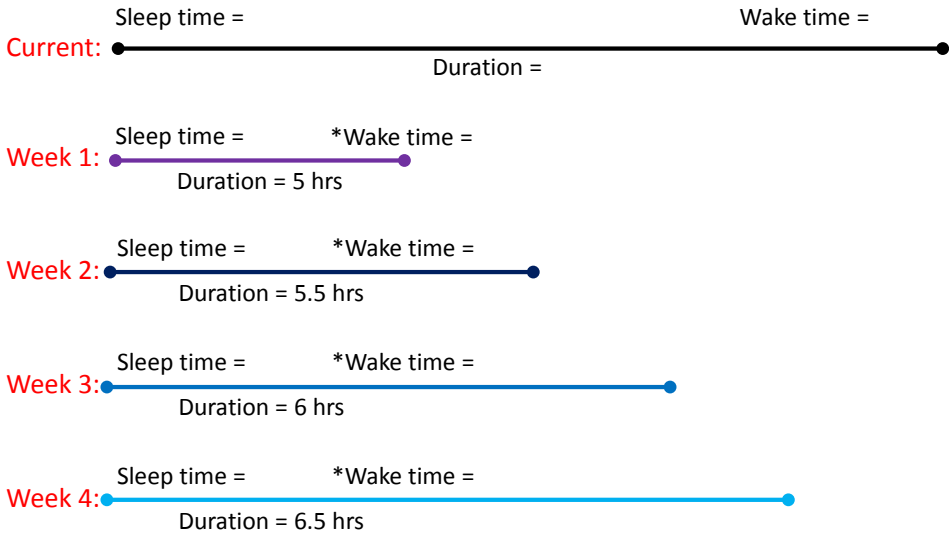
Sleep Restriction



- We have limited amount of sleep drive everyday
- Sleeping more means that you dilute your sleep drive and every hour of sleep is light and shallow
- Napping during the day also uses up your sleep drive
- If you sleep less, you have more sleep drive for each hour of sleep and your sleep will become deeper

APPENDIX

Sleep Restriction Worksheet



Important Note 1. It is important to remember that **wake time stays the same**. Sleep time changes to be earlier with each week.

Important Note 2. Notice the week where sleep quality is affected. The sleep duration before this week is the optimal sleep duration. For instance, if you start to struggle with 6.5hrs of sleep, your optimal sleep duration is 6hrs.

APPENDIX

Simple Sleep Tips

1. Set up a wake time and stick to it daily.

2. Set up your sleep environment to hypnotise you to sleep. Make it like a spa.

   Dark, cool and spacious. Use lavender or other aromas. Put on soft ambient music or sounds of waves or trees rustling in the wind. Use ear plugs and eye shades.

3. Prepare your body to sleep starting from the afternoon

   Stop caffeine before 3 pm. Power nap for 30 minutes maximum.

4. Set up and practise a relaxing pre-sleep routine

   1 hour before bed, switch off your computer and T.V. read a book and have a very light carbohydrate snack or warm glass of milk.

5. Go to bed only when you feel sleepy. Otherwise stay outside and do something relaxing until you feel sleepy.

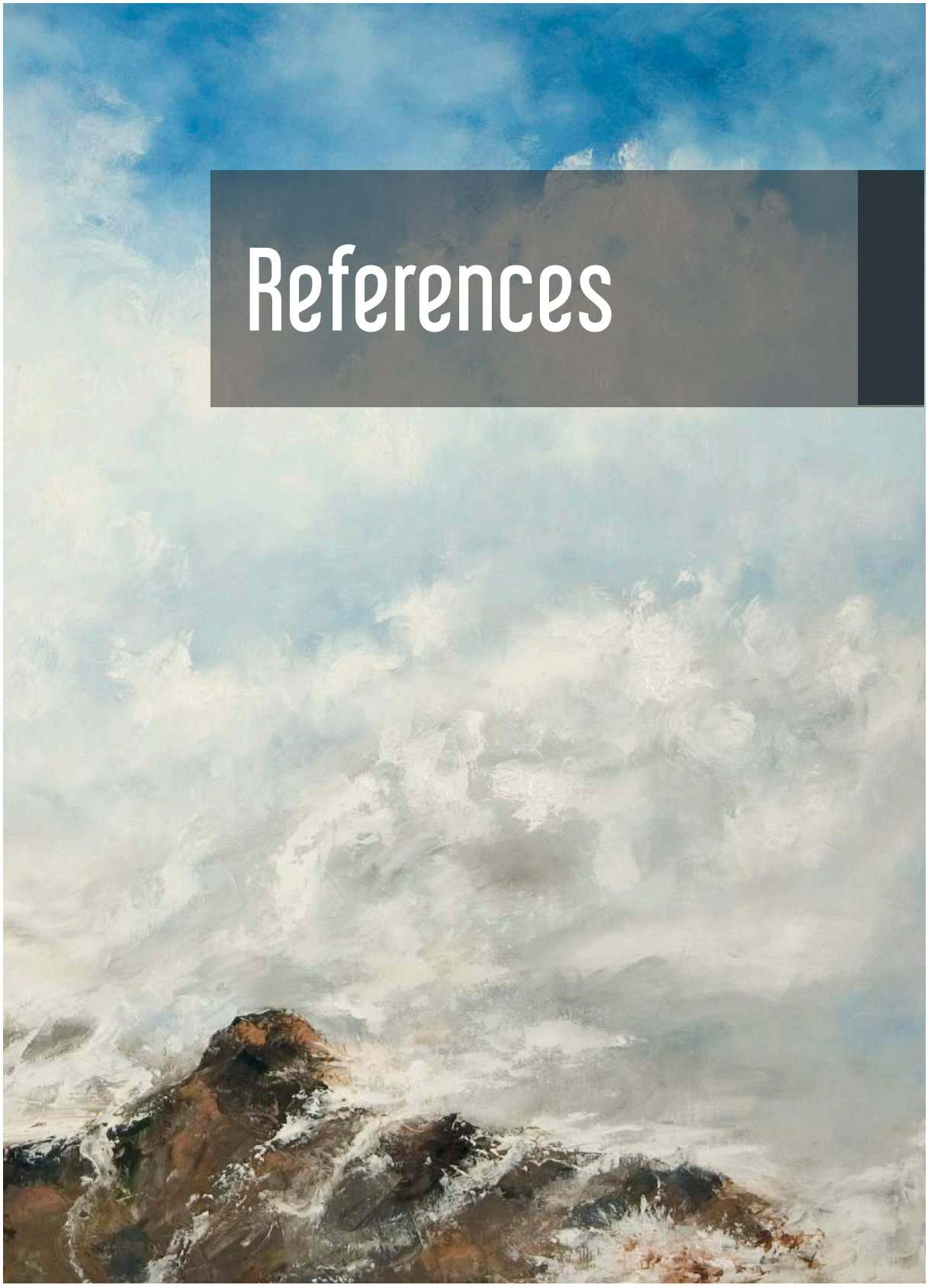
6. If you wake up at night and find it hard to go back to sleep, go outside and do something relaxing until you are sleepy. Then go to bed.

If you do these for 2 to 3 weeks, your sleep should improve

Key Points at a Glance

1. Brief behavioural sleep interventions can be effective in primary care.
2. Sleep interventions are about new habit formation and require patients to be consistent.
3. Factors that can affect sleep include environmental factors, lifestyle factors, psychological factors, physical factors and routine factors.
4. Different factors that disturb sleep require different behavioural strategies.

References



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- http://www.belmontwellness.com/for-mental-health-professionals/psychoeducational-handouts-quizzes-group-activities/
- https://www.nami.org/Learn-More/Treatment/Psychosocial-Treatments
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  http://marc.ucla.edu/body.cfm?id=22
- **Books:**
  Jon Kabat-Zinn (2005). Wherever You Go, There You Are. Hachette books.

  Chade-Meng Tan (2014). Search Inside Yourself: The Unexpected Path to Achieving Success, Happiness (and World Peace). HarperOne
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- **Free Audio Tracks:**

  https://www.mcgill.ca/counselling/self-help/audio-video

  http://www.mckinley.illinois.edu/units/health_ed/relax_relaxation_exercises.htm

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About the Health Wellness Programme

Health Wellness Programme (HWP) is an initiative started in 2013 by Eastern Health Alliance (EHA). The aim is to support Primary Healthcare Providers (PHPs) in their management of patients with emotional and psychological conditions such as depression, anxiety, adjustment issues, stress etc.

HWP is run by a group of mental health trained and clinically experienced nurses and allied health professionals within the community. It is not a psychiatric clinic, hence there will not be any diagnosis or medication provided to the patients. Family doctors who refer their patients to HWP continue to manage and provide medical treatment to them while they undergo psychological therapy.

HWP offers the following services: -

- Supportive therapy for individuals, caregivers and family
- Understanding mental and psychological conditions
- Stress management and emotion management
- Lifestyle behaviour modification
- Expressive / creative arts therapy

Team Members of Health Wellness Programme (HWP)

Front Row From Left:
Yang Chek, Pan Huimin, Lim Hui Khim

Back Row From Left:
Janet Chang, Dr Tan Wee Hong, Dr Jean Cheng, Dr Tan Wee Chong, Dr Andrew Peh