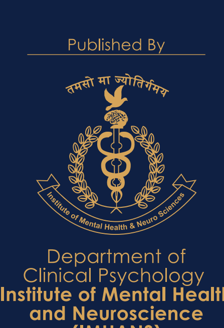
CONFERENCE PROCEEDINGS

TIME EFFECTIVE PSYCHOSOCIAL INTERVENTIONS IN MENTAL HEALTH

Published By



Department of
Clinical Psychology
**Institute of Mental Health
and Neuroscience
(IMHANS)**

TIME EFFECTIVE PSYCHOSOCIAL INTERVENTIONS IN MENTAL HEALTH

Proceedings of:

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Institute of Mental Health and Neurosciences (IMHANS),
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Cover design:
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Patron:
Dr. P Krishnakumar, Director, IMHANS

Reviewers:
Dr. Rytis Pakronis, Asso. Prof. in Psychology, Vytautas Magnus University, Lithuania
Dr. Biba Reboji, Director, Ribalon, Slovania
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Dr. Abdul Salam, Head, Department of Clinical Psychology, IMHANS
Dr. Seema P Uthaman, Head, Dept. of Psychiatric Social Work, IMHANS
Dr. Ragesh G, Lecturer, Dept. of Psychiatric Social Work, IMHANS
Mr. Baijesh A.R, Faculty member- Central Univesity of Karnataka
Mr. Ijas Abdul Majeed, Psychiatric Social worker,Bangalore

Managing Editors:
Mr. Jithin K, Clinical psychologist, DPRP, IMHANS
Mr. Anas A, Psychologist, Academy for Solution Focused Approaches & Research (ASFAR)

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Dear Delegates,

Greetings from ITCBP2017 Organising Team!

It gives immense pleasure to bring together eminent speakers, practitioners and scholars in Brief Psychotherapy in a first of its kind training conference happening in India. We have delegates from 10 different countries and all over India.

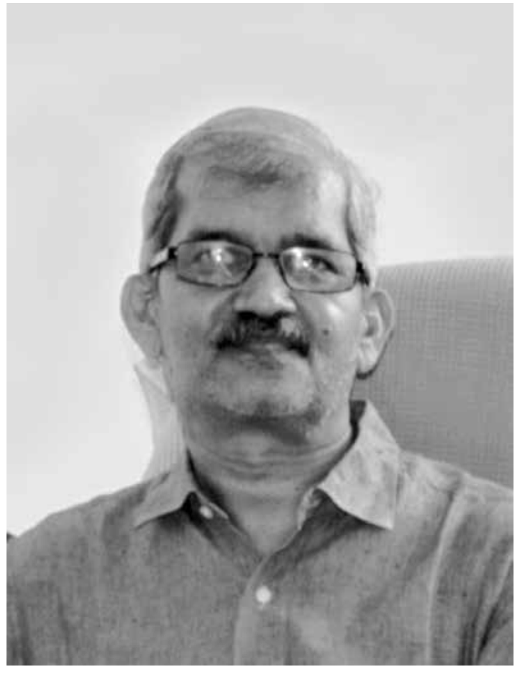
Apart from 5 keynotes, which are common for all delegates, the conference is structured with 21 workshops (spread over two days). The workshops will be held in 8 different halls from 11.30 A.M to 1 P.M (forenoon session) and 2 P.M to 3.30 P.M (afternoon session). Participants can opt for one workshop according to their interest.

On behalf of the team i welcome you all to the conference.

Wish you all a great learning experience!

Jaseem Koorankot, PhD
(Gen. Secretary, ASFP-I)
Organizing Secretary, ITCBP2017

MESSAGE



The Institute of Mental Health and Neurosciences (IMHANS) is a novice in the academic arena, though it started functioning way back in the nineteen eighties with the aim of developing into a centre of excellence in mental health. The institute became a recognised postgraduate teaching centre only in 2014, when we started the MPhil Psychiatric social work course for the first time in Kerala affiliated to the Kerala University of Health Sciences (KUHS). Our clinical psychology MPhil course commenced in this academic year and the department is still in infancy. In this scenario I am extremely happy that we are hosting the International Training Conference in Brief Psychotherapies (ITCBP-2017) at IMHANS.

Psychological disorders, especially among children, adolescents, elderly and other vulnerable groups are on the increase in our country. Qualified mental health professionals are grossly inadequate leading to a situation where anybody with communication skills can become a counsellor or therapist and the quacks thrive. We need more number of qualified professionals, at the same time quality is also important.

The conference has listed an array of international experts in the field of counselling and psychotherapy. I hope that interaction with these experts will benefit our students immensely and help them to become better professionals.

I congratulate our faculty, staff and students who have worked hard and taken all efforts to make this a unique event and wish all the success for the conference. I wish all the delegates a pleasant and productive stay at Kozhikode with a humble request to bear with us for minor apses.

Dr. P. Krishnakumar
Director
Institute of Mental Health & Neurosciences (IMHANS)

CONTENTS

SECTIONS	CONTENTS	PAGE NO.
PART I	PROGRAM SCHEDULE	8-13
PART II	ABSTRACTS OF KEYNOTES	14-19
PART III	ABSTRACTS OF WORKSHOPS	20-47
PART IV	ABSTRACTS OF RESEARCH PAPERS	48-75
PART V	FREE PAPERS	76-207
PART VI	REVIEWERS	208-213

Part I

PROGRAM SCHEDULE

21-12-2017 - THURSDAY		
WHEN?	**WHERE?**	**WHO AND WHAT?**
8.00am to 8.45am	Reception Area/ Lobby	Registration
8.45am to 8.55am	Main Hall	Salutation
9.00am to 10.00am	Main Hall	Inauguration
10.00am to 11.00am	Main Hall	**Dr. Arnoud Huibers** Keynote 1: Essentials of the Solution Focused Approach - Time Effective Interventions
11.00am to 11.20am	**Dining Hall B301**	**TEA BREAK & CHANGE HALLS**
11.30am to 1.00 pm	**Different Halls**	**Workshops**
	Main Hall Workshop 1	**Ms. Uma Krishnan** (Malayalam) Technology Based Intervention for children with Autism and Other Intellectual Disabilities
	Hall B204 Workshop 2	**Dr. Arnoud Huibers** Main Interventions of the Solution-Focused Approach.
	Hall B202 Workshop 3	**Dr. Michael Durrant** Solution-Focused Supervision and Leadership.
	Hall B302 Workshop 4	**Dr. Vibha Sharma** Time Effective Psychosocial Interventions for Dissociative Disorders.
	Hall B303 Workshop 5	**Ms. Aarathi Selvan& Ms. Divya Raj** Mindfulness in Clinical Practice
	Hall B304 Workshop 6	**Dr. MalikaVerma & Dr. Ajay Vijayakrishnan** Psychoanalysis in the Consulting Room
	Hall A124 Workshop 7	**Dr. Somdeb Mitra & Ms. Debalina Mitra** Brief Psychodynamic Therapy as a Tool to Unravel the Inner Turmoil of Emotionally Unstable Personalities.
	Neuroscience Lab Workshop 8	**Dr. Bhasi Sukumaran** Clinical Application of EMDR-Case Studies
1.00pm to 1.45pm	**Dining Hall B301**	**LUNCH BREAK & CHANGE HALL / CONTINUING IN SAME HALL**
2.00pm to 3.30pm	**Different Halls**	**Workshops**
	Main Hall Workshop 9	**Mr. Nigesh Kaloroth** (Malayalam) Recent trends and Challenges in the Management of Learning Disability
	Hall B204 Workshop 10	**Dr. Arnoud Huibers** Use of the Solution-Focused Circle Technique
	Hall B202 (Continuation)	**Dr. Michael Durrant** Solution-Focused Supervision and Leadership
	Hall B302 (Continuation)	**Dr. Vibha Sharma** Time Effective Psychosocial Interventions for Dissociative Disorders
	Hall B303 (Continuation)	**Ms. Aarathi Selvan & Ms.Divya Raj** Mindfulness in Clinical Practice
	Hall B304 (Continuation)	**Dr. MalikaVerma & Dr. Ajay Vijayakrishnan** Psychoanalysis in the Consulting Room

21-12-2017 - THURSDAY		
WHEN?	**WHERE?**	**WHO AND WHAT?**
2.00pm to 3.30pm	Hall A124 Workshop 11	**Dr. Abdul Salam** Brief Psychoanalytic Interventions in Couple Therapy
	Neuroscience Lab Workshop 12	**Ms. Hargun Ahluwalia & Ms. Fasli Sidheek K.P.** Trauma - Informed Care in Clinical Practice
3.30pm to 4.00pm	**Dining Hall B301**	**TEA BREAK & CHANGE HALLS**
4.00pm to 5.30pm	**Different Halls**	**Research Paper Presentations**
	Hall B204	**Ms. Gayathri Menon** Solution Focused Brief Therapy Addressing Social Phobia: A Case Study
	Hall B204	**Ms. Ojaswita Bhushan** A Review on Accelerated Experiential Dynamic Psychotherapy (AEDP)
	Hall B204	**Ms. Hargun Ahluwalia** Development of a Cognitive Behaviour Therapy Program for Women with Substance Use Disorders
	Hall B204	**Ms. Jennifa Fernandes** CBT as an intervention for marital disharmony due to substance abuse: A review of literature
	Hall B204	**Ms. Mariah Dias** Women a subject of offense: A review of literature
	Hall B204	**Ms. Chaitra Nagaraj Kumble** Trauma Histories among Women in a Reception Centre: Implications for Trauma Counselling
	Hall B202	**Ms. Guru Prasanna Lakshmi. P** Combination of psychotherapeutic techniques to adequately cope well with the body image issues in adolescents, diagnosed with E-wings Sarcoma followed by amputation - Two case series
	Hall B202	**Ms. Lareina D'Souza** Time Effective Psychosocial Interventions In Adolescent Mental Health, School Mental Health & Child Abuse
	Hall B202	**Ms. Hansi Hamza** Significance and Feasibility of Solution Focused Brief Therapy for Indian population
	Hall B202	**Ms. Pearlene Helen Mary. D** Reconceptualization of Self-Defeating Humor: Implications for Humor Intervention Programs
	Hall B202	**Mr. Tabasum Farooq** Social Support as an intervention in mental health
	Hall B202	**Ms. Aiswarya M Babu** Time Effective Psychosocial Interventions in Sexual Abuse.

22-12-2017 - FRIDAY		
WHEN?	**WHERE?**	**WHO AND WHAT?**
8.45am to 8.55am	Main Hall	Salutation
9.00am to 10.00am	Main Hall	**Dr. Frances Huber** Keynote 2: Mindfulness in Solution-Focused Brief Therapy: Every Moment is Precious.
10.00am to 11.00am	Main Hall	**Dr. Ben Furman** Keynote 3: Hope, Collaboration and Creativity - Cornerstones of Success in Coaching Children and Teens to Overcome Difficulties
11.00am to11.20am	**Dining Hall B301**	**TEA BREAK & CHANGE HALLS**
11.30am to 1.00 pm	**Different Halls**	**Workshops**
	Main Hall Workshop 13	**Dr. Seema P Uthaman & Dr. Salah Basheer** (Malayalam) Interventions in Autisms Spectrum Disorders: Combining Pharmacological & Psychosocial Perspectives
	Hall B204 Workshop 14	**Dr. Elliott Connie** Solution Building Couples Therapy: Brief Therapy with Relationships
	Hall B202 Workshop 15	**Dr. Ben Furman** Introduction to Kids' Skills – A Creative and Fun Approach to Helping Children Overcome Emotional and Behavioural Difficulties
	Hall B302 Workshop 16	**Dr. Frances Huber** Mindfulness for Challenging Situations in Solution-Focused Brief Therapy: We're All in This Together!
	Hall B303 Workshop 17	**Dr. Gitanjali Natarajan** Interpersonal Therapy: Relationship Matters
	Hall B304 Workshop 18	**Dr. Sherin P Antony** Play in Practice
	Hall A124 Workshop 19	**Mr. Baijesh A R** Acceptance and Commitment Therapy
	Neuroscience Lab Workshop 20	**Dr. Sudhesh N T, Dr. Santosh K R & Ms. Ruopfuvinuo Pienyu** Mindful Disciplining, Peaceful Parents: A Solution Focused Approach
1.00pm to 1.45pm	**Dining Hall B301**	**LUNCH BREAK & CONTINUING IN SAME HALL**
2.00pm to 3.30pm	**Different Halls**	**Workshops**
	Main Hall Workshop 21	**Dr. Sunish TV & Ms. Saija S** (Malayalam) Methods of Teaching and Curriculum Adaptations for Inclusive Education
	Hall B204 (Continuation)	**Dr. Elliott Connie** Solution Building Couples Therapy: Brief Therapy with Relationships
	Hall B202 (Continuation)	**Dr. Ben Furman** Introduction to Kids' Skills – A Creative and Fun Approach to Helping Children Overcome Emotional and Behavioural Difficulties
	Hall B302 (Continuation)	**Dr. Frances Huber** Mindfulness for Challenging Situations in Solution-Focused Brief Therapy: We're All in This Together!

22-12-2017 - FRIDAY		
WHEN?	**WHERE?**	**WHO AND WHAT?**
2.00pm to 3.30pm	Hall B303 (Continuation)	**Dr. Gitanjali Natarajan** Interpersonal Therapy: Relationship Matters
	Hall B304 (Continuation)	**Dr. Sherin P Antony** Play in Practice
	Hall A 124 (Continuation)	**Mr. Baijesh A R** Acceptance and Commitment Therapy
	Neuroscience Lab (Continuation)	**Dr. Sudhesh N T, Dr. Santosh K R & Ms. Ruopfuvinuo Pienyu** Mindful Disciplining, Peaceful Parents: A Solution Focused Approach
3.30pm to 4.00pm	**Dining Hall B301**	**TEA BREAK & CHANGE HALLS**
4.00pm to 5.30pm	**Different Halls**	**Research Paper Presentations**
	Hall B204	**Ms. Nishita Ravindra Tikekar** Psychosocial Interventions for PTSD in War-Exposed Children and Adolescents: A Review of Literature
	Hall B204	**Ms. Shama Shirish Keny** Causes and interventions for marital discord: A review of literature
	Hall B204	**Ms. Yusra Sayed** SFBT- A Miracle from a Minimalist Perspective
	Hall B204	**Ms. Sheetal Rose Jose** Residential Exposure With Response Prevention: A Time-Effective Intervention For A Severe And Chronic Case of OCD
	Hall B204	**Ms. Soumya N** Solution Focused Brief Therapy and Health Psychology A Review
	Hall B204	**Ms. Fathimath Leena** Reinforcements and Punishments Preferred By Parents: A Cross Cultural Study
	Hall B202	**Ms. Dhanya C** Social Cognition Intervention in Schizophrenia: Preliminary Evidences From an Innovative Programme
	Hall B202	**Dr. Milli Baby** The impact of experiential (T)group dynamics on locus of control, self esteem and resilience in students of fire engineering college-A pre and post study
	Hall B202	**Dr. A Thirumoorthy** Effectiveness of Solution Focused Brief Therapy tarining on Solution Focused Thinking
	Hall B202	**Ms. Hind Beegam R** Effect of Solution Focused vs. Problem Focused Questions in Affect, Solution Focused Orientation and Neuropsychological Changes.
	Hall B202	**Mr. Sonu S Dev** Solution-Focused Brief Therapy for Mild Depression in Private Psychiatry Setting

23-12-2017 - SATURDAY		
WHEN?	**WHERE?**	**WHO AND WHAT?**
8.45am to 8.55am	Main Hall	Salutation
9.00am to 10.00am	Main Hall	**Dr. Michael Durrant** Keynote 4: The Strengths Approach … Resilience … Positive Psychology … Isn't Solution-Focused Just a Version of these?
10.00am to 11.00am	Main Hall	**Dr. Elliott Connie** Keynote 5: Using Solution Focused Brief Therapy to Live Beyond Trauma
11.00am to11.20am	**Dining Hall B301**	**TEA BREAK**
11.30am to 1.00pm	Main Hall	Valedictory
1.00pm to 2.00pm	**Dining Hall B301**	**CHATS, MEET AGAIN TALKS AND LUNCH**
2.00pm to 3.00pm	Meetings	

Part II
ABSTRACTS OF KEYNOTES

CONTENTS

No	Speaker	Title	Page No.
1	Dr. Arnoud Huibers	Essentials of the Solution Focused Approach - Time Effective Interventions	15
2	Dr. Frances Huber	Mindfulness in Solution-Focused Brief Therapy: Every Moment Is Precious.	16
3	Dr. Ben Furman	Hope, Collaboration and Creativity - Cornerstones of Success in Coaching Children and Teens to Overcome Difficulties	17
4	Dr. Michael Durrant	The Strengths Approach … Resilience … Positive Psychology … Isn't Solution-Focused just a version of these?	18
5	Elliott E. Connie	Using Solution Focused Brief Therapy to Live Beyond Trauma	19

Session	Date	Time	Room No.
Keynote 1	21/12/2017	10am-11am	Main Hall

TITLE OF THE KEYNOTE

Essentials of the Solution Focused Approach - Time Effective Interventions

SPEAKER

Dr. Arnoud Huibers

DESIGNATION AND AFFILIATION

Director, Solution Centre, Consultant Psychologist and Psychotherapist and Teacher of the Solution Focused Psychology.

ABSTRACT OF THE KEYNOTE

A visual representation of the Essentials of the Solution-Focused Approach will be given, supported by video excerpts that will be shown and reflected upon for discussion and exchange of ideas. Participants will be invited to take a closer look at each of the interrelated essential principles of the Solution-Focused Approach and their time effective interventions. These interventions can be used in a variety of professional settings ranging from psychiatrist and patient, therapist and client, school counsellor and student, child psychologist and family to manager and team.

ABOUT THE SPEAKER

Arnoud Huibers, is the director of Solutions Centre, co-founded with Insoo Kim Berg in 2004. He is a licensed psychologist, systemic psychotherapist and trainer of the Solution Focused Approach in the Netherlands, Europe, the Caribbean and India. As a psychotherapist, he works in private practice, in Soesterberg, the Netherlands. He is founding member of the Dutch Association of Solution-focused practitioners (VOPN), founding member of the Academy for Solution-Focused Approaches and Research (ASFAR), member of the Dutch Society of: Psychologists (NIP), Psychotherapists (NVVP), Family Therapist (NVRG) and Child- en Youth Therapists (VKJP). He was trained at the University of Utrecht and completed his post-graduate degree at the Academic Medical Centre of Utrecht, the Netherlands.

CONTACT DETAILS

arnoudhuibers@sol-centre.org
www.solutions-centre.nl/en/

Session	Date	Time	Room No.
Keynote 2	**22/12/2017**	**9am-10am**	**Main Hall**

TITLE OF THE KEYNOTE

Mindfulness in Solution-Focused Brief Therapy: Every Moment Is Precious.

SPEAKER

Dr. Frances Huber

DESIGNATION AND AFFILIATION

Psychologist, St John of God Health Service, Sydney, Australia

ABSTRACT OF THE KEYNOTE

Mindfulness is a concept relatively new to Western Society but thousands of years old in Eastern Society. How might Mindfulness enhance the effectiveness of Solution-Focused Brief Therapy and thereby make therapy more time efficient for clients? Is Mindfulness for Therapists or Clients or both? Is Mindfulness a therapeutic technique or a stance? This keynote address these questions about Mindfulness and will tie this directly with key aspects of SFBT.

ABOUT THE SPEAKER

Frances Huber is a psychologist and Senior Associate of the Brief Therapy Institute of Sydney. She also works at St John of God Hawkesbury District Health Service Community Health Centre, where she provides counselling to adult clients presenting with a range of difficulties, including domestic violence and child sexual abuse, depression, relationship difficulties, etc. Frances has a background in high-school teaching and has previously worked in child and adolescent counselling services. She has experience training and supervising a wide range of practitioners in Solution-Focused Brief Therapy. She is a dedicated Mindfulness practitioner and practices Vipassana meditation and Bikram Yoga. She has presented at conferences in Australia and in Europe.

CONTACT DETAILS

Frances.Huber@sjog.org.au
www.briefsolutions.com.au/btis

Session	Date	Time	Room No.
Keynote 3	22/12/2017	10am-11am	Main Hall

TITLE OF THE KEYNOTE

Hope, Collaboration and Creativity - Cornerstones of Success in Coaching Children and Teens to Overcome Difficulties

SPEAKER

Dr. Ben Furman

DESIGNATION AND AFFILIATION

Manager, Helsinki Brief Therapy Institute

ABSTRACT OF THE KEYNOTE

In my keynote I will present a concept that has become known as the flowerpot theory. It postulates that in order to be successful in helping children and adolescents we need to make three things happen. We need to instill hope, build collaboration and inspire the creativity of our clients. Luckily there are simple techniques to make that happen and a wealth of such techniques will be covered in this brief talk.

ABOUT THE SPEAKER

Dr. Ben Furman is a psychiatrist from Finland and a world renowned teacher of solution-focused therapy. He is the father of Kids'Skills, an application of solution-focused therapy particularly suited for working with children and teenagers. Ben is the author of some 20 books many of which have been translated to several languages. To find out more about Ben visit his website at www.benfurman.com

CONTACT DETAILS

ben@benfurman.com
www.benfurman.com

Session	Date	Time	Room No.
Keynote 4	23/12/2017	9.00am-11am	Main Hall

TITLE OF THE KEYNOTE

The Strengths Approach… Resilience… Positive Psychology… Isn't Solution-Focused just a version of these?

SPEAKER

Dr. Michael Durrant

DESIGNATION AND AFFILIATION

Psychologist/Director, Brief Therapy Institute of Sydney

ABSTRACT OF THE KEYNOTE

Around the world, many counselling/welfare agency claims to be 'strengths-based" and many claim to draw upon "Positive Psychology" or to be "building resilience".

While it is true that a strengths approach is radically different from a more traditional "problem-focused" approach, and positive psychology offers much that has been lost in more traditional psychology approaches, I suggest that seeing Solution-Focused as "positive" or "strengths-based" seriously undermines what is radically different about the Solution-Focused approach.

In this keynote address, I will discuss the contributions a Strengths Approach, Positive Psychology and resilience offer us as clinicians and the difference they make to the way we view people. However, I will suggest that the Solution-Focused approach has some similarities with these perspectives but, ultimately, is radically different.

ABOUT THE SPEAKER

Founder and Director of the Brief Therapy Institute of Sydney, a psychologist with an international reputation in Solution-Focused Brief Therapy, Michael has consulted to counselling/therapy agencies and teams in Australia and overseas and has presented training workshops in North America, Europe & Southeast Asia. Michael is Honorary Academic Associate in the Faculty of Education and Social Work at the University of Sydney and was a visiting international faculty member on the Masters of Special Education program at Fontys University in The Netherlands.

He is Editor of the (international) Journal of Solution-Focused Brief Therapy and President of the Australasian Association for Solution-Focused Brief Therapy.

Michael has had published a number of books and professional articles and his books, published by W. W. Norton & Co in New York, have been translated into German, French, Dutch, Arabic and Japanese.

Michael has conducted more than 600 professional training workshops and is widely sought after as a speaker and trainer. He has been an invited keynote/plenary speaker at a number of international conferences.

CONTACT DETAILS

michael@briefsolutions.com.au
www.briefsolutions.com.au/btis

Session	Date	Time	Room No.
Keynote 5	23/12/2017	10am-11am	Main Hall

TITLE OF THE KEYNOTE

Using Solution Focused Brief Therapy to Live Beyond Trauma

SPEAKER

Elliott E. Connie

DESIGNATION AND AFFILIATION

The Solution Focused University

ABSTRACT OF THE KEYNOTE

The trouble with going through traumatic events is they often alter our lives, they take away our innocence, the remove our ability to smile. Often times, a person's life can be defined as before and after a traumatic event. The numbers of people impacted by traumatic events is staggeringly high and this means in session we have to be prepared to work with clients who have been through difficult things. It is important to understand that the task of building towards a client's desired outcome and solving a problem are inherently different and thus the work done in session by the professional is different. Unlike other approaches, the task of the professional is not changed due to the problem. Instead the focus is on eliciting a description of the presence of the desired outcome. In this plenary the presenter will demonstrate how the Solution Focused Approach is used in sessions when the client has experienced a trauma.

ABOUT THE SPEAKER

Elliott Connie, MA, LPC is a psychotherapist that practices in Keller, Texas. He has worked with thousands of individuals, couples, and families applying the solution focused approach to help them move their lives from the current problems towards their desired futures. He is the founder and Executive Director of The Connie Institute, an organization that conducts trainings to help clinicians to master the Solution Focused Approach in their work as well as developing training materials and conducting research. He is recognized around the world speaking at national and international conferences and events in such places as throughout the United States, Australia, New Zealand, South Africa, Russia, Switzerland, England, Poland, Sweden, Denmark, Scotland, Holland, Canada, and Asia training practitioners to apply solution focused questions and techniques in their work. He has authored or co-authored 3 books including "The Art of Solution Focused Therapy", "Solution Building in Couples Therapy" and "The Solution Focused Marriage".. He was mentored by noted authors and practitioners such as Bill O'Hanlon, Chris Iveson and Linda Metcalf.

CONTACT DETAILS

elliott@elliottspeaks.com
www.solutionfocusedbrieftherapy.com

Part III

ABSTRACTS OF WORKSHOPS

CONTENTS

No	Speaker	Title	Page No.
1	Ms. Uma Krishnan	Technology Based Intervention for Children with Autism and Other Intellectual Disabilities	23
2	Dr. Arnoud Huibers	Main Interventions of the Solution-Focused Approach.	24
3	Dr. Michael Durrant	Solution-Focused Supervision and Leadership	25
4	Dr.Vibha Sharma	Time Effective Psychosocial Interventions for Dissociative Disorders	26
5	Ms. Aarathi Selvan Ms. Divya Raj	Mindfulness in Clinical Practice	27
6	Dr. Malika Verma Dr. Ajay Vijayakrishnan	Psychoanalysis in the Consulting Room	28-29
7	Dr. Somdeb Mitra Ms. Debalina Mitra	A workshop on Brief psychodynamic therapy as a tool to unravel the inner turmoil of emotionally unstable personalities.	30-31
8	Dr. Bhasi Sukumaran	Clinical Applications of EMDR- Case Studies	32
9	Mr. Nigesh Kalorath	Recent Trends in the Management of Learning Disabilities	33
10	Dr. Arnoud Huibers	Use of the Solution-Focused Circle Technique.	34
11	Dr. Abdul Salam K P	Brief psychoanalytic therapy with couples	35
12	Ms. Hargun Ahluwalia Ms. Fasli Sidheek K.P.	Trauma - Informed Care in Clinical Practice	36
13	Dr. Seema P. Uthaman Dr. Salah Basheer	Interventions in Autism Spectrum Disorders: Combining Pharmacological and Psychosocial Perspectives	37
14	Elliott E. Connie	Solution Building Couples Therapy: Brief Therapy with Relationships	38
15	Dr. Ben Furman	Introduction to Kids' Skills - A Creative and Fun Approach to Helping Children Overcome Emotional and Behavioral Difficulties	39

No	Speaker	Title	Page No.
16	Dr. Frances Huber	Mindfulness for Challenging situations in Solution-Focused Brief Therapy: We're all in this together!	40
17	Dr. Gitanjali Natarajan	Interpersonal Therapy: Relationship Matters	41
18	Dr. Sherin P Antony	Play In Practice	42
19	Mr. Baijesh A. R.	Acceptance and Commitment Therapy	43
20	Dr. Sudhesh N T Ms .Ruopfuvinuo Pienyu Dr. Santhosh Kareepdath Rajan	Mindful Disciplining, Peaceful Parents: A Solution-Focused Approach	44-45
21	Dr. Sunish TV Ms. Saija S	Models of teaching and curriculum adaptations for inclusive education	46-47

Session	Date	Time	Room No.
Workshop 1	21/12/2017	11.30am-1.00pm	Main Hall

TITLE OF THE WORKSHOP

Technology Based Intervention for Children with Autism and Other Intellectual Disabilities

SPEAKER

Ms. Uma Krishnan

DESIGNATION AND AFFILIATION

Clinical Psychologist, NIT, Calicut
Director , Abhyan Center for differently abled

ABSTRACT

Intellectual disabilities are a major concern in the current society. Among them autism has received a major importance due to its high prevalence. There are different strategies were adopted to provide intervention for these individuals. The advent of technology has brought a massive change in the outlook in the treatment aspect in the western countries. The approach of technology based intervention is different from the traditional method, but it has taken the core aspects from the traditional method too. In the technological field iPad and other android tablet based intervention has gained much importance. As all the children interested to play in gadgets, using these gadgets in methodical way can bring changes in the approach of treatment for developmental disabilities. Studies reported improvements in communication and other related areas in children with autism and other developmental disabilities.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Will be able to understand the technology based intervention
2. Can use gadgets in their intervention pattern
3. Bring changes in intervention

WORKSHOP IS INTENDED FOR

- People who are comfortable in Malayalam Language
- Rehabilitation professional especially who works in disability management setting (CRE Topics)

ABOUT THE SPEAKER

Uma Krishnan, is a Clinical Psychologist, completed MPhil from Kasturba Medical College, Manipal. Currently working as clinical psychologist in NIT and Director of Abhyan center for differently abled. Was working in Bangalore as CP and in the field of disability. She has published 4 papers in different journals on psychological aspects of adolescents. She has received best paper award for the paper "Improving conversation skills using technology based intervention among children with intellectual disability". In the 2016 Dec SFBT International conference.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

umakrishnan11@gmail.com

Session	Date	Time	Room No.
Workshop 2	21/12/2017	11.30am-1.00pm	B204

TITLE OF THE WORKSHOP

Main Interventions of the Solution-Focused Approach.

SPEAKER

Dr. Arnoud Huibers

DESIGNATION AND AFFILIATION

Consultant psychologist and psychotherapist.
Teacher of the Solution Focused Psychology.

ABSTRACT

Main intervention techniques of the Solution-Focused Approach will be explained, shown on video, discussed and practiced. Ways to connect with the person of the client, not the problem, will be talked about and practiced. Different types of cooperation with clients will be looked at. What to do when you get stuck in a session with a client?

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Understand and use different Solution-Focused intervention techniques.
2. Make contact with the person (not the problem) at the beginning of a session.
3. Assess different types of cooperation with the client.

WORKSHOP IS INTENDED FOR

All levels

ABOUT THE SPEAKER

Arnoud Huibers, MSc, is director of Solutions Centre, co-founded with Insoo Kim Berg in 2004. He is a licensed psychologist, systemic psychotherapist and trainer of the Solution Focused Approach in the Netherlands, Europe, the Caribbean and India.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

arnoudhuibers@sol-centre.org
www.solutions-centre.org

Session	Date	Time	Room No.
Workshop 3	21/12/2017	11.30am-3.30pm	B202

TITLE OF THE WORKSHOP

Solution-Focused Supervision and Leadership

SPEAKER

Dr. Michael Durrant

DESIGNATION AND AFFILIATION

Psychologist/Director, Brief Therapy Institute of Sydney

ABSTRACT

This workshop explores the implications of Solution-Focused thinking for supervising and leading staff within welfare/counselling contexts by looking at what it might mean to use the same philosophy and process in supervision and leadership. If we are serious about trying to treat our staff in a way that is consistent with how we treat our clients, what difference might this actually make?

The workshop will draw upon Solution-Focused principles and practices AND from insights from the broader literature about “best practice” in supervision and leadership.

Participants will gain practical methods for working with staff in ways that enhance their sense of competence and effectiveness.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will:
1. Understand how the principles of the Solution-Focused approach may apply to supervision.
2. Have experienced asking Solution-Focused questions in a supervisory context.
3. Recognise how Solution-Focused supervision supports the Solution-Focused therapist.

WORKSHOP IS INTENDED FOR

Intermediate/advanced

ABOUT THE SPEAKER

Founder and Director of the Brief Therapy Institute of Sydney, a psychologist with an international reputation in Solution-Focused Brief Therapy, Michael has consulted to counselling/therapy agencies and teams in Australia and overseas and has presented training workshops in North America, Europe & Southeast Asia. Michael is Honorary Academic Associate in the Faculty of Education and Social Work at the University of Sydney and was a visiting international faculty member on the Masters of Special Education program at Fontys University in The Netherlands.

He is Editor of the (international) Journal of Solution-Focused Brief Therapy and President of the Australasian Association for Solution-Focused Brief Therapy.

Michael has had published a number of books and professional articles and his books, published by W. W. Norton & Co in New York, have been translated into German, French, Dutch, Arabic and Japanese.

Michael has conducted training widely on Solution-Focused supervision and was also a trainer of supervisors for the Psychologist Registration Board ion NSW, Australia.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

mchael@briefsolutions.com.au
www.briefsolutions.com.au/btis

Session	Date	Time	Room No.
Workshop 4	21/12/2017	11.30am-3.30pm	B302

TITLE OF THE WORKSHOP

Time Effective Psychosocial Interventions for Dissociative Disorders

SPEAKER

Dr.Vibha Sharma

DESIGNATION AND AFFILIATION

Associate Professor, Dept. of Clinical Psychology
Institute of Human Behaviour & Allied Sciences (IHBAS), Dilshad Garden, Delhi.

ABSTRACT

Presentation of persons, mainly women with Dissociative Disorders (including Conversion) is very common in any health set up. At specialized tertiary care centres like IHBAS, they report either to neurology or Psychiatry OPD. If analysed the pathway of care in such cases, these persons and families first contact to faith healers, and local shamans. Then they go to local physicians, sometimes even doing Doctor shopping. Generally, it is their 5th or 6th contact, when they reach to a Mental Health Professional, and especially to a Clinical Psychologist.

Objectives of the present workshop are to suggest and demonstrate time effective or brief psychosocial interventions for such persons with presentation of a variety of dissociative symptoms, and to equip the participants with brief and effective intervention for such cases.

The content of the workshop will include, brief assessment, then psychological formulation of such cases, method of sharing the formulation with the client and finally how to plan and provide short term solution based intervention sessions.

The method of the presentation of this workshop would be Interactive, as well as demonstrative, where role plays would be conducted.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Identify and psychologically formulate the problems of persons with Dissociative Disorders.
2. Learn to provide time effective brief psychosocial interventions for such cases.

WORKSHOP IS INTENDED FOR

Every one

ABOUT THE SPEAKER

Vibha Sharma, Ph.D. & M.Phil. In Clinical Psychology is Currently Associate Professor and Consultant at IHBAS Delhi (India), which is a leading Institute and Hospital in the area of Mental Health and Neurosciences. Her major achievements include four awards from various associations including Young Scientist Award; more than 50 publications in National and International Journals; an edited book on "Clinical Neuropsychology" and around 15 chapters in reference books. She has been invited as resource person in more than 80 seminars, conferences etc.; has presented around 40 papers in National and International conferences & seminars; and has delivered more than 50 public lectures on various mental health issues. She is member of 15 scientific bodies, Editing a Journal; supervised 5 PhD's and around 50 M.Phil. Dissertations.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

arnoudhuibers@sol-centre.org
www.solutions-centre.org

Session	Date	Time	Room No.
Workshop 5	21/12/2017	11.30am-3.30pm	B303

TITLE OF THE WORKSHOP

Mindfulness in Clinical Practice

SPEAKERS

1. **Ms. Aarathi Selvan**
2. **Ms. Divya Raj**

DESIGNATION AND AFFILIATION

1. Founder, Pause for Perspective, Hyderabad
2. Clinical Psychologist, Asha Hospital, Hyderabad

ABSTRACT

This workshop introduces practitioners to what entails mindfulness oriented psychotherapy, mindfulness informed psychotherapy and mindfulness based psychotherapy. We will look at tools needed for practitioners to enhance their own practice of mindfulness. Further, we will look at how mindfulness conceptualizes mental illness. The workshop will also introduce therapists to specific, effective and brief mindfulness tools that can be used by clients over time to manage different trans diagnostic symptoms of anxiety, depression and trauma. We will integrate the neurobiological underpinnings of mindfulness practice to make a strong case for use of mindfulness in therapy.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:

1. The workshop will also introduce therapists to specific, effective and brief mindfulness tools that can be used by clients over time to manage different trans diagnostic symptoms of anxiety, depression and trauma.
2. We will integrate the neurobiological underpinnings of mindfulness practice to make a strong case for use of mindfulness in therapy.

WORKSHOP IS INTENDED FOR

Everyone

ABOUT THE SPEAKERS

1. Aarathi Selvan NCC (USA), MPhil (ClPsy) is a Clinical Psychologist in India and a National Certified Counselor in the US. She is a certified Mindfulness Based Symptom Management teacher from the Ottawa Mindfulness Clinic and also a Mindfulness Self Compassion (MSC) practitioner. She is the founder of Pause for Perspective- a Mental Health and Well-being organization in the city of Hyderabad. Besides seeing clients in her practice she also leads 8 week Mindfulness programs as well as trains mental health practitioners in Mindfulness Based Psychotherapy program that is jointly conducted by Pause for Perspective and Ottawa Mindfulness Clinic, Canada. Additionally, she is a faculty at St.Francis Degree College in Hyderabad and a consultant and supervisor for several practitioners in Hyderabad.

2. Divya Raj is a Clinical Psychologist and Mindfulness Practitioner. She is currently a consultant psychologist at Asha Hospital. She has completed her Mindfulness Based Symptom Management Program and Mindfulness Based Psychotherapy Program. She is also an expert in dementia care. She has worked at NIMS previously and has taught at several leading colleges in Hyderabad.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

aarathi.selvan@gmail.com

Session	Date	Time	Room No.
Workshop 6	**21/12/2017**	**11.30am-3.30pm**	**B304**

TITLE OF THE WORKSHOP

Psychoanalysis in the Consulting Room

SPEAKERS

1. **Dr. Malika Verma**
2. **Dr. Ajay Vijayakrishnan**

DESIGNATION AND AFFILIATION

1. Consultant Clinical Psychologist & Psychoanalytic Psychotherapist
2. Consultant Psychiatrist & Psychoanalytic Psychotherapist, Tara Institute of Mental Health, Kozhikode

ABSTRACT

Psychoanalysis in the Consulting Room is a clinically oriented workshop to introduce important concepts in Psychoanalysis. The workshop will be a mix of interactive teaching and case presentations.

The focus will be on the Unconscious, Projective Identification and Countertransference.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:

1. The expected outcome is greater familiarity with the use of psychoanalytic thinking in current clinical practice.
2. They will know what is Projective Identification and its relevance in clinical work.
3. They will know what is countertransference and its relevance in clinical work.

WORKSHOP IS INTENDED FOR

For people engaged in clinical work, individuals working with children in any capacity.

ABOUT THE SPEAKERS

1. With a BA in Psychology from Lady Shri Ram College, Delhi; MA in Clinical Psychology from Delhi University & MPhil in Clinical Psychology from NIMHANS Bangalore, Malika went on to work and train in London, UK for 10 years gaining extensive experience in psychotherapy with adults, couples, families and groups.

   She is currently the only practicing therapist in India who has completed the 4 year Interdisciplinary Training in Adult Psychotherapy (M1) from the prestigious Tavistock and Portman Clinic, London - considered 'the most advanced psychoanalytic psychotherapy training in the UK in the public sector'. and currently practices at Tara Clinic. She offers psychoanalytic consultations and psychotherapy to adults, couples and families.

2. Graduating in Medicine and Surgery from Kuvempu University, Dr Ajay worked in NIMHANS, Bangalore before leaving for the UK.He completed basic and higher specialist training in General & Rehabilitation Psychiatry from the St George's and Charing Cross training schemes in London, UK. Thereafter he held a substantive consultant post in Hertfordshire NHS Trust till 2014.

   His previous academic posts include Assistant Professor at St George's University School of Medicine, Grenada, and Honorary Lecturer and Clinical Teaching Fellow at St George's University of London.he has received training in psychotherapy with adults and groups during his specialization. He has also been in personal analysis with a training analyst from the Institute of Psychoanalysis, London for a number of years.

   After 12 years working in the UK, he returned to India to establish a state-of-the-art mental health centre in Kozhikode. he maintains a psychotherapy practice at Tara Clinic. He also offers consultation and reviews to patients with complex and severe psychiatric problems. His specialist area of expertise is Personality Disorder.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

malika@taraclinic.in
ajay@taraclinic..in

Session	Date	Time	Room No.
Workshop 7	21/12/2017	11.30am-1.00 pm	A124

TITLE OF THE WORKSHOP

A workshop on Brief psychodynamic therapy as a tool to unravel the inner turmoil of emotionally unstable personalities.

SPEAKERS

1. **Dr. Somdeb Mitra**
2. **Ms. Debalina Mitra**

DESIGNATION AND AFFILIATION

1. Assistant Professor, University of Calcutta.
2. Faculty and Psychological Counsellor, Calcutta International School.

ABSTRACT

Emotions play a pivotal role in the process of adaptation as well as development of psychopathology. The physiological arousal levels associated with emotions are found to share a lot of commonality. Hence, the label or appraisal process utilized by an individual is of paramount importance. This also opens up the possibility of misrepresenting one emotion as a different one. Moreover, the individual may simply focus on the physiological conditions while missing the core underlying psychological process. There exists a large body of evidence which indicates that psychodynamic psychotherapy can be extremely useful in understanding the symptoms as well as alleviation of distress. Furthermore, the gains achieved in this process tends to persist and often patients show further improvement after the termination of therapy.

Often cases with core features of emotional instability present with complex symptoms such as dissociation, panic, deliberate self-harm, depression, uncontrolled anger. The current workshop is aimed at developing an understanding of psychodynamic formulation to facilitate treatment of such cases.

Therapists require to focus on specific aspects and underlying meanings of symptoms, client's nature of response in the process of therapy and finally, the counter-transference evoked within the session. The process of unravelling the inner meanings and the language used by the therapist holds the key to successful therapy.

The target of the workshop is to provide hands on experience to the participants to analyse and understand the meaning of the information obtained from the clients (using case vignettes) and working psychodynamically. How therapists with limited information about psychodynamics can go ahead and deal the cases with the help of their knowledge of CBT/REBT or any other model of therapy will be discussed.

Finally, the focus will also be on the similarities and differences of brief psychodynamic therapy and other models of treatment.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:

1. Formulate psychodynamic psychopathology of persons with complex symptoms as an expression of inner emotional instability.
2. Use the concepts in therapy with such clients – at-least the initial stages.
3. Be prepared to learn more advanced levels.

WORKSHOP IS INTENDED FOR

Intermediate (persons having basic concepts of practising psychotherapy).

ABOUT THE SPEAKERS

1. Somdeb Mitra is Assistant Professor at Department of Psychology, University of Calcutta and a consultant Clinical Psychologist with independent private practise. He has experience of teaching at M.Phil in Clinical Psychology for above six years. He has publications in indexed journals and also presented papers in national conferences. He has recently submitted his PhD thesis under Psychoanalyst Prof (Dr.) N. Sanyal (Professor, University of Calcutta). The thesis focuses on psychodynamic treatment of Borderline Personality Disorder patients. He regularly uses Brief Psychodynamic Psychotherapeutic techniques in private clinical practise and also teaches the same to his M.Phil in Clinical Psychology final year trainees in University of Calcutta.

2. Debalina Mitra is Faculty and Psychological Counsellor at Calcutta International School and a consultant Clinical Psychologist with independent private practise. Her previous experience includes teaching M.Phil trainees in University of Calcutta and conducting research. She has presented at national conferences and co-authored book chapter. She focuses on the psychodynamic-interpersonal perspective while dealing with her emotionally unstable patients in regular clinical practice. In her school too, she uses similar procedures while performing her duties as a counsellor. Group meetings with parents on a regular basis necessitates her to use processes of group therapy and counselling. She has training in the International Baccalaureate Board which gives her the edge to teach effectively focusing on the various aspects of knowledge.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

mitrasomdeb@yahoo.co.in
debalinac505@gmail.com

Session	Date	Time	Room No.
Workshop 8	**21/12/2017**	**11.30am-1.00pm**	**Neuroscience Lab**

TITLE OF THE WORKSHOP

Clinical Applications of EMDR- Case Studies

SPEAKER

Dr. Bhasi Sukumaran

DESIGNATION AND AFFILIATION

Prof. & Head, Department of Clinical Psychology, Sweekaar Academy of Rehabilitation Sciences, Secunderabad

ABSTRACT

The clinical applications of EMDR are well documented. The presentation will focus on case studies to demonstrate the application of EMDR in various clinical populations.

The first section of the presentation will deal will childhood issues and will feature a case of childhood trauma and PTSD, and illustrations of application in child abuse; emotional abuse, physical abuse and sexual abuse.

The second section will have case studies related to prolonged grief reaction and guilt, social anxiety, suicidal ideation, body dysmorphophobia and situational erectile dysfunction.

The third section will be devoted to two special applications of EMDR, the Positive Feeling State Protocol and the EMDR protocol for Pain Control. Management of sexual fetishism and chronic pain will be discussed.

EXPECTED LEARNING OUTCOME

WORKSHOP IS INTENDED FOR

Everyone

ABOUT THE SPEAKER

Dr. Bhasi Sukumaran is a Professor of Clinical Psychology with over 20 years of experience. His areas of interest are Neuropsychology and cognitive remediation.

He was initiated to Mindfulness practices by Dr M.P. Sharma(former HoD, Department of Clinical Psychology, NIMHANS).

He has been using Mindfulness Integrated Cognitive Therapy approaches in his clinical work and is also conducting Mindfulness Integrated Stress Management training sessions for corporate.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

bhasi.sukumaran@gmail.com

Session	Date	Time	Room No.
Workshop 9	21/12/2017	2.00pm -3.30pm	Main Hall

TITLE OF THE WORKSHOP

Recent Trends in the Management of Learning Disabilities

SPEAKER

Mr. Nigesh Kalorath

DESIGNATION AND AFFILIATION

Disability Management Officer (Consultant Clinical Psychologist) CDMRP, Dept. of Psychology, University of Calicut

ABSTRACT

As we all know that, Learning disability (LD) is not a single disorder, but includes disabilities in any of seven areas related to reading, language, and mathematics. These separate types of learning disabilities frequently co-occur with one another and with social skill deficits and emotional or behavioral disorders. Most of the available information concerning learning disabilities relates to reading disabilities, and the majority of children with learning disabilities have their primary deficits in basic reading skills.

This workshop contents framed with the focus to enhance the knowledge base about learning disabilities esp. to discuss concept of learning disability and its types, understanding various causes of learning disabilities, approaches and techniques used to diagnose or measure the learning problems, various interventional strategies, uses of technology in the intervention, cognitive retraining for learning problems etc.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Enhance the understanding about learning Disability
2. To learn various assessment strategies
3. To learn various intervention methods and technological advancements in

WORKSHOP IS INTENDED FOR

- People who are comfortable in Malayalam Language
- Rehabilitation professional especially who works in disability management setting (CRE Topics)

ABOUT THE SPEAKER

Mr. Nigesh Kalorath has completed his M.Phil. Clinical Psychology from University of Calcutta. He has publications in various national and international journals. He was formerly attached to the National Institute of Mental Health and Neuroscience as Clinical Psychologist. Presently He is working as a Disability management Officer (Consultant Clinical Psychologist) in community Disability Management and Rehabilitation Programme, at the Department of Psychology, University of Calicut.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

nigesh89@gmail.com

Session	Date	Time	Room No.
Workshop 10	**21/12/2017**	**2.00pm -3.30pm**	**B204**

TITLE OF THE WORKSHOP

Use of the Solution-Focused Circle Technique

SPEAKER

Dr. Arnoud Huibers

DESIGNATION AND AFFILIATION

Consultant psychologist and psychotherapist. Teacher of the Solution Focused Psychology.

ABSTRACT

The Solution-Focused Circle Technique will be explained, shown on video, discussed and practiced. The Circle Technique can be used working with different clients in different settings: young clients and adults, individual clients, families and groups, therapy settings and counseling in schools and universities.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:

1. Understand and use the Solution-Focused Circle Technique with different clients.
2. Make use of constructive language during a session.
3. Combine the Circle Technique with interviewing for signs of improvement.

WORKSHOP IS INTENDED FOR

All levels

ABOUT THE SPEAKER

Arnoud Huibers, MSc, is director of Solutions Centre, co-founded with Insoo Kim Berg in 2004. He is a licensed psychologist, systemic psychotherapist and trainer of the Solution Focused Approach in the Netherlands, Europe, the Caribbean and India.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

arnoudhuibers@sol-centre.org
www.solutions-centre.org

Session	Date	Time	Room No.
Workshop 11	21/12/2017	2.00pm -3.30pm	A124

TITLE OF THE WORKSHOP

Brief psychoanalytic therapy with couples

SPEAKER

Dr. Abdul Salam K P

DESIGNATION AND AFFILIATION

Head, Dept of Clinical Psychology, IMHANS, Kozhikode.

ABSTRACT

Psychotherapy, when it began was traditionally considered to be an individual affair. However, later developments added a relational perspective to the practice .Psychotherapy with couples is not merely a therapy for two individuals; it works on the space between them-'the third' in analytic parlance. The workshop will focus on applying analytic thinking to working with couples in brief psychotherapy. Theoretical background and clinical material from authors' practise will be utilised to help participants gain insights in this area

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Understand the basic concepts of brief psychoanalytic work.
2. Identify couples suitable for brief psychoanalytic therapy
3. Understand the practical issues involved in brief psychoanalytic therapy with couples

WORKSHOP IS INTENDED FOR

Intermediate

ABOUT THE SPEAKER

He completed his MA in Psychology from Barkatullah University,and got trained in Clinical Psychology (MPhil) from NIMHANS, Bangalore. Subsequently, he received his doctorate from NIMHANS, Bangalore for his work on Mindfulness in Social Phobia. He's been trained in Psychoanalysis and actively uses analytic framework in his clinical practice. His areas of interest include mindfulness as a transtheoretical construct and application of analytic thinking in individual and couple therapy.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

salampsycho@gmail.com

Session	Date	Time	Room No.
Workshop 12	21/12/2017	2.00pm-3.30pm	Neuroscience Lab

TITLE OF THE WORKSHOP

Trauma - Informed Care in Clinical Practice

SPEAKERS

1. **Ms. Hargun Ahluwalia**
2. **Ms. Fasli Sidheek K.P.**

DESIGNATION AND AFFILIATION

PhD scholars , Department of Clinical Psychology, National Institute of Mental Health and Neurosciences

ABSTRACT

The Trauma Recovery Clinic (TRC) was started in November 2013 at NIMHANS Centre for Well - Being, located in an urban residential area in South Bangalore, and is documented as a good practice model in the area of psychological trauma. Both facilitators have been part of TRC.

The proposed workshop aims at sensitization and skills training first level of trauma intervention – that of safety and stabilization.

Objectives:
1. Increase the understanding of clinical presentations of trauma
2. To introduce the principles of TIC in service delivery
3. Contextualize TIC in India

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Learn about the ways in which trauma may present in clinical symptoms
2. Contextualize trauma informed practices to their work setting
3. Feel equipped to ask about traumatic life events to patients and handle acute reactions

WORKSHOP IS INTENDED FOR

Counsellors and post graduate student (Beginner and intermediate levels)

ABOUT THE SPEAKERS

Both presenters are PhD Scholars and Junior Consultants working with vulnerable women in a clinical setting.

Ms Hargun, under the guidance of Prof. L.N.Suman, is working with women with substance use disorders, who present with a variety of personality disorders, mood disorders and traumatic experiences. Her interests lie in areas of women's mental health, addiction psychology, psychotherapy research and trauma recovery.

Ms Fasli, under the guidance of Dr. Veena A.S, is working with couples where one spouse has a diagnosis of borderline personality and also encounters comorbid mood disorders and traumatic life events. Her interests lie in personality disorders, psychotherapy research and couples and family therapy.

Both presenters have been resource persons and facilitators for workshops and symposia in the field of trauma and have presented at national and international conferences.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

gunn1802@gmail.com

Session	Date	Time	Room No.
Workshop 13	22/12/2017	11.30am to 1.00pm	Main Hall

TITLE OF THE WORKSHOP

Interventions in Autism Spectrum Disorders: Combining Pharmacological and Psychosocial Perspectives

SPEAKERS

1. **Dr. Seema P. Uthaman**
2. **Dr. Salah Basheer**

DESIGNATION AND AFFILIATION

1. Assistant Professor & Head Department of Psychiatric Social Work, Institute of Mental Health And Neuro Sciences (IMHANS), Calicut
2. Scientific Research Officer.Child Developmental Services, Institute of Mental Health and Neuro Sciences (IMHANS), Calicut

ABSTRACT

Recent reports have suggested there is a raise in prevalence of Autism Spectrum Disorder (ASD). Further, many recent studies have provided a wealth of information on evidence based practices in the treatment of ASD, both in terms of pharmacological and psychosocial. Given this background, this workshop aims to help professionals involved in the care of subjects with ASD understand, the 'when' and 'how' of implementing these interventions in ASD. This will be an interactive workshop.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:

1. nBetter understanding of the biological and psychosocial factors of ASD.
2. Importance of early identification, training and psychosocial interventions in ASD
3. When and how these interventions will be more appropriate.

WORKSHOP IS INTENDED FOR

- People who are comfortable in Malayalam Language
- Rehabilitation professional especially who works in disability management setting (CRE Topics)

ABOUT THE SPEAKERS

1. Dr. Seema P. Uthaman is working as Assistant Professor and Head at the Department of Psychiatric Social Work at IMHANS, Calicut. She has finished her P hD and M Phil in Psychiatric social Work from NIMHANS, Bengaluru. She has more than 15 years of clinical, teaching and research experience in the filed of mental health and disability. She has many publications related to the field.

2. Dr Salah Basheer is working as scientific research officer in IMHANS, Calicut. He has completed his MBBS from Government Medical College, Kozhikode. Following which as a part of Indian Council of Medical Research MD-PhD talent scheme, he received his clinical training in child psychiatry and PhD in Clinical Neuroscience from NIMHANS, Bangalore. He has presented his research work in international conferences and has peer reviewed publications in international journals. He has also received research grants including travel support.

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

seemapradeepk@gmail.com

Session	Date	Time	Room No.
Workshop 14	22/12/2017	11.30am-3.30pm	B204

TITLE OF THE WORKSHOP

Solution Building Couples Therapy: Brief Therapy with Relationships

SPEAKER

Elliott E. Connie

DESIGNATION AND AFFILIATION

The Solution Focused University, USA

ABSTRACT

Using the Solution Focused Approach with couples is equally simple as using the approach with individuals. However, it can be much harder to apply. This is due to the fact that 2 people's desired outcomes are in the room and the romantic relationship can lead to tense conversations in session. In this workshop the presenter will demonstrate how to conducts a solution focused session with a couple from the beginning to the end, regardless of the problem that brought them into session. Combining stories from his practice along with video demonstrations and loads of practice exercises, attendees to this workshop are sure to leave armed with a new set of skills to be able to apply in their couple's sessions.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:

1. Attendees will be able to identify and perform key solution focused tasks when working with couples.
2. Attendees will be familiar with the differences between using the solution focused approach with individuals vs. with couples.
3. Attendees will be familiar with the key components to a solution focused session, from the beginning to the end.

WORKSHOP IS INTENDED FOR

Everyone

ABOUT THE SPEAKER

Elliott Connie, MA, LPC is a psychotherapist that practices in Keller, Texas. He has worked with thousands of individuals, couples, and families applying the solution focused approach to help them move their lives from the current problems towards their desired futures. He is the founder and Executive Director of The Connie Institute, an organization that conducts trainings to help clinicians to master the Solution Focused Approach in their work as well as developing training materials and conducting research. He is recognized around the world speaking at national and international conferences and events in such places as throughout the United States, Australia, New Zealand, South Africa, Russia, Switzerland, England, Poland, Sweden, Denmark, Scotland, Holland, Canada, and Asia training practitioners to apply solution focused questions and techniques in their work. He has authored or co-authored 3 books including "The Art of Solution Focused Therapy", "Solution Building in Couples Therapy" and "The Solution Focused Marriage".. He was mentored by noted authors and practitioners such as Bill O'Hanlon, Chris Iveson and Linda Metcalf.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

elliott1519@gmail.com
www.solutionfocusedbrieftherapy.com

Session	Date	Time	Room No.
Workshop 15	22/12/2017	11.30am-3.30pm	B202

TITLE OF THE WORKSHOP

Introduction to Kids' Skills - A Creative and Fun Approach to Helping Children Overcome Emotional and Behavioral Difficulties

SPEAKER

Dr. Ben Furman

DESIGNATION AND AFFILIATION

Psychiatrist, teacher of solution-focused therapy. Manager of Helsinki Brief Therapy Institute

ABSTRACT

Kids' Skills in a innovation that was developed in the 90s in Finland to help children of all ages to overcome emotional and behavioral problems, or mental health issues. The method is 100% solution-focused and it is simple to learn even if it requires a new way of thinking about problems. In Kids' Skills problems are converted into skills that children learn with the support of their family and friends. To get an idea of what Kids' Skills is all about, check out Ben's 20 minute long YouTube video about it.

https://goo.gl/N5ywMk

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Use the 15 steps of Kids' Skills to help children overcome all kinds of problems
2. Convert problems into skills that children can learn
3. Know where to find more information about Kids' Skills

WORKSHOP IS INTENDED FOR

Everyone

ABOUT THE SPEAKER

Dr. Ben Furman is a psychiatrist from Finland and a world renowned teacher of solution-focused therapy. He is the father of Kids'Skills, an application of solution-focused therapy particularly suited for working with children and teenagers. Ben is the author of some 20 books many of which have been translated to several languages. To find out more about Ben visit his website at www.benfurman.com

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

ben@benfurman.com
www.benfurman.com

Session	Date	Time	Room No.
Workshop 16	22/12/2017	11.30am-3.30pm	B302

TITLE OF THE WORKSHOP

Mindfulness for Challenging situations in Solution-Focused Brief Therapy: We're all in this together!

SPEAKER

Dr. Frances Huber

DESIGNATION AND AFFILIATION

Psychologist, St John of God Health Service, Sydney, Australia

ABSTRACT

Mindfulness has become a buzz word in Western Society and in psychotherapy – and, of course, has its roots in India thousands of years ago. What happens in Solution-Focused Brief Therapy when the therapist practices Mindfulness? When you are struggling using SFBT, how can Mindfulness help you and your client? This will be a participatory workshop in which we will examine case studies, engage in group discussion and reflection exercises to explore how Mindfulness fits in with your experiences of working with clients in different settings. We may consider a range of issues such as loss and grief, suicidality and the mandated client.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will:
1. Understand the concept of Mindfulness (theory and application) in therapy.
2. Be able to link Mindfulness with specific SFBT strategies.
3. Recognise how the Mindful SFBT therapist benefits the client(s)

WORKSHOP IS INTENDED FOR

All levels

ABOUT THE SPEAKER

Frances Huber is a psychologist and Senior Associate of the Brief Therapy Institute of Sydney. She also works at St John of God Hawkesbury District Health Service Community Health Centre, where she provides counselling to adult clients presenting with a range of difficulties, including domestic violence and child sexual abuse, depression, relationship difficulties, etc. Frances has a background in high-school teaching and has previously worked in child and adolescent counselling services. She has experience training and supervising a wide range of practitioners in Solution-Focused Brief Therapy. She is a dedicated Mindfulness practitioner and practices Vipassana meditation and Bikram Yoga. She has presented at conferences in Australia and in Europe.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

Frances.Huber@sjog.org.au;
frances@briefsolutions.com.au

Session	Date	Time	Room No.
Workshop 17	**22/12/2017**	**11.30am-3.30pm**	**B303**

TITLE OF THE WORKSHOP

Interpersonal Therapy: Relationship Matters

SPEAKER

Dr. Gitanjali Natarajan

DESIGNATION AND AFFILIATION

Associate Professor & HOD, Department of Clinical Psychology, Amrita Institute of Medical Sciences.

ABSTRACT

Majority of clients who come seeking help in our clinical setting, are predominantly concerned and distressed about problems in their interpersonal relations. Their mental wellbeing is greatly influenced the quality of their social support. This is especially true during stressful life events. During such times, good interpersonal relations and strong social support can act as buffers that prevent distress and depressive symptoms.

The workshop aims to cover basic concepts of Interpersonal Psychotherapy (IPT) – to understand the IPT model, learn the assessment methods in IPT, and familiarize with IPT techniques and to discuss how to apply IPT during the three different interpersonal problem crises.

A good workable knowledge in IPT enables the therapist to gain an in depth understanding about the client's interpersonal relations, and provides techniques to help the client improve his interpersonal relationship, increase social support, and thereby achieving reduction in distressing symptoms.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Understand the IPT model
2. Learn about various IPT techniques
3. Familiarity with IPT tools

WORKSHOP IS INTENDED FOR

Everyone

ABOUT THE SPEAKER

Associate Professor and HOD in Department of Clinical Psychology, Amrita Institute of Medical Sciences, Kochi. Areas of specialisation are IPT, ACT and Marital therapy. Attachment styles and Rejection Sensitivity are my areas of interest.

MPhil Clinical Psychology with Best Outgoing award from Nimhans, PhD from Amrita University, Fulbright Doctoral Fellowship at Columbia University, New York. First and only certified IPT clinician in India.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

gitanjalin@aims.amrita.edu
gitanjalinatarajan@gmail.com

Session	Date	Time	Room No.
Workshop 18	22/12/2017	11.30am-3.30pm	B304

TITLE OF THE WORKSHOP

Play In Practice

SPEAKER

Dr. Sherin P Antony

DESIGNATION AND AFFILIATION

Director- Psycho-Diagnostics & Child Psychotherapy Training & Research Initiatives, Bangalore
Adjunct Faculty at Acharya Institute of Graduate Studies, Bangalore.

ABSTRACT

This workshop attempting to gain understanding the interface of child developmental theories in practicing play therapy along with few techniques. Contribution of Erikson, Melanie Klein, John Bowlby and Piaget to Play as therapeutic way to deal with children and the relevance of the theories in the context of play is the primary goal of the workshop.

Exploring techniques in play experientially and in a reflective manner is the second goal of the workshop.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Understand the interface of Child developmental theories in the therapy.
2. Skill development in how to use techniques through practice.

WORKSHOP IS INTENDED FOR

- Participants who are willing to buy Play therapy Materials which may cost 50 INR Per set
- Maximum number of participant in this workshop is limited to 35

ABOUT THE SPEAKER

She is trained at NIMHANS, Bangalore in clinical psychology. She had worked at Ramaiah Memorial Hospital, Bangalore, as a Clinical psychologist. She is associated with Acharya Institutes as teacher. She is also a research guide for Ph. D programme at Jain University. She is a Play Therapy Trainee under PTUK & Play Therapy International (PTI). She is one of the directors of Training & Research Initiatives (TRI), Bangalore.

Her research interests have included a focus on Psychological interventions among child & adolescent mental health, Play therapy in children and neuropsychological assessment and retraining.

Involvement in teacher sensitization programmes in the college Campus that looks at tapping the potential and resources among college teachers for mental health promotion among youth and training programmes in happiness that focus on enhancing personal wellbeing.

Involvement in conducting seminars among school and college students in the areas of Stress Management, Academic Stress management, Resilience, Relationship, CBT, Sex education, Parenting and Mental health concerns.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

Frances.Huber@sjog.org.au;
frances@briefsolutions.com.au

Session	Date	Time	Room No.
Workshop 19	22/12/2017	11.30am-3.30pm	A124

TITLE OF THE WORKSHOP

Acceptance and Commitment Therapy

SPEAKER

Mr. Baijesh A. R.

DESIGNATION AND AFFILIATION

Clinical Psychologist - Chetana Hospital
Clinical Psychologist- The Hyderabad Academy of Psychology
Faculty member- Central University of Karnataka
Psychological Services Consultant- Silver Oak Health

ABSTRACT

ACT is an orientation to psychotherapy that is based on functional contextualism as a philosophy and RFT as a theory. As such, it is not a specific set of techniques. ACT protocols target the processes of language that are hypothesized to be involved in psychopathology and its amelioration and other such processes. Technologically, ACT uses both traditional behavior therapy techniques, as well as others that are more recent or that have largely emerged from outside the behavior tradition, such as cognitive defusion, acceptance, mindfulness, values, and commitment methods.

The workshop aims at learning the theoretical basis of ACT, the use of ACT in a wide variety of clinical problems, how to apply ACT in your own life, to create a sense of vitality, meaning and fulfilment.

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. Understand ACT framework
2. Understand how to use ACT principles in own life
3. Incorporate ACT framework in conceptualizing, planning and implementing an intervention at a basic level

WORKSHOP IS INTENDED FOR

Intermediate

ABOUT THE SPEAKER

Baijesh A. R. is a Clinical Psychologist based at Hyderabad. As a consultant clinical psychologist he has a regular clinical practice where clients with various psychological- interpersonal problems seek psychological assessments and psychotherapy. He is an SFBT practioner, a member of EBTA and an accredited member of ASFP-I. He is a visiting faculty for different universities and consultant to different organizations. A mindfulness practitioner and guide, he extensively use mindfulness based interventions and ACT in his clinical practice and research. He is trained in ACT with Russ Harris, a pioneer in the field. Apart from clinical practice and teaching, he also provides training, conducts workshops, carry out independent research and provide supervision. He has published scientific articles and has written chapters in books.

DURATION OF THE WORKSHOP: 3.00 HOURS

CONTACT DETAILS

arbaijesh@gmail.com

Session	Date	Time	Room No.
Workshop 20	22/12/2017	11.30am-3.30pm	Neuroscience Lab

TITLE OF THE WORKSHOP

Mindful Disciplining, Peaceful Parents: A Solution-Focused Approach

SPEAKERS

1. **Dr. Sudhesh N T**
2. **Ms .Ruopfuvinuo Pienyu**
3. **Dr. Santhosh Kareepdath Rajan**

DESIGNATION AND AFFILIATION

1. Assistant Professor, Christ University
2. Research Assistant, Christ University
3. Assistant Professor, Christ University

ABSTRACT

Discipline refers to any body of knowledge that can be teachable. It is synonymous with intimidation or punishment; however, discipline need not necessarily be achieved only through force. Intimidation and punishment will result in fear, guilt, and shame, which will likely obstruct the relationship of the parent and the child. Parents shall rather adopt other parenting techniques that will have a positive impact on the child. The main aim to conduct the training module is to impart solution focused techniques which can be used as a substitute for disciplining process. Solution-focused brief family therapy views problems as being developed and maintained within the context of human interactions. Here it is integrated with five key elements of mindful disciplining—Unconditional love, Space, Mentorship, Healthy boundaries, and Mistakes. The love of the parents to the child shall be unconditional; need no qualification to provide love, expecting nothing in return. Space designates non-interference in the child's life where the child will understand one's feeling and emotions. Mentoring happens, when the child starts trusting the parents for the sensible guidance processes emerging from their life experiences. Healthy boundaries control the flow in one direction, thus helping the child to regulate the impulses and to increase flexibility in responses (enabling the self-disciplining). Mistakes, the thought that something should not have happened, shall be followed by forgiving, from which the child shall learn how to deal with the pain, how to forgive oneself and others, and the art of humility. Warm and supportive parents had children's who were caring and compassionate to each other. On the other hand, strict, permissive, or disengaged parents had children, who though sometimes show warm to each other, were mostly highly rivalrous and sometimes aggressive.

Keywords: Mindful disciplining, peaceful parenting, unconditional love, space, mentoring, healthy boundaries, mistakes

EXPECTED LEARNING OUTCOME
By end of the workshop, the participants will be able to: 1. Understand the alternatives which can be used during disciplining. 2. Have a better understanding of the role of the child and the parents
WORKSHOP IS INTENDED FOR
All levels
ABOUT THE SPEAKERS
1. Dr.Sudhesh N.T. is the Assistant Professor (Psychology) at Christ University, Bengaluru, and Karnataka. He has published eight articles in national and international journals, and two book chapters. He did his doctoral work on the topic "Training need Analysis and designing of training modules in selected Organizations". It was basically focused on training needs of high school teachers in Kerala state. He is the current President of IALSE (Indian Association of Life Skills Education) Bangalore, Karnataka chapter. With research and skill expertise in life skills training, he has conducted several life skills training and community intervention programs in the last 10 years. He has been a Supportive Supervisor in GFATM7 (Global Fund for AIDS, Tuberculosis & amp; Malaria) project for 3 years at MG University, Kerala. He is also a co-investigator on a major research project. His research interests include Adolescent and Youth Psychology, Life skills Education, Social intervention, Training and development and Qualitative research methods. 2. RuopfuvinuoPienyu is the Research Assistant in the Department of Psychology at Christ University (Bangalore, Karnataka) in India since May 2017. Her area of focus is positive psychology, and particularly on well-being, strengths and coping. She has authored 2 publications 3. Santhosh Kareepadath Rajan is the Assistant Professor of the Department of Psychology at Christ University (Bangalore, Karnataka) in India, since 2016. His research interests spans positive-solution-focused-correctional-psychology, which includes resilience, strengths, and pratixas (newly emerging concept). He has authored 19 publications (one book, two chapters and 16 journal articles). He is the member of International Positive Psychology Association, and is professionally associated with Association of Solution Focused Practices-India.
DURATION OF THE WORKSHOP: 3.00 HOURS
CONTACT DETAILS
sudhesh.nt@gmail.com sudhesh.n@christuniversity.in

Session	Date	Time	Room No.
Workshop 21	22/12/2017	2.00pm -3.30pm	Main Hall

TITLE OF THE WORKSHOP

Models of teaching and curriculum adaptations for inclusive education

SPEAKERS

1. **Dr. Sunish TV**
2. **Ms. Saija S**

DESIGNATION AND AFFILIATION

1. Assistant Professor, Composite Regional Centre for Persons with Disabilities-Kozhikode(CRC-K)
2. Lecturer in Special Education, Composite regional Centre for Persons with Disabilities-Kozhikode(CRC-K)

ABSTRACT

The workshop will explain about inclusive education, models of teaching and curriculum adaptations for inclusive education. The Inclusion is an educational practice in which children with disabilities are educated in classrooms with children without disabilities.

The objectives of the workshop is
1. To discuss various models of teaching in inclusive education and
2. To describe curricular adaptations and its applications inside the inclusive classrooms

The content include various models of teaching that is co-teaching, consultative services, paraprofessional support, peer tutoring and IEP. Also discuss modifications to curriculum or testing, accommodations for specific disabilities, and other services an individual student needs in order to access the district curriculum in a general education classroom. The workshop will help the teachers to understand and identify different models of teaching which is useful for the child according to their needs in inclusive classroom. Also helps the teachers to identify and appropriate curricular adaptations inside the classroom

EXPECTED LEARNING OUTCOME

By end of the workshop, the participants will be able to:
1. To know the various models of teaching and its applications in inclusive classrooms
2. To understand the curriculum adaptations
3. To identifying appropriate curricular adaptations and its application in inclusive classroom

WORKSHOP IS INTENDED FOR

- People who are comfortable in Malayalam Language
- Rehabilitation professional especially who works in disability management setting (CRE Topics)

ABOUT THE SPEAKERS

1. Dr. Sunish TV, is Asst. Professor in Special Education at Department of Special Education, Composite Regional Centre for Persons with Disabilities, Ministry of Social Justice and Empowerment, Govt. of India, Kozhikode, Kerala. He has published a good number of research papers and contributed chapter in edited books. He has presented several scientific papers in international and national seminars. He is a member of several committees constituted by nationally reputed institutions like Rehabilitation Council of India, Kerala University, Thiruvananthapuram

2. Ms. Saija S: Completed MSC from M.G university, Kottayam. MEd Special Education(MR) from NIEPID, Hyderabad. Also Completed BEd spl. Edn. (LD) from Thakur Hariprasad institute of research and rehabilitation, Hyderabad. She have 7 years of teaching experience in various teacher training centres At present working as lecturer in special education, Composite regional centre for persons with disabilities, Kozhikode

DURATION OF THE WORKSHOP: 1.30 HOURS

CONTACT DETAILS

sunishtv@gmail.com
saija2006@gmail.com

Part IV

ABSTRACTS OF RESEARCH PAPERS

CONTENTS

No	Speaker	Title	Page No.
1	• Ms. Gayathri Menon	Solution Focused Brief Therapy Addressing Social Phobia: A Case Study	51
2	• Ojaswita Bhushan	A Review on Accelerated Experiential Dynamic Psychotherapy (AEDP)	52
3	• Ms. Hargun Ahluwalia • Dr. Prabhat Chand • Dr. L.N. Suman	Development of a Cognitive Behavior Therapy Program for Women with Substance Use Disorders	53
4	• Jennifa Fernandes • Sequoiah Eunice Fernandes • Swezel Concy Leitao	CBT as an Intervention for Marital Disharmony Due to Substance Abuse: A Review of Literature	54
5	• Mariah Dias • Roma Prabhudessai • Jumana Khan • Barbara Da Silva	Women a Subject of Offense: A Review of Literature	55
6	• Ms. Chaitra Nagaraj Kumble • Dr. L N Suman	Trauma Histories among Women in a Reception Centre Implications for Trauma Counselling	56
7	• Guru Prasanna Lakshmi . P	Combination of Psychotherapeutic Techniques to Adequately Cope Well with the Body Image Issues in Adolescents, Diagnosed with E-Wings Sarcoma Followed by Amputation - Two Case Series	57
8	• Lareina D'Souza • Joyson D'Souza	Time Effective Psychosocial Interventions in Adolescent Mental Health, School Mental Health & Child Abuse	58
9	• Ms.Hansi Hamza • Mrs.Lalitha Subramanian	Significance and Feasibility of Solution Focused Brief Therapy for Indian Population	59
10	• Pearlene Helen Mary. D • Shefaley Phebe. K • Mary Ann. S	Reconceptualization of Self-Defeating Humour: Implications for Humour Intervention Programs	60
11	• Mr. Tabasum Farooq	Social Support as an intervention in mental health	61
12	• Ms. Aiswarya M Babu	Time Effective Psychosocial Interventions in Sexual Abuse.	62

No	Speaker	Title	Page No.
13	• Nishita Ravindra Tikekar • Shyamoli Sarah Ivanka Menezes Sousa • Eshani Chamdrashekhar Bakhle	Psychosocial Interventions for PTSD in War-Exposed Children and Adolescents: A Review of Literature	63
14	• Shama Shirish Keny • Sherly Fernandes • Sijourney Fernandes	Causes and interventions for marital discord: A review of literature	64
15	• Amreen Lakdawala • Yusra Sayed	SFBT- A Miracle from a Minimalist Perspective	65
16	• Ms. Sheetal Rose Jose	Residential Exposure With Response Prevention: A Time-Effective Intervention for A Severe And Chronic Case of OCD	66
17	• Ms. Soumya. N • Dr. Abdul Salam K.P	Solution Focused Brief Therapy and Health Psychology: A Review	67
18	• Fathimath Leena • Dr. Sherin P A	Reinforcements And Punishments Preferred By Parents: A Cross Cultural Study	68
19	• Ms. Dhanya C • Dr. Keshav Kumar • Dr. Jagadisha Thirthalli	Social Cognition Intervention In Schizophrenia: Preliminary Evidences From An Innovative Programme	69
20	• Dr. Milli Baby • Ms. Hemlata Dubey	The Impact Of Experiential (T)Group Dynamics On Locus of Control, Self Esteem And Resilience in Students Of Fire Engineering College-A Pre And Post Study	70
21	• Dr. A Thirumoorthy • Mr. Ijas Abdul Majeed • Dr. Jaseem Koorankote	Effectiveness of Solution Focused Brief Therapy Training on Solution Focused Thinking	71
22	• Hind Beegam R • Mohamed Muqthar P • Jaseem Koorankot, PhD	Effect of Solution Focused vs. Problem Focused Questions in Affect, Solution Focused Orientation and Neuropsychological Changes.	72
23	• Sonu S Dev • Liya Ajayan	Solution-Focused Brief Therapy for Mild Depression in Private Psychiatry Setting	73
24	• Vineesh U Sathianathan • Santhosh Kareepadath Rajan	Role of Reinforcements in Gamification	74

Session	Date	Time	Room No.
Research Paper 1	21/12/2017	4.00pm – 5.30pm	B204

TITLE

Solution Focused Brief Therapy Addressing Social Phobia: A Case Study

PRESENTER

Ms. Gayathri Menon

DESIGNATION AND AFFILIATION

PhD Scholar (Clinical Psychology), Amity Institute of Behavioural Sciences, Jaipur, Rajasthan.

ABSTRACT

Social phobia is a condition that involves excessive manifestation of anxiety in social situations marked by physiological disturbances and avoidance. Real or perceived scrutiny from others becomes a fundamental diagnostic indicator. Considering fewest utilization of solution focused brief psychotherapy in the management of social phobia, the present study was an effort to propose and implement a tailor made therapeutic version of the same. The purpose of the work was to address, immediate symptoms of "sense of scrutiny" and "avoidance", using the strategies of solution focused brief therapy in a nineteen-year-old boy, diagnosed with social phobia. He experienced difficulties attending classes, public speaking and confronting the opposite sex along with other physiological disturbances. The research design adopted was single case study design constituting a specific case of social phobia. After undertaking informed consent, data were collected via case history, MSE, Behavior Analysis, coping questions, miracle questions and scaling questions. Further, Human Figure Drawing Test, Beck's Depression Inventory, Hamilton Anxiety Rating Scale was administered as a part of psychometric assessment. Data availed was used for diagnostic conceptualization and psychotherapeutic management. The present case study management shows the effectiveness of solution focused therapy in individuals with social phobia, implying the utility of the intervention in the concerned population respectively.

Key Words: adolescent, social phobia, solution focused brief therapy,

CORRESPONDING AUTHOR

Ms. Gayathri Menon
gayumenon2010@gmail.com

Session	Date	Time	Room No.
Research Paper 2	**21/12/2017**	**4.00pm – 5.30pm**	**B204**

TITLE

A Review on Accelerated Experiential Dynamic Psychotherapy (AEDP)

PRESENTER

Ojaswita Bhushan

DESIGNATION AND AFFILIATION

Student, MSc. Counselling Psychology, Christ University, Bengaluru

ABSTRACT

Introduction: Accelerated Experiential Dynamic Psychotherapy (AEDP) is one of the newer models of psychotherapy. Developed by Dr Diana Fosha, it came out as a structured therapy only in the late 1990s- early 2000s; majorly as an integrative model combining together the psychodynamic, experiential, behavioral and gestalt approaches, to name a few (Fosha, 2002). The notions of 'self-ability' and 'state transformation' are central to the therapy. Initially developed as a healing approach to trauma, AEDP is increasingly being used in the treatments of dissociative disorders as well as personality disorders.

Rationale: AEDP as a framework has been started to be practiced on a large scale in the West. To what extent, it is applicable in India is what drives this paper

Objectives: The objectives of this paper were to study and understand the concepts underlying AEDP framework as well as see the strengths and limitations from the Indian perspective.

Brief Review: This particular paper is a review of the different articles that have been written explaining the framework and efficacy of AEDP philosophy. The paper focuses on the therapy itself, highlighting its origins, the integrative approach, major principles, the techniques involved and the outcomes of the therapy. The process of state transformation and certain areas of application of the therapy have also been elucidated upon along with its applicability in the Indian context as a short-term therapy highlighting its strengths and limitations.

Conclusion: The present framework has many important integrative concepts that require extensive training; however challenging, it can be worth to see its application within the Indian scenario.

CORRESPONDING AUTHOR

Ojaswita Bhushan
ojaswita.bhushan@psy.christuniversity.in

Session	Date	Time	Room No.
Research Paper 3	21/12/2017	4.00pm – 5.30pm	B204

TITLE

Development of a Cognitive Behavior Therapy Program for Women with Substance Use Disorders

PRESENTERS

1. **Ms. Hargun Ahluwalia**
2. **Dr. Prabhat Chand**
3. **Dr. L.N. Suman**

DESIGNATION AND AFFILIATION

1. PhD Scholar, Department of Clinical Psychology
2. Additional Professor, Department of Psychiatry
3. Professor and Head, Department of Clinical Psychology

National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore.

ABSTRACT

In Substance Use Disorders (SUDs), Cognitive Behavior Therapy (CBT) has been found to be an effective treatment towards the outcomes of substance use severity and health. However, literature on adaptation of CBT for this population is grossly limited and literally non- existent in the Indian subcontinent. The present study aimed at developing a CBT intervention adapted to the needs of substance-using women in India.

Objectives: To describe the development and components of a cognitive behavior therapy program for women with substance use disorders

Method: A therapy program was developed using a review of literature and interviews with 8 experts, 8 women with substance use disorders and their 8 caregivers, at a tertiary care deaddiction centre in South India. The CBT program adapts skills training, dialectical behavior therapy and trauma – focused approaches to the unique socio-cultural needs of women with SUDs in India.

Findings: Interviews provided insights into frequency of sessions and duration of therapy as well as content deemed appropriate for the population. A 10 - session intervention progam focusing on motivational enhancement, relapse prevention, health and nutrition and emotional regulation was prepared. Separate sessions with caregivers using behavioral couple's therapy principles and elective sessions that can be chosen additionally were also developed.

CORRESPONDING AUTHOR

Hargun Ahluwalia
gunn1802@gmail.com

Session	Date	Time	Room No.
Research Paper 4	21/12/2017	4.00pm – 5.30pm	B204

TITLE

CBT as an Intervention for Marital Disharmony Due to Substance Abuse: A Review of Literature

PRESENTERS

1. **Jennifa Fernandes**
2. **Sequoiah Eunice Fernandes**
3. **Swezel Concy Leitao**

DESIGNATION AND AFFILIATION

Students at Parvatibai Chowgule College Of Arts And Science Autonomous , Gogol Margao-Goa

ABSTRACT

Over the decade it has been reported that substance abuse (i.e. destructive or unsafe utilization of psychoactive substances.) plays a facilitative role in Intimate Partner Violence by precipitating or exacerbating violence, thus leading to Marital disharmony, causing an unpleasant atmosphere involving discord and conflict; prompting at times rape and physical assault.

Objective: The main aspects of the study have aimed to examine the interventions that will be effective in helping the couples overcome substance dependence which will in turn reduce marital discord.

Rational: The current paper tries to assess which CBT intervention was most efficient and time effective. Lastly it would help us find how substance abuse leads to disharmony within a family and also how the interventions can be beneficial to the family as a whole.

Brief review: evidence has indicated Male-to-female physical aggression was nearly eight times as likely on days of substance abuse as on days of no abuse (Fals-Stewart, 2003). Studies have shown a consistent pattern of more abstinence, reduced domestic violence, happier relationships, for addict patients who receive behaviour couple therapy and improved psychosocial functioning of offspring. Emotion focused therapy [EFT] has also been effective by inciting a change in static dyadic satisfaction thus improving relationships,.

Conclusion- BCT is also effective along with other psychosocial interventions such as 12 step approach, substance abuse domestic violence treatment, network and solution focused therapy, self-help groups, individual or group substance abuse counseling, and recovery medications Being cost effective, adding BCT to the treatment toolbox of community-based providers will make the intervention available to more families who are very likely to benefit.

Keywords- Substance Abuse, Marital Disharmony, Intimate Partner Violence, Cognitive Behaviour Therapy, Psychosocial Interventions, Emotion Focused Therapy.

CORRESPONDING AUTHOR

Jennifa Fernandes
jenfernz410@gmail.com

Session	Date	Time	Room No.
Research Paper 5	21/12/2017	4.00pm – 5.30pm	B204

TITLE

Title: Women a Subject of Offense: A Review of Literature

PRESENTERS

1. **Mariah Dias**
2. **Roma Prabhudessai**
3. **Jumana Khan**
4. **Barbara Da Silva**

DESIGNATION AND AFFILIATION

1. Student, Dept. of Psychology, Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.
2. Student, Dept. of Psychology, Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.
3. Student, Dept. of Psychology, Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.
4. Assistant Professor, Department of Psychology, Parvatibai Chowgule College of Arts & Science, Autonomous, Goa-India

ABSTRACT

Background: Over the years, there has been a rapid rise in crimes against women in India. Rape and domestic violence are some of India's most common crimes against women. It is reported that at every 20 min, a woman is raped in India. This review focuses on psycho-social interventions for women who are subjected to offenses such as rape and domestic violence of studies in India.

Objective: To examine the impact of rape and domestic violence against women in India.

Review: Evidence indicated that a set of prejudicial, stereotyped or false beliefs about rape, rape victims, and rapist exist in the community and are found to be very much prevalent amongst youth and higher among males. Studies have found a link between the behaviour of some Indian men and the values that give men proprietary rights over women and girls, economic dependence of women on men, cultural definitions of appropriate sex roles, education level and occupation of women, standard of living, media exposure, and partner's alcoholic behaviors are found to be possible predictors of domestic violence. Psychological interventions such as CBT, PTSD interventions, counseling, and exposure therapy have shown positive results.

Conclusion: Though there is evidence of some interventions to help women who are victims of domestic violence and rape, further research is needed, especially on high-quality with quantitative data outcome.

Keywords: Rape, Domestic Violence, India, Culture, Machismo, Women, Men, Interventions, PTSD, CBT, Exposure Therapy.

CORRESPONDING AUTHOR

Mariah Dias
diasmariah25@gmail.com

Session	Date	Time	Room No.
Research Paper 6	21/12/2017	4.00pm-5.30pm	B204

TITLE

Trauma Histories among Women in a Reception Centre Implications for Trauma Counselling

PRESENTERS

1. **Ms. Chaitra Nagaraj Kumble**
2. **Dr. L N Suman**

DESIGNATION AND AFFILIATION

1. PhD Scholar, Department of Clinical Psychology, NIMHANS, Bengaluru
2. Professor & Head, Department of Clinical Psychology, NIMHANS, Bengaluru

ABSTRACT

The aim of the study was to explore trauma histories among women in a government run Reception Centre in Bengaluru. The sample consisted of 30 women aged between 18-43years (Mean age: 25.87). The details related to their socio-demographic profile were obtained through a Socio-demographic Data Sheet, and a Semi-structured Interview Schedule was developed to obtain trauma histories. The data obtained was analysed using descriptive statistics, and thematic analysis was used to analyse qualitative data. The results showed that almost all of the women in the Reception Centre had experiences of interpersonal trauma, in various stages of development. The perpetrators are often closely related family members or significant others. The various forms of trauma experiences found were neglect, severe physical abuse, emotional abuse, rejection or abandonment, sexual abuse and financial abuse. Severe physical and emotional abuse was experienced by a majority of them during their childhood or adolescence. Various individual and family related risk factors were found, and re-victimization risk was found to be high. The results indicate that there is a need for Trauma Informed Care in such shelters, as the women are vulnerable to mental health problems. It is also important to sensitize the shelter staff about trauma informed services.

CORRESPONDING AUTHOR

Chaitra Nagaraj Kumble
chaitra.kumble@gmail.com

Session	Date	Time	Room No.
Research Paper 7	21/12/2017	4.00pm-5.30pm	B202

TITLE

Combination Of Psychotherapeutic Techniques to Adequately Cope Well with the Body Image Issues in Adolescents, Diagnosed with E-Wings Sarcoma Followed by Amputation - Two Case Series

PRESENTER

Guru Prasanna Lakshmi . P

DESIGNATION AND AFFILIATION

Psy.D (Doctor of Clinical Psychology) Final year Department of Clinical Psychology, Sweekaar Academy of Rehabilitation Sciences

ABSTRACT

Adolescence was seen as a time of great uncertainty about the self. Issues of self-identity subconsciously come to pervade everything that is done. To regain psychological equilibrium the adolescent is faced with the task of balancing the instinctual wishes of the id against the social demands of the ego.(Anna Freud - Egopsychology)

According to D.W. Winnicott (1965) relative dependence and independence concepts, the child adapts to the external reality in the absence of a mother or secured figure and could develop independence by understanding that himself and the environment can be said to be interdependent.

E-wing sarcoma is a rare tumour that occurs most often in adolescents. Adolescents and young adults (AYAs) with cancer must simultaneously navigate the challenges associated with their cancer experience, whilst striving to achieve a number of important developmental milestones at the cusp of adulthood. The disruption caused by their cancer experience at this critical life-stage is assumed to be responsible for significant distress among adolescents and young adults living with cancer.(Ursula M. Sansom-Daly et al; 2013) Adolescents experience physical and psychosocial changes as part of their normal development. It can be reported that they have lower scores on quality of life (Qol) and self - perception when additional changes occur due to cancer treatment.

(Christel A.H.P. van Riel et al , 2014) .

Purpose of this study is to understand the emotional distress related to body image issues when the amputation is only the remediation for the further progression of the cancer to other parts of the body. A Two case series, Pre and Post design, intervention study was adopted. The 2 opposite gender adolescents assessed Cognitive flexibility, Depression, Anxiety and Stress levels by using Neuropsychological testing WCST and DASS for the therapeutic purpose. Brief CBT approach with coping skills and Relaxation training along with family therapy was given as an intervention package. The pre assessment showed Cognitive inflexibility on WCST and moderate levels of Depression, Anxiety and Stress on DASS rating scale. After the 15 sessions of intervention, post assessment results on DASS was found to be nil significant. The two adolescents were observed to be with improved quality of life. They appeared to be stable and was prepared for the amputation in the process of treatment.

Key words: E- wings sarcoma , Amputation, Adolescents, body image issues, psychological distress

CORRESPONDING AUTHOR

Guru Prasanna Lakshmi . P
guru.psychologist @gmail.com

Session	Date	Time	Room No.
Research Paper 8	**21/12/2017**	**4.00pm-5.30pm**	**B202**

TITLE

Time Effective Psychosocial Interventions In Adolescent Mental Health, School Mental Health & Child Abuse

PRESENTERS

1. **Lareina D'Souza**
2. **Joyson D'Souza**

DESIGNATION AND AFFILIATION

1. Student, Smt. Parvatibai Chowgule College of Arts and Science(Autonomous)
2. Student, Smt. Parvatibai Chowgule College of Arts and Science(Autonomous)

ABSTRACT

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, and can work productively and fruitfully. Mental Health is a crucial facet in any stage of the human lifespan.

Mental health problems affect about 1 in 10 children and young people. Children are often fathomed to be immune to mental problems and illness, and to the evils of the world. However children too may face the same adversities as adults do and may be victims of abuse. Adolescence is the age when individuals explore the world and themselves, and may face problems such as drug abuse, depression and anxiety as a result of their experiences. Alarmingly, however, 70% of children and young people who experience a mental health problem have not had appropriate interventions at a sufficiently early age.

Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults.Providing children with an environment that demonstrates love, compassion, trust, and understanding will greatly impact a child so that they can build on these stepping stones to have a productive lifestyle.

Schools are not only a place for academics, but may be a place where children and adolescents may share their problems in a safe environment and learn to deal with them effectively.

This paper explores the use of effective psychosocial interventions such as Solution Focused Therapies, Group Therapies, Interpersonal Therapies, Family Therapies and Cognitive Behavioral Therapies in helping adolescents and children to cope with problems.

The contents of the paper are based on published research, and information is gathered from online databases and various journals.

Keywords: Brief psycho-social therapies, mental health in school

child abuse, adolescent mental health

CORRESPONDING AUTHOR

Lareina D'Souza
lareinadsouza@gmail.com

Session	Date	Time	Room No.
Research Paper 9	21/12/2017	4.00pm-5.30pm	B202

TITLE

Significance and Feasibility of Solution Focused Brief Therapy for Indian Population

PRESENTERS

1. **Ms.Hansi Hamza**
2. **Mrs.Lalitha Subramanian**

DESIGNATION AND AFFILIATION

1. MPhil Clinical Psychology Student, Department of Psychology, Sri Ramachandra University, Chennai.
2. Lecturer, Department of Clinical Psychology, Sri Ramachandra University, Chennai.

ABSTRACT

With the advancement in mental health treatment, people are now increasingly aware of non-pharmacological interventions. However, in today's fast paced life, conventional therapies may be time consuming and hence people tend to choose brief psychotherapies. Solution focused brief therapy (SFBT), an approach to psychotherapy is future-focused, goal-directed and focuses on solutions rather than problem-solving. Since its inception, a number of studies have documented the importance of SFBT in different conditions such as depression, anxiety, deliberate self-harm, obsessive compulsive disorder, schizophrenia, marital issues, caregiver burden and adolescent parenting. This article seeks to find out the significance and feasibility of SFBT in Indian settings through review of literature from over the past decade. Outcome of analysis will be presented and discussed in detail in the conference.

CORRESPONDING AUTHOR

Hansi Hamza
hansihamza66@gmail.com

Session	Date	Time	Room No.
Research Paper 10	**21/12/2017**	**4.00pm-5.30pm**	**B202**

TITLE

Reconceptualization of Self-Defeating Humour: Implications for Humour Intervention Programs

PRESENTERS

1. **Pearlene Helen Mary. D**
2. **Shefaley Phebe. K**
3. **Mary Ann. S**

DESIGNATION AND AFFILIATION

1. Student, Master of Clinical Psychology (Christ University, Bengaluru)
2. Student, Master of Clinical Psychology (Christ University, Bengaluru)
3. Student, Master of Clinical Psychology (Christ University, Bengaluru)

ABSTRACT

The theoretical focus of humour intervention is to increase positive emotions to overcome negative emotions through the development of emotional resilience. In the 7-humor habit program (7HHP) one of the key humour habits is the integration of humiliating self-directed jokes in everyday life to promote effective coping. Self-defeating humour helps to switch thoughts effectively by playfully laughing at perceived flaws both within and outside the person's sensitive interests. But, long term benefits of the intervention are found to be negligible. Existing literature suggests that even though humour in general is a healthy coping mechanism the use of self-defeating humour may be maladaptive. This humour style may accentuate the emotional element but may not necessarily develop only positive emotions. The present paper addresses the stagnant negative emotions highlighting the discrepancy in experiential affect. This puts the use of self- defeating humour in the 7 Humour Habits Program (7HHP) in question. The current study posits a comprehensive conceptual model of self-defeating humour, the mechanisms by which this form of humour develops and operates in an individual. In this model, early maladaptive schemas operate in association with humour, resulting in both behavioural expression (e.g., laughter) and negative emotional experience, paradoxically perpetuating negative self-evaluative beliefs. Furthermore, the model suggests pivotal implications of self-defeating humour.

CORRESPONDING AUTHOR

Pearlene Helen Mary. D
pearlenedaniel@gmail.com

Session	Date	Time	Room No.
Research Paper 11	**21/12/2017**	**4.00pm-5.30pm**	**B202**

TITLE

Social Support as an intervention in mental health

PRESENTER

Mr. Tabasum Farooq

DESIGNATION AND AFFILIATION

Research Scholar, Dept. Of Psychology, Aligarh Muslim University, Aligarh, UP.

ABSTRACT

Social Support is regarded as a buffer against hazardous effects of stressors. On one side, social support reduces anxiety and depression and on other side it improves self-image and ability to cope amidst stressful situations. Some world famous organizations are based upon the concept of providing support to those who suffer and the results are positive. Alcoholics anonymous can be cited as an example. Despite of tremendous benefits of social support, the era of digitization has blacklisted this blessing from our lives. Instead of relying upon support systems like family and friends, people are diverted to gadgets when they encounter any stressor in their lives. Present paper aims at reviewing literature in order to understand the different mechanisms through which social support acts in order to enhance one's mental health. Besides, social support will be discussed not as a theoretical concept but as a therapy in itself. There is a dire need to revive our support systems so as to get maximum possible benefit from them. No single therapy can benefit a person if it is not linked to support.

Key words: Social Support

CORRESPONDING AUTHOR

Tabasum Farooq
tabooo.khan2@gmail.com

Session	Date	Time	Room No.
Research Paper 12	**21/12/2017**	**4.00pm-5.30pm**	**B202**

TITLE

Time Effective Psychosocial Interventions in Sexual Abuse.

PRESENTER

Ms. Aiswarya M Babu

DESIGNATION AND AFFILIATION

Assistant Professor, MA in Child Psychology and Child Development, Department of Psychology, Parvatibai Chowgule College of Arts & Science Autonomous, Gogol- Margao

ABSTRACT

Effective brief therapy enables the clients to problem-solve, facilitates the relationship with the provider, and ultimately clarifies the patient's situation. Childhood sexual abuse (CSA) is a pervasive and egregious crime defined as "a sexual act between an adult and a child, in which the child is utilized for the sexual satisfaction of the perpetrator" (Lev-Weisel 2008). Adult survivors of CSA are at increased risk for a number of mental health issues including depression, anxiety, and post-traumatic stress disorder (PTSD) (Dube 2005; Sachs-Ericsson 2009). There is undeniable evidence that CSA is associated with a substantial increased risk of psychopathology, especially post-traumatic stress disorder (PTSD), depression, and substance abuse (Molnar, Buka & Kessler, 2001; Putnam, 2003)

This paper purports to study the efficacy of the interventions most suitable in dealing with adults and children who have undergone sexual abuse. The different approaches explored in this area would be therapies such as Cognitive Behaviour Therapy, Eye Movement Desensitisation & Reprocessing, Solution Focused Behaviour Therapy, Prolong exposure therapy, Cognitive processing, Supportive therapy etc.

Key Words: Brief Therapy, Childhood sexual abuse (CSA, Depression, Anxiety, Post traumatic stress disorder, Cognitive Behaviour Therapy, Eye Movement Desensitisation & Reprocessing, Solution Focused Behaviour Therapy, Prolong exposure therapy, Cognitive processing, Supportive therapy.

CORRESPONDING AUTHOR

Aiswarya M Babu
ash30may@gmail.com

Session	Date	Time	Room No.
Research Paper 13	**22/12/2017**	**4.00pm – 5.30pm**	**B204**

TITLE

Psychosocial Interventions for PTSD in War-Exposed Children and Adolescents: A Review of Literature

PRESENTERS

1. **Nishita Ravindra Tikekar**
2. **Shyamoli Sarah Ivanka Menezes Sousa**
3. **Eshani Chamdrashekhar Bakhle**

DESIGNATION AND AFFILIATION

Students, Parvatibai Chowgule College of Arts and Science

ABSTRACT

Children are most affected by war, which is a fundamental change in their social structure, which should support their normal development. (T.S. & K., 2008) Worldwide, 1 in 6 children lives in a war zone and it is more likely for civilians to suffer injury or death than for soldiers in battle. (Rieder & Choonara, 2012) This turns the war into a health issue of great importance. The physical, sexual and emotional violence that children from war-zones experience ruins their innocence and impairs the very the foundations of their lives. It is important to address these issues as the children in war-zones suffer from severe psychological trauma which attenuates future perspectives and leaves a grave impact on their perception of the world. To determine time effective psychosocial interventions for PTSD in war-exposed children and adolescents. Children experience violence, displacement and torture during the war which affects their mental health. Psychosocial intervention emphasizes on restoration. School based, trauma focused treatment program for war exposed people found to be very effective (Cox, et al., 2007). Participation in a mind-body skills group program which included meditation, guided imagery, breathing techniques, movement, etc., showed significant improvement in symptoms. (Staples, Abdel Atti, & Gordon, 2011) Although the most promising interventions to reduce war related PTSD include cognitive behavioural therapy (CBT), testimonial psychotherapy, narrative exposure therapy (NET) and eye movement desensitisation and reprocessing (EMDR). (Ehntholt & Yule, 2006) The detailed analysis is on-going but the preliminary findings suggest that trauma focused CBT, NET, EMDR and family/ community based interventions are the most effective. Studies conducted in the field are limited, making it incorrect to draw assumptions from them. A multi-faceted perception which requires the observational, methodological and compassionate abilities of anthropologists, scientists and a counsellors would work the best. This provides a deeper understanding of the trauma and its impact on those affected.

CORRESPONDING AUTHOR

Nishita Ravindra Tikekar
nishita.tikekar@gmail.com

Session	Date	Time	Room No.
Research Paper 14	22/12/2017	4.00pm – 5.30pm	B204

TITLE

Causes and interventions for marital discord: A review of literature

PRESENTERS

1. **Shama Shirish Keny**
2. **Sherly Fernandes**
3. **Sijourney Fernandes**

DESIGNATION AND AFFILIATION

Students of Parvatibai Chowgule college of arts and science, Margao, Goa

ABSTRACT

The research paper aims to assess the different "time effective psychosocial interventions in couple and marital disharmony". Marriage is a legalised social unity between a boy and girl making a couple. It upholds and binds the interpersonal intimacy to the extent of sexual needs which are mutually agreed upon. Marital disharmony often occurs mainly because of financial concerns, sharing household responsibilities, parenting, and relationship with in-laws, addictions turned out to be common triggers of marital arguments among dual career couples.

Source: For the current study, review of literature of which 30 most recent research articles were selected and data was collected from secondary sources like journals and research articles from internet. The major aspects of the paper have aimed to examine the interventions for inevitable disagreements among married couples while shouldering the duties of marriage and home, leading to highly stressful lives. The current paper also tries to assess which interventions were most efficient and time effective. Lastly, it would help find which are the most common causes of marital disharmony and the most suitable interventions for them. Infertility, lack of trust, sexual deprivation, communication gap etc. are also seen to be the causes of marital disharmony.

From the papers reviewed it was found that avoiding the idle mind by engaging in hard work, use of family counselors, listening carefully to spouse, developing a positive attitude, communicating are resolution strategies for resolving marital disharmony.

Solution-focused therapy, motivational interviewing, short term dynamic psychotherapy, Marital Therapy, marriage enrichment workshops are also the useful interventions used.

The study can be of great use to marriage counselors as it will help them to know what will be the most effective intervention is for some of the causes of marital disharmony. Couples having issues in their married life can themselves find an appropriate solution to deal with their problems too.

CORRESPONDING AUTHOR

Shama Shirish Keny
skshama73@gmail.com

Session	Date	Time	Room No.
Research Paper 15	**22/12/2017**	**4.00pm – 5.30pm**	**B204**

TITLE

SFBT- A Miracle from a Minimalist Perspective

PRESENTERS

1. **Amreen Lakdawala**
2. **Yusra Sayed**

DESIGNATION AND AFFILIATION

Post Graduate, Students, Psychology at Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.

ABSTRACT

In understanding and assisting clients, psychologists often use an eclectic approach, and draw upon various theories of psychotherapy to guide them in the therapeutic process of developing solutions. Of the many theories, and approaches to psychotherapy, authors here focus on the theoretical model of Solution-Focused Brief Therapy (SFBT) - a postmodern, humanistic systems approach, which is future-focused, and goal-oriented. This model associates assumptions, and strategic techniques with the clinical process from a non-pathological view, and maintains a directed narrow focus of inquiry, and optimism based on a here-and-now perspective. SFBT places great value on building solutions, rather than solving problems, it is a collaborative talk-therapy that typically takes place over a short period of time. As part of an evaluative study to subjectively determine the validity, cogency, effectiveness, and logic of the assumptions, and methodologies employed by SFBT, this paper will explore its applications, strengths, and weaknesses.

This paper will provide a better understanding of solution focused brief therapy, it can also be used for school counselling, individual and family therapies and it can also be used in counselling organisational units

CORRESPONDING AUTHOR

Yusra Sayed
yusra.sayed95@gmail.com

Session	Date	Time	Room No.
Research Paper 16	22/12/2017	4.00pm – 5.30pm	B204

TITLE

Residential Exposure With Response Prevention: A Time-Effective Intervention for A Severe And Chronic Case of OCD

PRESENTER

Ms. Sheetal Rose Jose

DESIGNATION AND AFFILIATION

Psy. D. Trainee (IIIrd year), Department of Clinical Psychology, Sweekaar Academy of Rehabilitation Sciences, Secunderabad

ABSTRACT

Obsessive-Compulsive Disorder (OCD) is marked by persistent preoccupations and repetitive behaviors that correspond to obsessions. The primary treatment for OCD—exposure with response prevention (ERP)—directly targets psychological factors through two elements: exposure to triggers of compulsive rituals and prevention of ritualized response. Majority of clients undergo ERP on an out-patient basis, with a caregiver being assigned the role of a co-therapist to implement the treatment plan at home. This case study of a severe and chronic OCD patient opens doors to provide insights regarding time-effectiveness of ERP without any psychiatric medications, when administered by a qualified therapist co-residing with the client round the clock.

Methods: The client, 'SV', presented with obsessions of contamination regarding masturbation and associated compulsions of cleaning everything directly or indirectly in contact with the act since 6 years. A single case-study design was employed, and information about presenting complaints, past, family, and personal history, premorbid functioning, and mental status were collected through a clinical interview. Severity of symptoms was assessed through Yale-Brown Obsessive-Compulsive Scale. ERP was done intensively, with a co-therapist residing with him on a daily round-the-clock basis. Obsessions were dealt with through intensive psychoeducation and cognitive restructuring. As part of relapse prevention, activity scheduling was done to enhance quality of time spent daily.

Results and Findings: After eleven sessions, the client reported that that his obsessions of contamination had reduced, and repetitive washing and cleaning were no longer an issue. Post-therapy scores on Y-BOCS indicated subclinical level of obsessions and compulsions, compared to the pre-therapy extreme severity of symptoms.

Conclusion: This case study suggests that the outcome of ERP in treatment of OCD would be extremely favorable, even for treatment- resistant OCD, if done on a daily, round-the-clock basis with the client residing with the therapists. It sheds light on time-effectiveness of ERP when done as described.

CORRESPONDING AUTHOR

Sheetal Rose Jose
sheetal.1991@yahoo.co.in

Session	Date	Time	Room No.
Research Paper 17	22/12/2017	4.00pm – 5.30pm	B204

TITLE

Solution Focused Brief Therapy and Health Psychology: A Review

PRESENTERS

1. **Ms. Soumya. N**
2. **Dr. Abdul Salam K.P**

DESIGNATION AND AFFILIATION

1. Post Graduate Student, Hyderabad Central University
2. Asst. Professor Dept. Clinical Psychology, IMHANS, Kozhikode

ABSTRACT

Solution Focused Brief Therapy (SFBT) places focus on a person's present and future circumstances and goals rather than past experiments. In this goal-oriented therapy, the symptoms or issues bringing a person to therapy are typically not targeted.

Health psychology is the study of psychological and behavioural process in health, illness and health care. It is concerned with understanding how psychological, behavioural and cultural factors contribute to physical health and illness. Psychological factors can affect health directly.

Until recently the majority of solution focused brief therapy research has focused on the application and effectiveness of SFBT in family therapy, counselling in mental health and educational setting. SFBT is an approach aimed at achieving a patient's goals or 'preferred future' through identifying and utilizing their expertise. SFBT may have significant efficacy in helping those with chronic physical conditions to live improved, meaningful lives.

This is a review of studies which examines the effectiveness of solution focused practice in health related issues. The relevant studies were identified from PubMed and Google scholar data bases. This review shows that five studies were reported in application of SFBT on health related issues. Out of five studies two studies were case studies, one qualitative study and other two were pilot studies from 2003-2014 and was limited to published studies in health psychology.

This paper which discuss about all these studies with respect to research methodology, conceptualisation and other implications.

The findings suggest that solution focused brief therapy affect the health related issues. SFBT is effective for patients when developing effective coping responses the stressors associated with chronic physical disease and pain.

CORRESPONDING AUTHOR

Soumya. N
soumyanenmini@gmail.com

Session	Date	Time	Room No.
Research Paper 18	22/12/2017	4.00pm – 5.30pm	B204

TITLE

Reinforcements And Punishments Preferred By Parents: A Cross Cultural Study

PRESENTERS

1. **Fathimath Leena**
2. **Dr. Sherin P A**

DESIGNATION AND AFFILIATION

1. Post Graduate Student, Department of Psychology, Acharya institute of Graduate Studies, Bengaluru.
2. Asst. Professor, Department of Psychology, Acharya Institute of Graduate Studies, Bengaluru

ABSTRACT

The structural and functional changes in family systems have brought about tremendous changes leading to the shrinking of joint family system and the shift of culture from collectivistic to individualistic culture. These have brought about many changes in the role identity of the parents which has shown impact on the parenting process to modify the behavior of children. Reinforcements and punishments are important components in the parenting process. Previous researches and studies have proved that parents adopt different types of reinforcements and punishments in the parenting process to modify the behavior of the children.

Aim & Objectives: This study is aimed to develop a module for Parental awareness program in adopting reinforcements and punishments in the parenting process to modify the behavior of their children. The objectives of the study are multifold. Firstly to formulate a checklist on the types of reinforcements: social, activity, tangible, token, and sensory and also the punishments based on the review of literature and books published in this context. Secondly to explore the different types of reinforcements and punishments preferred by parents in the parenting process to modify the behavior of their children. And finally to find out the differences among mothers and fathers in their preferences in reinforcements and punishments to modify the behavior of their children and also to find out the relationship between the socio-demographic data and the preferences made by parents in the reinforcements and punishments in the parenting process to modify the behavior of their children across cultures.

Materials & Methods: Sample included 30 male and 30 female biological parents of the play age children (3-6 years) who resided in the urban city of Bangalore/India and Male/Maldives and have also being in the marital relationship for not more than15 years. Single parents, parents of children with disability and parents without any educational background(illiterate) were excluded from the sample. Participants were selected through purposive sampling. Measures included socio-demographic data sheet and a checklist , both developed by the researcher.

Analysis and Data: The collected data were analyzed and discussed using percentage analysis, T test, Pearson's correlation. Practical implications and recommendations for further research were also discussed with a special focus on developing a module for parental awareness program.

CORRESPONDING AUTHOR

Fathimath Leena
le.ena@hotmail.com

Session	Date	Time	Room No.
Research Paper 19	22/12/2017	4.00pm – 5.30pm	B202

TITLE

Social Cognition Intervention In Schizophrenia: Preliminary Evidences From An Innovative Programme

PRESENTERS

1. **Ms. Dhanya C**
2. **Dr. Keshav Kumar**
3. **Dr. Jagadisha Thirthalli**

DESIGNATION AND AFFILIATION

1. PhD Research Scholar, Department of Clinical Psychology, NIMHANS, Bengaluru
2. Professor, Department of Clinical Psychology, NIMHANS, Bengaluru
3. Professor, Department of Psychiatry, NIMHANS, Bengaluru

ABSTRACT

Background & Aim: Social cognition interventions in Schizophrenia are coupled with neuro-cognitive interventions for better treatment implications. This study aims to assess preliminary evidence of effectiveness of an innovative social cognition intervention programme on enhancing social cognition. Methods: 6 clinical subjects diagnosed with Schizophrenia Spectrum Disorders of chronic nature were assessed on symptomatology, social cognition and social functioning at baseline. Further they were invited to participate in an innovative 18-day intervention programme for social cognition developed along the lines of cognitive retraining. Post-intervention assessment was done to assess changes in symptomatology, social cognition and social functioning. Results & Conclusions: A comparison of baseline and post–intervention assessment scores reveals reduced symptomatology, enhanced social cognition and social functioning. The findings will be further discussed in view of the various domains involved and the feasibility of brief socio-cognitive interventions.

CORRESPONDING AUTHOR

Dhanya C
dhanya84@rediffmail.com

Session	Date	Time	Room No.
Research Paper 20	22/12/2017	4.00pm – 5.30pm	B202

TITLE

The Impact Of Experiential (T)Group Dynamics On Locus of Control, Self Esteem And Resilience in Students Of Fire Engineering College-A Pre And Post Study

PRESENTERS

1. **Dr. Milli Baby**
2. **Ms. Hemlata Dubey**

DESIGNATION AND AFFILIATION

1. Asst. Professor & Head, Dept. of Psychology, Vasantrao Naik Government Institute of Arts and Social Sciences, Nagpur.
2. Part-time Assistant Professor, Indian Institute of Fire Engineering, Nagpur

ABSTRACT

A typical fire safety engineering program coursework provides students with a solid foundation in the design, testing, analysis and implementation of fire protection systems. Students gain an advanced understanding of science, engineering, mathematics and computers in order to better solve technical problems but the problems related to self also needs to be dealt with for which this paper tried to attempt to explore the role of Experiential learning in boosting self esteem(SE) and resilience(R) among the students and also help students to have more internal Locus of Control(LOC). A T-group or training group is a form of group training where participants themselves learn about themselves through their interaction with each other. They use feedback, problem solving, and role play to gain insights into themselves, others, and groups. This was a twenty hours program distributed in five days on 52 students of first semester studying in Indian Institute of Fire Engineering College, Nagpur.

LOC describes the degree to which you perceive that outcomes result from your own behaviors, or from forces that are external to yourself. Your LOC is absolutely essential to your R and one of the major building blocks to increasing it, while the third variable SE is a person's positive or negative attitude toward himself or herself, and is closely associated with personality functioning.

The current training program had more work-based learning opportunities, or placements undertaken as part of training, which can provide opportunities to help students develop the competencies that underpin their mental well being. The pre-test was administered for which Wagnild and Young's R scale, Rosenberg SE scale and Rotters LOC was used on day one and the post test administered on the last day. Results of the pre test showed that SE was average, resilience was moderately high and LOC was internal. Post test results showed significant change in level of SE ($t=4.95, p<0.01$) and R ($t=3.31, p<0.01$) while no change was seen in LOC.

CORRESPONDING AUTHOR

Dr. Milli Baby
milli_baby_1977@yahoo.co.in

Session	Date	Time	Room No.
Research Paper 21	22/12/2017	4.00pm – 5.30pm	B204

TITLE

Effectiveness of Solution Focused Brief Therapy Training on Solution Focused Thinking

PRESENTERS

1. **Dr. A Thirumoorthy**
2. **Mr. Ijas Abdul Majeed**
3. **Dr. Jaseem Koorankote**

DESIGNATION AND AFFILIATION

1. Associate professor & Head, Dept. of Psychiatric Social Work, NIMHANS, Bengaluru
2. Psychiatric Social Worker, Bengaluru
3. Lecturer, Dept. of Clinical Psychology, IMHANS, Kozhikode

ABSTRACT

In recent years Solution Focused therapy has gained popularity among practitioners and researchers. However, the paucity of training on Solution Focused Brief Therapy (SFBT) is evident in India. In order to fill the gap in training needs, Department of Psychiatric Social Work started training workshops on SFT. Present study examines the effectiveness of SFBT workshops on the participants solution focused thinking which is key aspect in Solution Focused therapy. Participants were assessed on their Solution Focused Inventory (SFI) scores at pre and post of the workshops. Result reveals that there is a significant change in the SFI scores of participants after the workshop, which is indicative of solution focused training can be effective in developing solution focused thinking among the participants who are predominantly trained in problem focused therapies.

CORRESPONDING AUTHOR

Dr. A Thirumoorthy
thirumoorthia04@yahoo.co.in

Session	Date	Time	Room No.
Research Paper 22	22/12/2017	4.00pm – 5.30pm	B202

TITLE

Effect of Solution Focused vs. Problem Focused Questions in Affect, Solution Focused Orientation and Neuropsychological Changes.

PRESENTERS

1. **Hind Beegam R**
2. **Mohamed Muqthar P**
3. **Jaseem Koorankot, PhD**

DESIGNATION AND AFFILIATION

1. Post Graduate Student, Dept. Psychology, Annamalai University, TN
2. Under Graduate Student, Dept. Psychology, Annamalai University, TN
3. Lecturer, Dept. of Clinical Psychology, IMHANS, Calicut

ABSTRACT

There have been a number of outcome studies examining the impact of solution focused brief therapy. However, literature review could not find any study attempting to find out how does SFBT work in neuropsychological perspective. The present study primarily aims at understanding if there is any significant difference in neuropsychological components (attention, working memory, processing speed, planning, set shifting ability etc) during when the therapist attempts to take the clients (with depression), in problem focused mental schema and solution focused mental schema. Also, the study attempts to understand the changes in their affect, Solution Focused Orientation (SFI), and also their subjective rating of distress while bringing the clients (with depression) in problem focused mental schema and solution focused mental schema. This study may bring new insights for explaining how does SFBT work and may guide us in offering a scientific explanation as in how SFBT differ from problem focused therapy. The results may also guide future studies in neuropsychological aspects of therapies and especially that of SFBT.

CORRESPONDING AUTHOR

Jaseem Koorankot, PhD
jaseemclt@gmail.com

Session	Date	Time	Room No.
Research Paper 23	22/12/2017	4.00pm – 5.30pm	B202

TITLE

Solution-Focused Brief Therapy for Mild Depression in Private Psychiatry Setting

PRESENTERS

1. **Sonu S Dev**
2. **Liya Ajayan**

DESIGNATION AND AFFILIATION

MPhil Trainees, Sweekar Academy of Rehabilitation Sciences, Hyderabad

ABSTRACT

People living with mild depression and mostly goes both undiagnosed and untreated. Untreated depression is a grave concern, researches indicate that it can lead to significant distress, functional impairment and can cause psychological suffering along with worse medical outcomes, including immunosuppressive effects. The present study is a preliminary investigation, evaluating the efficacy of SFBT in the management of Mild Depression among individuals who are undergoing therapy. A total of 11 individuals who were diagnosed with mild depression in a Psychiatric Hospital Setting were recruited for the study. There were 2 drop-outs, and the remaining 9 participants subjected to 10 weeks SFBT treatment program for mild depression. The participants were assessed by Beck Depression Inventory- II (BDI) and Solution Focused Inventory, pre- and post intervention. The assessment scores, pre- and post intervention, were compared and was found as statistically significant at 0.05 level on both BDI (z= 2.67) and SFI (z= 2.67). Post- intervention, all 9 participants were interviewed by an independent clinician for mild depression, and only one person met the ICD- 10 diagnostic criteria for depression. The findings of the study indicate a preliminary efficacy of SFBT in treating depression among people infected with mild depression.

CORRESPONDING AUTHOR

Baijesh AR

Session	Date	Time	Room No.
Research Paper 24	22/12/2017	4.00pm – 5.30pm	B202

TITLE

Role of Reinforcements in Gamification

PRESENTERS

1. **Vineesh U Sathianathan,**
2. **Santhosh Kareepadath Rajan**

DESIGNATION AND AFFILIATION

1. M.Sc. Behaviour Science, Department of Psychology, Christ University, Bangalore, Karnataka
2. Assistant Professor, Department of Psychology, Christ University, Bangalore, Karnataka

ABSTRACT

Gamification is the use of game design elements in non-game contexts (Deterding, Dixon, Khaled & Nacke 2011), which uses the token method of reinforcement to modify individual behaviours (Kazdin, 1977). Gamification is considered as a solution for enhancing work motivation in employees. The present study is an attempt to find out the importance of reinforcement in the process of 'Insignio' gamification, a gaming frame work that brings in the gaming aspects for a large group of individuals at work. The sample included 50 teams in one multinational IT organisation. As per the findings, when reinforcement decreases in gamification, employee motivation towards work decreases and as a result work performance decreases. Regular and continued reinforcements play a critical role in employee motivation towards work and employee work performance. The study also gives an insight into the importance of praise, learning and continuous improvement.

Key words: Token, Reinforcement, Gamification, Work motivation, Employee performance

CORRESPONDING AUTHOR

Vineesh Sathianathan ,
vineesh.sathianathan@wipro.com

Part V
FREE PAPERS

CONTENTS

No	Authors	Title	Page No.
1	• Michael Durrant	The strengths approach ... Resilience ... Positive psychology ... Isn't Solution-Focused just a version of these?	78-85
2	• Frances Huber	Mindfulness and Solution-Focused Brief Therapy: Time is precious	86-95
3	• Jaseem Koorankot • Santhosh K R • Fathima Shabnam • Sidra Abdul Latheeef	Different Types of Questions in Psychotherapy	96-101
4	• Vineesh U Sathianathan • Santhosh Kareepadath Rajan	Role of Reinforcements in Gamification	102-109
5	• Lareina Randolfina D'Souza • Mr. Joyson Elton D'Souza	The efficacy of brief psychotherapies in chilhood and adolescence	110-119
6	• G. Ragesh • Ameer Hamza • K. Sajitha	Psychiatric Social Work in Perinatal Mental Health Care Settings in India	120-129
7	• Hamza. Hansi • Subramanian. Lalitha	Significance and feasibility of solution-focused brief therapy in the indian context	130-135
8	• Soumya N • Abdul Salam	Solution Focused Brief Therapy and Health Psychology: A Review	136-141

No	Authors	Title	Page No.
9	● Ms. Minu William ● Ms. Jibby Varghese	Extent of time spent on social networking site by spouse; partner perception and quality of marital life among young married couples	142-149
10	● Akhil. P	Risk Factors of Poor Academic Performance in Indian Children: A Psychosocial Perspective	150-153
11	● Sheetal Rose Jose ● Babu Paikkattu	Residential exposure with response prevention: a time-effective intervention for a severe and chronic case of ocd	154-163
12	● Nishita Ravindra Tikekar ● Shyamoli Sarah Ivanka Menezes Sousa ● Eshani Chamdrashekhar Bakhle	Psychosocial Interventions For PTSD in War-Exposed Children and Adolescents: A Review of Literature	164-171
13	● Roma Prabhudessai ● Jumana Khan ● Mariah Dias	Women a Subject of Offense: A Review of Literature	172-183
14	● Aleena George ● Anitha S ● Seema P Uthaman	Motivation enhancement thrapy in poly substanc abuse	184-187
15	● Anitha.S ● Aleena George ● Seema.P.Uthaman	A clinical case study of obsessive compulsive disorder with exposure response prevention therapy	188-191
16	● Baijesh A. R ● Sonu S. Dev ● Liya Ajayan ● Rithika Alladi	Solution-Focused Brief Therapy for Mild Depression in a Private Psychiatry Setting	192-197
17	● Pearlene Helen Mary D ● Shefaley Phebe K ● Mary Ann S	Reconceptualization of Self-Defeating Humor: Implications for Humor Intervention Programs	198-207

THE STRENGTHS APPROACH ... RESILIENCE ... POSITIVE PSYCHOLOGY ... ISN'T SOLUTION-FOCUSED JUST A VERSION OF THESE?

Michael Durrant

The therapeutic process has, historically, been one dominated by various different views and theories of how mental distress occurs and how it can be ameliorated (Marks, 2012). Whatever our therapeutic approach or orientation, our jobs exist because people have difficulties of various sorts. Therefore, it is hardly surprising that our field has been dominated by ideas about problems, pathology, dysfunction and so on. One of the significant events in the last few years was the release of the 5th Edition of the Diagnostic and Statistical Manual of Mental Disorders by the American Psychiatric Association. Even professional commentators in India suggest that, although it is primarily an American document, the "impact [of the DSM-5] will be felt far beyond the boundaries of psychiatry and that of the United States of America" (Jacob et.al., 2013). There are some critiques and vigorous debates about the extent to which the DSM-5 can be applied to a large and diverse culture as in India (e.g. Jacob et.al., 2013; Jain, 2013); however, none of these discussions dispute the fundamental thesis that our work must begin from some understanding and classification of mental difficulties or illnesses. Indeed, Jain (2013) comments that the "identification of insanity, and its symptoms has been [central] in south Asia for several millennia."

Recently, some disruptive ideas have found their way into the mental health field. Resilience-building, the Strengths Approach and Positive Psychology have come from a completely different perspective. Whereas Freud famously said that the best psychotherapy could hope to do was to help the client move from their symptoms "into ordinary unhappiness" (Freud & Breuer, 2004), these approaches have looked far beyond "ordinary unhappiness" to happiness, strength and successful living. For example, according to Peterson (2008), "Positive psychology studies what makes life most worth living." These approaches begin the task of working with people from a non-problem perspective. Solution-Focused Brief Therapy similarly approaches people from a non-problem perspective; however, it was developed separately from these other approaches. A number of authors within the Solution-Focused community regard SFBT as a manifestation of these other approaches. For example, "The solution-focused approach is a strengths-based approach which emphasize people's resources and resilience and how these can be used in the pursuit of purposeful, positive change" (Grant, Cavanagh, Kleitman, Spence, Lakota & Yu, 2012).

While SFBT shares a broad perspective with these "more positive" approaches, I suggest that it should NOT be seen as a "positive approach" and is distinctly different from these apparently compatible approaches (Durrant, 2016).

RESILIENCE

Resilience is "an individual or group's process of continual development of personal competence while negotiating available resources in the face of adversity" (Worlsey, 2011).

In the epidemiological study of the spread of disease, researchers noted that not all people who were clearly at high risk of contracting a disease would actually do so. Resilience referred to the "protective factors" that prevented some even high-risk individuals from becoming sick. Garmezy (cited in Masten & Powell, 2003) brought the concept of resilience into the mental health field, as he studied those children who managed to adapt and survive various natural and psychological disasters. Whilst a dynamic process, resilience was seen as developing in response to adversity and to include internal (personal) and external (family and community) factors. Resilience was initially seen as a somewhat "special" characteristic, but more recently resilient functioning has been seen as a more common or normative response to adversity (Hunter, 2012).

THE STRENGTHS APPROACH

The Strengths Approach was first proposed by Rapp (Rapp & Goscha, 2006). Case managing people in the transition from psychiatric hospital to the community, they began to focus on how to harness the strengths the person had displayed rather than seek to ameliorate the risk factors. This approach -- commonly referred to as "strengths-based" -- is widespread in the non-government welfare and counselling sphere. This perspective recognises the resilience of individuals and focuses on the potentials, strengths, interests, abilities, knowledge and capacities of individuals, rather than their limits (Grant & Cadell, 2009).

Strengths-based work rests upon a growing body of research into individual, family and community strengths. A number of authors also explicitly identify a strengths focus as reflecting particular professional values. For example, McCashen (2005, p. 1) asserts that "finding and building on strengths is an essential means to respectful and empowering practice".

POSITIVE PSYCHOLOGY

"Positive Psychology is the scientific study of human flourishing, and an applied approach to optimal functioning. It has also been defined as the study of the strengths and virtues that enable individuals, communities and organisations to thrive." (Positive Psychology Institute, 2012).

Seligman and Csikszentmihalyi (2000) observe that, since at least World War II, psychology has become a "science largely about healing". A focus on healing is inevitably a focus on identifying, understanding and repairing damage. Thus, even though "healing" may be seen as a noble activity, it fundamentally is driven by a focus on problem and pathology. They point out that the removal or absence of problem does not necessarily equate with positive experience. "Not being depressed" is not necessarily the same as "being happy". Thus, positive psychology has promoted an active focus on positive qualities and experience, such as happiness, optimism, well-being, flourishing, creativity and so on.

STRENGTHS: THE COMMON FACTOR

There is a great deal of overlap between a resilience focus, strengths-based work and positive psychology and perhaps the major difference between the three is that they were similar ideas developed in three different places -- resilience in psychiatry, strengths in social work and positive psychology in academic psychology. What they have in common is the emphasis on people's strengths.

Positive psychology refers to itself as a "psychology of human strengths" (Aspinwall & Staudinger, 2003) and Seligman and Csikszentmihalyi (2000) claim that psychology must be the study of strength and virtue. It particularly emphasises the important of strengths in preventative work, describing strengths as acting as a buffer against adversity.

Similarly, resilience is often described in reference to strengths, particularly strengths that assist the person to deal with adversity. "Resiliency theory provides a conceptual framework for considering a strengths-based approach" (Zimmerman, 2013). Henderson and Milstein (2003) claim that resiliency research challenges us to focus on strengths and describe strengths as a "lifeline to resilience". Indeed, the words "strength" and "resilience" are often found in the same sentence in many places.

IF IT WORKS, IT'S SOLUTION-FOCUSED

McKergow (2016) points out that some people assert that "if it helps the client, it must be Solution-Focused". Using this definition, we could justifiably see positive and strengths approaches under te Solution-Focused umbrella. However, McKergow suggests that such a broad definition ends up not being helpful. Bannink suggests that SFBT should be seen as a form of Cognitive-Behavioural Therapy (CBT). I do not see the point of this assertion. While there might sometimes be some similarities in what the therapist does, the fundamental assumptions of SFBT and CBT are fundamentally in conflict. (Johnsen, 2014). McKergow calls this description of SFBT as a form of CBT "bizarre" (McKergow, 2016). Further, it raises the question of whether or not it is actually helpful to diminish the distinctions between approaches.

Following McKergow's (2016) observation, I suggest that "if it helps the client, it must be Solution-Focused" is NOT helpful in clarifying what it is we think we do. If I claim to be a Cognitive Behavioural therapist, I presume that it is helpful to be clear about what I do, and about what it is I do that makes it "Cognitive Behavioural" and not something else (even if that something else is actually helpful). Indeed, Gaudiano (2008) specifies as characteristics of CBT its "manualised approach" and the fact that the approach has been "codified".

Part of the rationale behind the launch of the Journal of Solution-Focused Brief Therapy was that an academic-standard journal could (and should) begin to decide that certain contributions were -- or were not -- considered Solution-Focused -- even if they were still intellectually, clinically and practically worthwhile.

SOLUTION FOCUS VS "POSITIVE".

Positive psychology has "an explicit focus on the positive" (Seligman & Peterson, 2003).

By contrast, SFBT is NOT about "looking for positives". When we are discussing exceptions or successes, being positive may lead to the client feeling that their distress has gone unacknowledged. We might think it is about "looking for positives" ... however, if it doesn't feel "positive" to the client, you should probably let the client go home and just continue talking to yourself! Exceptions and/or examples of the preferred future are significant not because they are positive (and, indeed, they may not be positive, they may be really hard!) but because they are different and point to the possibility of the preferred future being a reality.

The Solution-Focused approach is much more interested in the fact that the client has the demonstrated ability to be successful (even a little bit), with a genuine curiosity about what aspects of the client -- which had perhaps been hidden from them previously -- had led to the client being able to do this.

Positive reinforcement, Positive feedback, even Empowerment, seem like something the therapist DOES to the person. George (2016) comments that it is easy to fall into the trap of trying to "get" the client to notice strengths; whereas Solution-Focused questions are more helpfully seen as invitations. When the Solution-Focused therapist asks, "How did you do that?" is not about empowering the client, it is about inviting the client to reflect on his/her on behaviour in a particular way.

HOW DOES A SOLUTION-FOCUSED APPROACH FIT WITH THE STRENGTHS APPROACH?

Saleebey, one of the founders of the Strengths Approach, (1992, p15) suggests that a Strengths Approach is not a model of practice but rather a "collation of principles, ideas and techniques". Rather than being a service delivery model, the 'strengths approach' is a framework or set of beliefs and values that guide practice. McCashen (2005) defines the Strengths Approach as an alternative "approach to people that is primarily dependent upon positive attitudes about people's dignity, capacities, rights, uniqueness and commonalities". (p. v)

Thus, I would argue that the Strengths Approach is a "stance" or "position" we take rather than a model of practice or a consistent "map" that may guide our work with clients.

Seen this way, we might see SFBT as sharing a strengths-based philosophy; however, SFBT is clearly and explicitly a therapeutic model, with a structure and techniques.

Further, Iveson (2008) suggests the problem with focusing on strengths (quite apart from them being the reification of very abstract concepts, see below). He suggests that, as soon as we focus on a particular strength -- "I had a lot of will-power", "I was very brave", etc. -- and or harnessing that strength, we potentially diminish the significance of the times when that strength did not seem to be there, but nonetheless the person was able to be successful.

Thus, he suggests that Solution-Focused Brief Therapy more usefully focuses on "what did you DO to cope/succeed/get through this?", rather than "what does this tell us about your strength?". He contrasts a detailed description of successful action with an identification of an hypothesised entity ("strength").

For example (Evan George, personal communication, 18/8/2016) ,

Therapist: What did it take to do that?
Client: I guess it took a lot of willpower.
Therapist: And what did you see yourself doing, as you tackled that situation, that flowed from that willpower [strength]?'
[Response with lots of detail]
Therapist: Tell me about a time that you managed to act that way even though you weren't feeling that willpower within you.'

STRENGTHS AS "THINGS"

In Positive Psychology, a strength should be trait-like (Seligman & Peterson, 2003). It is a thing that can be measured. Seligman and Peterson (2003) encourage Positive Psychology to develop a "list of strengths", such that strengths can be measured and they look forward to a "global questionnaire to measure strengths across time".

Silberberg (2001) cautions against a "strengths-based" approach becoming an approach which identifies the qualities of "strong" families and then prescribes them … or "coaches" families that are seen as deficient in any particular strengths. "Rather than teaching families a set of strength practices, our task is to facilitate families in the process of identifying their own strengths." (Silberberg, 2001, p. 55).

McKergow and Korman (2009) have bravely sought to suggest what Solution-Focused is NOT. They conclude,

Our view of SFBT is that solution-focused therapists do not use nor draw upon most of psychological theory that is taken for granted by other therapeutic traditions. (p. 35)

They comment that the history of the development of SFBT has been a history of the application of Ockham's Razor and that the Solution-Focused literature has always striven to make the description of what we do as simple as possible.

SFBT can be viewed as a form of practice that helps clients simplify their lives. It does this by simplifying how therapists and clients talk together about life, and by helping clients focus on and attend to what they say is important and helpful to them. (p. 38).

Thus, one of the things they suggest that SFBT does NOT do is appeal to any hypothesized, internal psychological mechanisms or entities. Among the list of "hypothesized, internal mechanisms" they cite, are included not only "personality traits", "attitudes" and "weaknesses" but also "strengths" and (by implication) "resilience".

They make it clear that Solution-Focused therapists might choose to talk to clients about such things as "strengths"; however, they suggest that SFBT does not think of "strengths" or "resilience" as things that must be changed, developed, nurtured or strengthened. They suggest that thinking our role is to change, nurture, build or develop "strengths" or "resilience"

… leads us immediately into doing something in therapy that is not Solution-Focus. This sets SFBT apart from other models. (p.40)

McKergow and Korman are clear that some of these other ways of thinking may well be helpful, and might be encouraged -- however, in the interests of clarity, they ought not be described as "Solution-Focused".

RESEARCH

There is much research about resilience and strengths. Most of the research focuses on the identification or existence of strengths and much resilience research explores the protective effects of strengths. Despite the frequent references to "building strengths" or "fostering resilience", there is much less research on the efficacy of a strengths- or resilience-focus in therapeutic activities. One of the agencies in Sydney most closely associated with a "strengths-based" approach concedes that there is little research evidence for its effectiveness in intervention with families when compared to more traditional, problem-solving approaches (Scerra, 2011). Miller, Worsley, Hanstock and Valentine (2016) describe most of the resilience-building programs that have been the subject of research to be aimed at non-clinical populations.

By contrast, there is increasing evidence of the effectiveness of SFBT as an intervention in clinical situations. Franklin, Trepper, Gingerich and McCollum (2012, p. v) claim that "SFBT has considerable empirical support and is an intervention that is firmly grounded in research evidence" and they comprehensively review research demonstrating the effectiveness of the approach with a range of seemingly serious clinical problems, including adolescent behaviour difficulties, drug and alcohol problems, adult mental health problems, and more. Macdonald, (2014) identifies more than 120 relevant studies as well as data from more than 5000 cases with measured success rates exceeding 60%.

CONCLUSION

SFBT shares with Positive Psychology, the Strengths Perspective and a focus on resilience a broad philosophical stance that moves away from a focus on pathology and problem.

I have heard some colleagues say, "I am client-focused … I always begin by asking the client what she/he thinks it would be helpful for us to talk about". I would suggest that this is NOT being "client focused" … it is really about being [therapy] session-focused. It is asking "what should we talk about here" rather than asking "how would you like your life to be different when you leave here?"

Korman (2004), amongst others, suggests that an integral aspect of a Solution-Focused conversation is that it begins by exploring how the client wants things to be different.

So, I would suggest that there are essential characteristics of "Solution-Focused" work, which separate it from Positive Psychology, the Strengths Perspective and a focus on resilience.

1. It begins with some version of "How will you know that our talking has been useful?" or "How are you hoping that our talking together will make a difference in your life [work, marriage, etc.]?'
2. It is essentially future-focused (Miracle Question or some other question that builds a detailed description of the client's preferred future).
3. It explores when the client has already been able to achieve aspects of the preferred future.
4. It does not assume that the therapist knows what the client needs to do (to solve their problem, to build resilience, to harness their strengths, etc). (Durrant, 2016).

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ABOUT THE AUTHOR

MICHAEL DURRANT

Founder and Director of the Brief Therapy Institute of Sydney, a psychologist with an international reputation in Solution-Focused Brief Therapy, Michael has consulted to counselling/therapy agencies and teams in Australia and overseas and has presented training workshops in North America, Europe & Southeast Asia. Michael is Honorary Academic Associate in the Faculty of Education and Social Work at the University of Sydney and was a visiting international faculty member on the Masters of Special Education program at Fontys University in The Netherlands.

He is Editor of the (international) Journal of Solution-Focused Brief Therapy and President of the Australasian Association for Solution-Focused Brief Therapy.

Michael has had published a number of books and professional articles and his books, published by W. W. Norton & Co in New York, have been translated into German, French, Dutch, Arabic and Japanese. Michael has conducted more than 600 professional training workshops and is widely sought after as a speaker and trainer. He has been an invited keynote/plenary speaker at a number of international conferences.

MINDFULNESS AND SOLUTION-FOCUSED BRIEF THERAPY: TIME IS PRECIOUS

Frances Huber

Over ten years ago, I attended my first ten day silent Vipassana meditation retreat in the tradition of Goenka, in Blackheath, in the Blue Mountains west of Sydney. It was my first serious step on a long road. I'm a different person, a happier person, for travelling this road. I am not a Buddhist but I value Buddhist philosophy. In More than miracles, Steve de Shazer and his colleages acknowledged that Solution-Focused Brief Therapy (SFBT) is influenced by Buddhism (de Shazer & Dolan, 2007). Vipassana meditation and mindfulness has deepened my understanding of key concepts that influence and, I believe, significantly improve my practice as a Solution-Focused Brief therapist.

As in the Buddhist tradition of teaching, I present a few ideas for your consideration and reflection, rather than to be accepted in blind faith. You decide if they fit for you based on your knowledge and personal experience and, if so, hold on to them and make use of them. What does not fit for you, I invite you to cast aside. If you are unsure but think there may be value in some ideas, put them on a "maybe" shelf (Amaro, 2011).

In one of his discourses, Goenka (2002) talks about the delicious sweet rice and milk dish called kheer. If you don't like the black pebbles, take them out. Later you may discover that these hard pebbles are cardamon pods that impart so much depth and flavour and you'll want to put them back into the dish, but for now, leave them out. Don't throw out the entire bowl of kheer.

You may be familiar with the story of the Buddha walking in the forest with a group of monks. He picks up a handful of leaves from the forest floor and asks, "how many leaves are on the forest floor and how many leaves are in my hand?" The monks answer, "There are a great many leaves on the forest floor whereas there are only a few leaves in your hand." The Buddha explains that he knows many truths, like there are many leaves on the forest floor, but that he has chosen a handful that will be of most practical use (Amaro, 2011).

Sadly, I do not have the wisdom of the Buddha and thus I beg your understanding and indulgence that I have chosen leaves, or ideas, that I hope will be of practical use for you.

There is a story of a man on a horse galloping seemingly heading for somewhere important. "Where are you going?" a bystander asks. "I don't know, ask the horse," the rider answers. Thich Nhat Hanh likens the horse to our habit energy, pulling us along. Our habit energies are often stronger than our volition and we might say and do things that are unhelpful, that we regret, causing us to be at war with ourselves and create difficulties for those around us (1998).

Shamatha is the practice of stopping our habit energies, stopping the strong emotions that rule us. By stopping and practising mindfulness in this moment we can learn vipashyana, deep looking, seeing things as they really are. When we touch deeply in the present moment, we generate understanding, acceptance, love and the desire to relieve suffering and bring joy (Hanh, 1998). Consider mindfulness in your role as therapist. Perhaps therapy is a unique opportunity to stop the galloping horse and look deeply. According to Steve de Shazer, one of the lessons therapists can learn from philosopher Ludwig Wittgenstein is "Don't think, but observe" (Eric McCollum in Nelson, 2005).

When I meet a new client for the first time, I orient them to the work we might do (in a similar style to Korman, 2004) .

> *Thank you for coming. I hope that us talking together will be helpful for you. Obviously there is no guarantee of that. However, I can guarantee that I will do my best and I'm sure you will, too. By the time you leave here, what do you hope to notice that will be different, in how you think or how you feel or what you catch yourself doing, later today or maybe over the next few days or in the next week, that will tell you that coming here and talking has made a small difference for you?*

A common answer from clients is "I don't know" and we remember that they mean, "I don't know yet". We might offer compassion and empathy for their struggle, "Yes, it is a difficult question, isn't it?" We stop and wait. SFBT is guided by what clients want and believe is helpful for them. So as therapists we must stop and wait to hear what they want different in their lives. Only then can we move to a new question.

Our clients work hard but we work hard, too. To sit in silence and wait can be painful for us as therapists. We may feel discomfort, doubt and worry. We may doubt the client's ability, doubt the efficacy of the SFBT approach or doubt our skills as a therapist. We want to feel comfortable again and so the wild horse of habit may run away with us and trick us into behaviour that is not helpful for the client but makes us feel better.

Jon Kabat-Zinn has been credited for introducing mindfulness into mainstream psychotherapy. His definition of mindfulness (Kabat-Zinn, 1994) is "Mindfulness means paying attention in a particular way: on purpose, in the present moment, and non-judgmentally."

In recent years there has been an exponential increase in interest and research into the benefits of mindfulness for clients. A plethora of mindfulness-based courses, literature and resources such as apps on smart phones and tablets have led to criticisms of mindfulness developing into McMindfulness (like McDonalds) because of its commercialism. The concepts of meditation and mindfulness have become more widely accepted and generally better understood, although certain myths persist, such as "It is just a relaxation technique", "it's just about breathing", " It should be easy to learn", "It's not for me because my mind is just busy with thoughts all the time", "It means being able to focus on nothing".

Criticism has also arisen about differences between western and eastern traditions of mindfulness and meditation and that mindfulness has "lost its essential Buddhadharma in translation to the Western world" (Kabbatt-Zinn, 2011).

Mindfulness is the practice of satipatthana, the establishment of awareness from the Maha-Satipatthana Suttanta, considered the most important teaching of the Buddha. (Confalonieri, 2003). Using the language of Pali, the language that the teachings of the Buddha were originally recorded, these are some key concepts:

- Sati – to be aware, to remember (to come back to the present moment)
- Patthana – establishing an awareness of how things are, not how we would like them to be
- Annica – change is constant
- Dukkha – suffering, discontent, unsatisfaction
- Sankara – mental formation, mental reaction, mental conditioning
- Upekkha – equanimity; the state of mind free from craving, aversion, ignorance
- Sampajanna – constant thorough understanding of impermanence
- Samadhi – concentration, control of one's mind (Confalonieri, 2003)

Mindfulness begins with the simple act of natural breathing in and knowing that you are breathing in, breathing out and knowing that you are breathing out … being rather than doing. Awareness of the simple eventually expands to the awareness and mindfulness of the more complex and involuntary actions (Moore, 2012). Buddhist monk, Ajahn Amaro, describes mindfulness as the "refinement of innate abilities we already possess; the capacity to focus attention and the ability to investigate, explore and contemplate the nature of this experience" (Amaro, 2011).

Mindfulness is not a technique, but a "way of being and seeing, resting on a foundation of deep enquiry into the nature of self " (Kabat-Zinn, 2011).

Mindfulness meditation is transforming.

> *… hence the ideal of long-term transformation: becoming a better human being for one's own well-being and that of others as well. These two go together…. Meditation … truly means cultivation – cultivating new qualities, new ways of being. It also means familiarization: familiarization with a new way of seeing the world; for example, not grasping at permanence, and instead seeing the dynamic flow of interdependence. Meditation means familiarization with qualities that we have the potential to enhance, like unconditional compassion, openness to others, and inner peace. It's also familiarization with the very way the mind works. So often we are full of thoughts that ceaselessly go through our mind. We hardly notice what's going on. (Kabat-Zinn & Davidson, 2011.p 25).*

Our minds rush into the past and delve into the future. It takes training to focus on this present moment and to keep returning to this present moment. When we are gripped by something, we might be able to hold our attention for longer but on average as human beings we might only focus about 5 seconds at a time …We generate millions of thoughts, probably more than 100 million in our lifetime (Dijksterhuis, 2015).

IS MINDFULNESS USEFUL FOR OUR CLIENTS?

Mindfulness is not one of the techniques traditionally taught in SFBT. However, In Solution-Focused practice we routinely ask about times the client handled the difficulty differently, and we ask, "How did you do that?". I notice that clients often talk about already using techniques like deep breathing to calm themselves without having been taught this anywhere in particular.

One young client, 17 years of age, told me that during an argument with her boyfriend, she was able to stop yelling, walk away and go ride her bike focusing on feeling the wind on her face and pushing pedals on the bike just riding for ten minutes and then returning home to her boyfriend and they were able to talk reasonably.

Without anyone telling her to do this, she tapped into her own wisdom and was able to stop her own galloping horse. She has also been able to cut her use of marihuana from being completely wiped out every day to the occasional bong when she felt depressed to now not using at all, even though her parents continue to use marihuana and even though she is continuing to deal with chronic physical pain and other significant stressors. When I asked her how she decided to not use marihuana anymore, she said that she noticed that she'd feel good for a while and then crash and be really emotional and she'd get into more arguments with everyone including her boyfriend. She said she doesn't want to do that anymore and that she notices she thinks more clearly and feels happier and more motivated not using drugs. She was using mindfulness skills.

Human beings in Latin is *Homo sapiens sapiens*, which literally means the species that knows and knows that it knows, acknowledging our core capacity for awareness and meta-awareness (Katbat-Zinn & Davidson, 2011). We all have the seeds of mindfulness within us and are already using these skills to some extent but maybe not with conscious awareness of how it makes a difference for us and how we can do more of it.

Meditation is the ability to focus and the capacity to investigate, explore and contemplate the experience itself. These two capacities are natural to us, and meditation develops them, like cultivating a seed and giving it the conditions to grow and flourish. This is the purpose and nature of meditation. (Amaro, 2011).

DO THERAPISTS BENEFIT FROM PRACTISING MINDFULNESS? HOW CAN MINDFULNESS INFORM OUR WORK USING SFBT?

Eric McCollum suggests that,

> *we have been taught that observation is a merely passive activity as a "prelude" to the "real work" of therapy… observation is an intervention and it is more powerful than we might ever guess. If we bring the same level of mindful attention to client's vision of the future without the problem to their recollections of times that the problem did not occur, to their musings about what we would tell them that a miracle had happened, that we bring to eating just one raisin, new worlds will open for them. And for us. (Nelson, 2005).*

I suggest that, as Solution-Focused Brief therapists, we use mindfulness every moment we are with a client asking questions and listening to the answers. But perhaps, with focused awareness, that the seed of mindfulness within all of us can grow to further benefit our work with clients.

Eve Lipchick suggests, "for the sake of our clients we should think of ourselves first as human beings, second as therapists, and only last as therapists who practice a particular model" (2002). The Dalai Lama says that he intentionally searches for what he has in common with every person he meets. As human beings we have more in common with each other than what is different about each other.

"We are the same, we are all human beings. Of course there may be differences in cultural background or way of life, there may be differences in our faith, or we may be a different color but we are human beings, consisting of the human body and the human mind. Our physical structure is the same, and our mind our emotional nature are also the same. Whenever I meet people, I always have the feeling that I am encountering another human being just like myself. I find it much easier to communicate with others on that level. If we emphasize specific characteristics, like I am Tibetan or I am Buddhist , then there are differences. But those things are secondary. If we leave differences aside, I think we can easily communicate, exchange ideas, and share experiences (Dalai Lama & Cutler, 1998).

Remembering or being mindful of this when sitting with a client can make us less focused on the differences between us and them, less likely to be judgemental or make assumptions. We can be more accepting that they, too, are on a journey in life, struggling, just as we are ourselves.

As human beings we all want to be happy. We all want to hang on to what is pleasant in life and we want to eradicate what is unpleasant. We crave what feels good -- and so SFBT asks in detail about how the person wants it to be.

SUFFERING

Buddhism teaches that *dukkha* or suffering is an inherent part of life, of our existence. The experience of physical and emotional pain, also called natural pain, is inescapable given we have a mind and body. However, a second element of suffering is when the mind adds to the pain, such as anger, resentment or anxiety (Amaro, 2011) and Buddhist teachings focus on this because you can do something about this aspect of pain.

If we accept that as human beings *dukkha* is inevitable then we must accept that dukkah is also a part of our role as therapist and with deep understanding of this, we can use this to develop empathy and compassion for ourselves and for our clients.

In my scant spare time I love to indulge in the reading and writing of creative fiction. Dinty Moore wrote an inspiring book called *The Mindful Writer (2012)*. I have adapted his writer's credo into a therapist credo:

The four noble truths transposed for therapists:

- The therapist life is difficult, full of disappointment and dissatisfaction
- Much of this dissatisfaction comes from the ego, from our insistence on controlling both the process of therapy and how a client reacts to the therapy
- There is a way to lessen the disappointment and dissatisfaction and to live a more fruitful way of conducting therapy
- The way to accomplish this is to make both the practice of therapy and the outcome less about ourselves. To thrive, we must be mindful of our motives and our attachment to desired outcome.

Note that this is not pessimism but to accept the truth of suffering and recognize that there is a way out of suffering. Therefore it is path of optimism and realism and "workism" because each person has to work to achieve equanimity (Goenka, 1987).

It is interesting to note that de Shazer (1997) comments that the practice of SFBT requires "radical acceptance" -- accepting how the client wants things to be, not how we think the client ought to want things to be. He discusses ways to "go with" a client's idiosyncratic answer to the Miracle Question, rather than trying to reshape it to fit our ideas about the "best" outcome.

Of the three types of actions: physical, vocal and mental (Hart, 1987), normally we might consider physical actions most important, followed by verbal actions and of least importance are mental actions. Consider that you can be arrested for having assaulted someone or having verbally abused someone but you are unlikely to be convicted for abusive thoughts. But to Dhamma, the law of nature, mental action, or volition, is most important. When we have the conscious awareness, the right thought, the right intention, of working with clients, this takes precedence over our verbal actions and our physical actions. I have asked questions badly and been surprised and impressed how a client will make efforts to turn my question into something effective.

My first memorable experience of using SFBT was with a woman who struggled with the continued impact of past trauma, including domestic violence and sexual assault. She was perhaps in her late thirties or early forties but her face bore deep lines, her hair was pulled back into a tight bun, and she presented each time dressed in a black t-shirt and black leggings and sneakers.

Buoyed by new learnings from my first SFBT training, I decided to plunge in by asking her the miracle question. Did I ask it perfectly? I doubt it. Nevertheless, she answered, hesitantly at first and then in more detail including wanting to change her name back to her maiden name. At the end of the session, we agreed to meet again in a few weeks' time and when we parted, I called out to her, "Goodbye Dorothy Smith [name changed to protect her privacy]!"

She swiveled and stared at me. "I've not heard that name for a long time," she muttered.

When she returned to counselling, a different woman sat before me. Her hair curled framing her face and she wore a brightly coloured top and a skirt. She proudly showed off her driver's license with her new name, her maiden name. "When I left here I went to the bank and everywhere and changed my name." She said, face glowing. "And now my children are also talking about wanting to change their surname to mine."

I was witness to a miracle.

Did changing her name or changing her clothes or changing her hair resolve all difficulties for her? No, of course not. But by calling out her name as I did, had significance for her that she was able to make use of outside the counselling room -- and the world outside the counseling room, the client's day-to-day life, is where it matters.

SFBT is an approach that was born of observation of what worked in therapy, what helped a client shift into the direction the client wanted to go. SFBT is an approach based on pragmatism rather than endless theory to be debated. SFBT is a constructionist approach; we co-create a new reality with our clients that may enable clients to tap into something within themselves and to move into a particular direction with increased awareness and purpose; a step towards conscious and deliberate living.

There are 3 different types of learning and development of *panna* (wisdom):

1. *bhavana-maya-panna* – wisdom that develops through direct personal experience
2. *Suta-maya-panna* – wisdom acquired by simply listening to someone else
3. *Cinta-maya-panna* – wisdom obtained through reasoning and intellectual analysis (Confalonieri, 2003).

Learning from direct experience leaves the strongest imprint. Whatever I learned during my first SFBT course, *suta-maya-panna* or received wisdom and *cinta-maya-panna*, intellectual understanding, are useful as inspiration or guidance. However, it was not as important as this experience with my client. *Cinta-maya-panna* is experiential wisdom, based on my own experience gives the most benefit. It gave me faith in the SFBT approach and confidence to continue to hone my skills.

Mindfulness or deep looking in the present moment is a reminder that "a person is not a finished, unchanging entity but a process flowing from moment to moment. There is no real being, merely an ongoing flow, a continuous process of becoming (Hart, 1987, pp. 28-29). SFBT does not focus on the intricacies of the client's past difficulties, but on their successes in the present and future. The discussion of the client's preferred future (from present to future) is drawing attention to a particular, possible ongoing flow.

Deep listening is listening with eyes, ears, heart and awareness and focus. Mindfulness enables us to practice *Ting* (Fiske, 2008), the Chinese character for listening consisting of the combination of characters (or pictograms) of ear (to listen), king (to pay attention as if the other person were king), ten and eye (be observant as if you had ten eyes), one (listen with individual attention) and heart (listen also with your heart in addition to your ear and eye). In all East Asian languages, including Tibetan, the words for heart and mind are the same and thus mindfulness can also mean heartfulness (Kabat-Zinn, 2011), which is a reminder to practice compassion.

Thus mindfulness is also "cultivation of the heart"…which includes cultivating the immeasurable qualities of loving-kindness, compassion, empathetic joy, and equanimity (Allan Wallace in interview, Kabat-Zinn & Davidson, 2011, p. 63).

Practising compassion, sometimes mistaken for pity rather than kindness, in therapy is not always easy and is about discerning what is "good for us as well as what is good for those around us. Compassion isn't always about being soft and yielding; it also demands strength and force at times" (McCollum, 2015). In SFBT, our compassion is driven by how the client wants things to be rather than by an exploration of the past pain. It might come from a different "direction" or focus; but, nonetheless, it is still compassion.

Eric McCollum (2015) suggests that those of us working in the helping professions may struggle with self-compassion, the ability to "rest in a sense of acceptance, able to forgive ourselves when we stumble, and not needing to continually strive to be other than who we are" but how important it is for our work with clients because "by preserving our own integrity allows us to continue to be compassionate without having to retreat and regroup if we become depleted, thereby abandoning the person who is the object of our compassion".

Every moment we are moving towards or away of something. Back in my early days of university, I studied economics and learned about the concept of opportunity cost. When we spend one dollar on a drink that drink costs not just one dollar but everything else that we could have done with that same one dollar but that we didn't buy.

When we ask a question in therapy, we have foregone many other possible questions. Where we focus our attention in sessions with clients is also saying something about what we are not focusing on. By focusing our attention and asking more questions about it redirects client's attention. When a client says, "I just want to not feel depressed anymore," we ask "how do you want to feel instead". The practice of mindfulness is mind training, enabling us to "improve our capacity to focus … and learning how to think when we choose to think, and learning how not to think when we choose not to … the second capacity, the element of investigation, supports a quality of understanding" (Amaro, 2011).

SFBT in known for being a strengths-based approach. As Lipchik suggests, from a practical perspective, the "simple act of being alive" and even finding their way to our office implies strengths, skills and resources (2012). In SFBT we do not point out to clients their strengths but we help them to tap into what is already within them and what is ever changing and evolving. Resilience is not something we teach but we can co-create the awareness for a client of how they have already demonstrated resilience when faced with their life's challenges. One of our favourite questions in SFBT is, "How did you do that?" This seemingly innocuous question invites clients to reflect on growing and evolving success, without imposing any ideas from outside. This is in marked contrast with many more traditional approaches where therapist-expertise drives how the client *should* be successful.

Clients already have the seeds of competencies and in SFBT we maximize opportunity to nurture and water these seeds. One way we do this by asking about pre-session change. Weiner-Davis et al (1987) conducted research and found that, with no clinical difference between mandated clients and voluntary clients, that two thirds of clients reported that, between the time of making an appointment and when they actually attended therapy, significant changes had occurred and that these were changes they wanted to continue.

Asking, "How did you do that?" contains the implicit message that you did that … it didn't just happen. We aim to maximize clients' sense of agency and self-efficacy, make ourselves as redundant as quickly as possible and, as Insoo Kim Berg said, to minimize our footprint in our clients' lives (George, 2007).

Mindfulness is about retaining a beginner's mind. When I attended training to be a volunteer for Lifeline, a national 24-hour telephone helpline service, they explained that I must always wear an "L plate" around my neck". L is for Learner. When we learn to drive in Australia we must put an L plate on the car to show other drivers we are only learning and they should to take care around us.

As a therapist with some experience and professional training, it can be seductive to begin believing that you know something about how to help clients. You might be tempted to toss away the L plates. But every client situation is unique. We are different each time we sit with the same client and the client is different each time. When resources are limited and time is precious, how brief is Solution-Focused Brief Therapy? Recognising that clients are on a journey, I like to ask scaling questions. If 0 is when you began therapy with me and 10 is when you tell me that you don't need to see me anymore, where are you now?

Mindfulness teaches us that there are 5 enemies that do not allow us to see as things are; they muddy and agitate the waters so we cannot see.

1. Craving
2. Aversion
3. Agitation
4. Drowsiness or laziness
5. Doubt

However, there are also 5 friends to counter these enemies and maintain our equanimity and calm and clear the waters.

1. Faith
2. Effort
3. Awareness
4. Concentration
5. Wisdom (Goenka, 1987)

We want to be able to stop the wild horse and to look deeply. We want to act, not react. We want to act with wisdom, not react blindly. Every moment counts in therapy because it will not come again. Swedish Solution-Focused therapist, Harry Korman, says that the best way io make therapy brief, is to GO SLOWLY. Mindfulness helps me do that. Time is precious.

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ABOUT THE AUTHOR

FRANCES HUBER

Frances Huber is a psychologist and Senior Associate of the Brief Therapy Institute of Sydney. She also works at St John of God Hawkesbury District Health Service Community Health Centre, where she provides counselling to adult clients presenting with a range of difficulties, including domestic violence and child sexual abuse, depression, relationship difficulties, etc. Frances has a background in high-school teaching and has previously worked in child and adolescent counselling services. She has experience training and supervising a wide range of practitioners in Solution-Focused Brief Therapy. She is a dedicated Mindfulness practitioner and practices Vipassana meditation and Bikram Yoga. She has presented at conferences in Australia and in Europe.

DIFFERENT TYPES OF QUESTIONS IN PSYCHOTHERAPY

Jaseem Koorankot,
Santhosh K R,
Fathima Shabnam &
Sidra Abdul Latheeef

ABSTRACT

The article reports about the paradigm shift that has occurred in the usage of questions during psychotherapeutic sessions. Initially questions and questioning were just tools to gather information. Recent approaches to psychotherapy adopt questions as interventions. It is true that these approaches apply questions and questioning in different ways. However, studies indicate a cognitive change or cognitive restructuring in the beneficiaries, as an effect of questioning.

Key words: Questions, Psychotherapy, cognitive change

QUESTIONS IN PSYCHOTHERAPY

Questions are, at times, forms of intervention in psychotherapy. During the therapeutic sessions, we employ them more frequently than statements or assertions. In specific psychotherapeutic approaches such as narrative therapy (Epston & White, 1992), Brief Therapy (Watzlawick, Weakland&Fisch, 1974), Problem-Solving Therapy (Haley, 1976) and Solution Focused Therapy (de Shazer, 1985), questioning is commonly implemented as a method of intervention.

Ever since the emergence of psychotherapy, questions are the most straightforward tool for information-gathering. New and alternative approaches to psychotherapy view questions in a more original perspective and adopt them as interventions. Many of the modern interactional therapy models such as systemic, solution-focused, post-modern, narrative or discursive therapies rely extensively on questioning. Though the therapeutic questions used in these approaches are entirely different from each other, the motive in using them is to bring a shift in the direction of the therapeutic dialogues in a particular way and thereby achieve the desired behavioural changes. McGee and his colleagues (McGee, Del Vento, &m Bavelas, 2005) developed a model describing the relationship between question and answer to demonstrate the effect of questions in psychotherapy. McGee illustrated through his model that the wording of a question could lead the focus of the therapeutic conversation in a particular direction. In the model, McGee put forward two central proposals. The first proposal says that therapists' questions contain implicit presuppositions. These suppositions are logically implied assumptions but are unstated. For instance, the question "What made you do it?" contains a presupposition that something made the client do it. On the other hand, asking "What could you have done differently?" presupposes that the client could have done something

differently; that is, the client can choose among alternative actions. The second proposal in his model says that questions are interactional, that is, the presuppositions in the therapeutic questions lead to having an interactional effect on the client. These presuppositions in the question make the client answer the question in a direction that is mmanticipated by the therapist. The presuppositions centre the client in a specific heading, and by noting the further questions; the client indirectly acknowledges its presuppositions and joins the therapist in investigating its course. McGee (1999), with the help of numerous examples taken from published therapy sessions, explained that the presuppositions implied in questions in traditional forms of psychotherapy and questions in therapies belonging to the alternative paradigm are different. He emphasised that the choice is left to the practitioner to decide how to ask questions so that it can influence the conversations in a specially museful way.

RESEARCH ON EFFECT OF QUESTIONS DURING THERAPY SESSIONS

Several studies have shown that questions, compared to the statements, can be used as practical tools in changing attitudes (Petty, Cacioppo, &Heesacker, 1981; Swasy& Munch, 1985; Burnkrant& Howard, 1984; Zillerman, 1972; Howard, 1986; Howard, 1990; Howard &Kerin, 1994). For example, in a study by Howard and Kerin (1994) a radio program was completed on the benefits of vitamin supplements with either a statement (Your daily intake of vitamins should meet your daily needs) or a question (Does your daily intake of vitamins meet your daily needs?). When the listeners were surveyed on their attitudes towards vitamins more favourable attitudes were noted among the subjects who listened to the version of the program with the question.

In addition to investigating the effectiveness of questions when compared to statements, there have been many studies, which analysed how the wordings in a question make different impacts. In a study, Loftus and Palmer (1974) found that subjects estimated higher speeds for a question that asked; 'How fast were the cars moving when they crashed?' Versus a question that replaced crashed with bumped or hit. All the subjects viewed the same accident videotape. However, the presuppositions embedded in the verb affected their estimates.

The impact of changing a word in a question is illustrated by a field experiment conducted by Heritage, Robinson, Elliott, Beckett, and Wilkes (2007). In this study, the physicians asked their patients either "Is there something else you wish to address in the visit today?" or "Is there anything else you wish to address on the visit today?" Results indicated that the "something" version led to significantly more concerns than the "anything" version.

Similarly, there have been examinations that exhibited how the focus of a question has distinctive effects. For example, Ross, McFarland, Conway, and Zanna (1983) asked subjects to describe particular events in the later lives of the clinical patients by reading their detailed clinical cases. Then the subjects had to estimate the likelihood of the events in question. Results showed that the probability of the subjects' events was assigned to find the predictive evidence was significantly higher than the probability of the event for which they had not been seeking evidence. It implies that the focus set by the question affected the findings of the subjects. In a lab experiment by Healing & Bavelas (2011), the effects of different forms of questions taken from psychotherapy were tested. The experimenter took an interview of subjects about a difficult task they had just done using a contrasting set of questions. Results took immediately afterwards and one week later indicated that questions which had a different focus, but same topic affected the subjects, producing varied viewpoints and behavioural changes.

DIFFERENT TYPES OF QUESTIONS IN PSYCHOTHERAPY

Tomm (1988) discussed four different types of questions in Psychotherapy. According to him, there are lineal, circular, strategic and reflexive questions. Lineal questions are used to clarify the sequence of events over time, and they focus on client's understanding of the situation. Circular questions are asked in psychotherapy with the intention to generate a more comprehensive contextual understanding for the interviewer. Strategic questions intend to influence the clients in a way to get the clients to adopt the interviewer's ideas as more useful. Reflexive questions aim at mobilising the clients' knowledge and competencies with the assumption that client is the expert and change agent in their own life. In addition to this general classification of questions, each therapeutic framework has formulated its very own specific classification of questions.

COGNITIVE CHANGES DURING THERAPEUTIC QUESTIONING

Attempts have been made to explain the effectiveness of psychotherapy concerning neuropsychological perspective. One explanation is that engaging in a therapeutic relationship may help clients modify neural systems, integrate neural functions, and improve emotional regulation by enhancing cortico-limbic and orbitofrontal development, even during adulthood (Siegel, 1999). Similarly, neuroscientific studies support the contention that brain development and changes over time has an interpersonal foundation (Schore, 2003; Siegel, 1999). Further, Siegel maintains that a combination of emotional and interpersonal factors is primary in the neurological changes associated with symptom reduction or healing. SFBT is said to originate from social constructionism (Cantwell & Holmes, 1994), which claims that the individuals develop ideas of nature of his problems, competence and possible solutions based on their communication with others. Although further research is still needed to continue to explore this, it is reasonable to hypothesise that the interpersonal relationship and the presence of positive emotions aroused from miracle question provide optimal conditions for positive change from a neuropsychological perspective.

Psychotherapy alters the neurochemistry and physiology of the brain by providing a stimulus that leaves a memory trace. It is the study of learning and memory that makes us understand how psychotherapy produces emotional and behavioural changes in patients (Liggan& Kay, 1999).

Psychotherapy is valid interventions that has direct effects on the brain, the changes that are reported include:

1. Changes in cerebral metabolic rates
2. Alteration in serotonin metabolism
3. Effect on the thyroid axis
4. Stimulating processes akin to brain plasticity.

Psychotherapies try to enhance patients' functions such as problem-solving capacities, self-representation, and regulation of affective states. The brain areas that are associated with these functions include the dorsolateral prefrontal cortex, ventral anterior cingulate cortex, dorsal anterior cingulate cortex, ventral and dorsal subregions of the medial prefrontal cortex, posterior cingulate cortex, precuneus, insular cortex, amygdala, and ventrolateral prefrontal cortex. (Frewen et al., 2008)

Examples of how specific psychotherapies impact brain are as follows:

Family therapy helps to alter the way in which parents respond to the heritable characteristics of their children to positively influence genetic expression. Kandel (1998) suggests that the learning about oneself that occurs in psychotherapy may in itself influence the structure and function of the brain.

Similar decreases in cerebral metabolic rates in the head of the right caudate nucleus are noted while treating OCD with both behaviour therapy and fluoxetine (Baxter et al., 1992). PET and SRE measures of local cerebral metabolic rates for glucose showed the same response in reaction to the two different treatments.

Cognitive therapy seems to influence thyroid hormone levels in people suffering from major depression (Joffe et al., 1996). Striking decreases in thyroxine was noted among patients responding to cognitive behaviour therapy, while an increase in thyroxine was noted among non-responders. In another study involving depressed patients, it was found that cognitive therapy produced biological changes in sleep architecture which were identical to the changes induced by antidepressant medication (Thase et al., 1998).

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ABOUT THE AUTHORS

JASEEM KOORANKOT, PhD

is a Licensed Clinical Psychologist by profession and a trained Solution Focused Practitioner. He is currently working as Lecturer in Clinical Psychology at Institute of Mental Health and Neurosciences (IMHANS), Calicut, Kerala. He is a person who has shown an inordinate passion towards solution focused practice from the beginning of his career. Jaseem has published many scientific articles in the area of Solution Focused Practice(SFA) and presented papers and conducted workshops in European Brief Therapy Association's (EBTA) annual meets. Apart from Training and Practice, he is actively involved in research and won grants. He is also a trained Clinical Supervisor of Solution Focused Brief Therapy. He has facilitated several introductory and advance level workshops on solution focused approaches in India and abroad. Jaseem is also the founder and Present General Secretary of Association of Solution Focused Practices – India (ASFP - I) - www.asfpindia.org, the one and only professional body for Solution Focused Practices in India. He Co - founded Academy for Solution Focused Approaches and Research (ASFAR)- www.asfar.in- with Dr. Arnoud Huibers in 2016, which is the only one institute in India, that solely train professionals in Solution Focused Approaches.

SANTHOSH KAREEPADATH RAJAN, PhD

is the Assistant Professor of the Department of Psychology at Christ University (Bangalore, Karnataka) in India, since 2016. His research interests spans positive-solution-focused-correctional-psychology, which includes resilience, strengths, and pratixas (newly emerging concept). He has authored 19 publications (one book, two chapters and 16 journal articles). He is the member of International Positive Psychology Association, and is professionally associated with Association of Solution Focused Practices-India.

MS. FATHIMA SHABNAM

is a Psychologist, currently working as a Personnel Policy Consultant at Al Habari Group, Qatar. She has associated with research projects on SFBT and has co-authored articles in international publications. Fields of Interest are research and training in the areas of Organizational Psychology.

MS SIDRA ABDUL LATHEEF

is currently working as a counselling Psychologist at Human Care Foundation, Calicut. She has completed her post graduation in M.A Applied psychology from Jamia Millia Islamia, New Delhi. Her graduation in psychology was completed from LISSAH College, Calicut University.

ROLE OF REINFORCEMENTS IN GAMIFICATION

Vineesh U Sathianathan &
Santhosh Kareepadath Rajan

ABSTRACT

Gamification is the use of game design elements in non-game contexts (Deterding, Dixon, Khaled & Nacke 2011), which uses the token method of reinforcement to modify individual behaviours (Kazdin, 1977). Gamification is considered as a solution for enhancing work motivation in employees. The present study is an attempt to find out the importance of reinforcement in the process of 'Insignio' gamification, a gaming frame work that brings in the gaming aspects for a large group of individuals at work. The sample included 50 teams in one multinational IT organisation. As per the findings, when reinforcement decreases in gamification, employee motivation towards work decreases and as a result work performance decreases. Regular and continued reinforcements play a critical role in employee motivation towards work and employee work performance. The study also gives an insight into the importance of praise, learning and continuous improvement.

Key words: Token, Reinforcement, Gamification, Work motivation, Employee performance

Role of Reinforcements in Gamification

Gamification is considered as a solution for enhancing work motivation and employee performance. The basic idea behind the application of gamification as a performance-enhancing intervention process is our love, as human beings, to play games. And, since time immemorial, gaming is a popular form of recreation (Nicholson 2013). As per the findings of Bright, Harvey and Wheeler (1985), people enjoy being involved in one or other forms of games. Games merge fun with challenges and sometimes include components that are difficult to learn, explore and master. There are games which challenge our cognition, and that will provide opportunities to persevere. Further, each game has the potential to givem experiences of success and thereby to feel right about them.

A game board which can be dated back to approximately 5870 +/- 240 BC verifies that Neolithic people had leisure time to win or lose at games of chance or skill (Rollefson 1992). Puddephatt (2003) has explored on how people engage in strategic activity in the context of a chess game, where he posits that serious players often view, experience, and enact various aspects of the game in different ways than their casual counterparts. He argues that life is usually very much like a game, as the processes of strategic interaction often associated with gaming activity are adopted widely throughout everyday life.

People always strive to achieve their best, which keeps them motivated. Human motivation can be broadly classified as intrinsic and extrinsic motivation (Ryan 2000). Extrinsic motivation has been extensively studied and used in organisational settings which include monetary and non-monetary rewards. According to Sonawane (2008) functions of non-monetary rewards are promising in the corporate world. Non-monetary rewards are formal rewards, when a token reinforcement is given to employees, as a recognition of their efforts or/and achievements.

Research studies on token reinforcements reveal exciting findings in the fields of psychiatry, clinical psychology, education, and mental health (Kazdin, 1977). In token reinforcement systems, the concept of operant conditioning is employed to modify individual behaviours (Kazdin, 1977). The token reinforcements are awarded for each instance of demonstration of expected behaviour by the participants. The token can be presented before, alongside or immediately after the manifestation of the behaviour. By repeated instances of token presentation, the neutral token becomes the reinforcing entity (Doll 2013).

During Gamification, we will use game design elements in non-game contexts (Deterding, Dixon, Khaled & Nacke 2011). The concept of gamification has been popular since 2000's and currently being widely adopted in various areas including business, marketing, corporate management, and wellness and ecology initiatives (Dicheva 2015). Many researchers have worked extensively on gamification and documented them. The role of reinforcements has been extensively studied for more than a century now.

'Insignio' is a gamification framework that will add a new dimension for individuals to excel at the workplace. The term 'Insignio' is derived from the word insignia, denotatively, a badge or sign which shows that a person is a member of a particular group or has a specific rank. In ancient times, an insignia had been an emblem of a specific or general authority, a symbol or token of personal power, status or office, or of an official body of government or jurisdiction. There is documented evidence of an elaborate hierarchy of military rank and insignia developed and prominently used by the Aztecs which dates back to the thirteenth century. Noblemen rose through the ranks based on the number of captives they had taken in battle and were rewarded with ever more flamboyant uniforms to advertise their prowess (Rounds 1979, Harper & Duran 1964).

In the notes of Fredricksmeyer (1997), we can see the arguments on the origin of the royal insignia of Alexander the Great, owing to its significance in history. Alexander the Great wanted to create something unique on his own, to showcase his conquests and sanction of his Graeco-Macedonian gods (Hammond 1989). Citing another instance, Priest (1936) talks about thirty-four small examples of Chinese textiles which are the insignia worn at court on official or special occasions. They consolidated a list of 9 civil ranks and nine military ranks. The history of insignia indicates the importance of tokens existed throughout history.

Insignio Gamification adopts similar tokens to improve the work motivation and to enhance employee performance. The implementation of such token reinforcements is quite typical in the interventions through gamification. However, there are limited studies which explored how they play a role in improving the work motivation-enhancing the employee performance. The present study is an attempt to find if token reinforcements in gamification influence work motivation and thereby control employee performance. In any organisation setting, consistency of employee work performance is the key. We claim that when reinforcement decreases in gamification, work motivation lessens and as a result employee performance decreases.

OBJECTIVES

The objective of this study was to find out the role of token reinforcement in gamification to enhance employee performance.

METHOD

The sample size included fifty teams where the team size varied between three members to twenty-two members. The intervention was conducted over a period of one year starting October 2016 and ending in September 2017. The total duration was divided into four quarters viz. quarter 1: October 2016 to December 2016, quarter 2: January 2017 to March 2017, quarter 3: April 2017 to June 2017, quarter 4: July 2017 to September 2017. The data from each team was collected on a weekly basis and used to derive performance index. The consolidated data was shared with all the employees for the complete duration of the intervention.

Procedure

Before the commencement of gamification intervention, in-person workshops were conducted for one hour with more than half the teams to help them understand the gamification approach and the intention. The objectives were stated, and guideline documents were shared with respective teams. The guideline document was available for the access of the team members during intervention.

Insignio gamification framework: The framework brings in the gaming aspects for a large group of individuals who are associated with a specific customer to achieve their business objectives (Chou 2016). The group has a hierarchical structure, where an individual is a part of the team and reports to a project manager. A project manager may be responsible for one or more teams and reports to a delivery manager. A delivery manager would be responsible for multiple projects (portfolio) and shall have multiple project managers reporting.

The gamification framework is defined to address two essential aspects as mentioned below,

1. A clear and streamlined path to raise the potential of every team member, defined as the 10x journey.
2. A mechanism to differentiate and reward each significant contribution from every team member.

The framework consists of the rewards defined across various stakeholders in the organisation structure and the levels to be achieved. Five different categories of rewarding mechanism shall be used.

1. Koins: Team members and teams accumulate koins, that shall be awarded to them based on the contributions concerning the value brought in.
2. Ribbon: Team members earn a ribbon on successful completion of an activity.
3. Badge: Each team earns a badge for every 133 koins accumulated or if every team member earns a ribbon. A team is defined as follows
4. Medal: Each project manager earns a medal for every 333 koins accumulated or if every team with the project manager earns a badge or there may be specific criteria's defined.
5. Capstone: Each delivery manager earns Capstone for every 3333 GoTkoins accumulated or if every project manager earns a medal.

The objective of the 10x journey is to achieve a black belt. A team, project manager or delivery manager must move through each level to reach 10x, which is the highest achievement. The 10x journey is broadly categorised into three levels viz beginner, intermediate and advanced. At each level, there are three belts to be achieved to move to the subsequent level. The complete duration of the intervention is planned for 12 months (starting 1st October 2016 and ending on 30th September 2017). The progress of each category is baselined every quarter.

Process: during quarter 1, there were awareness sessions as well as the regular distribution of various rewards; during quarter 2, awareness sessions were stopped. However the reward distribution continued; during quarter 3, the reward distribution was limited to few teams; during quarter 4 no rewards were distributed.

Statistical analysis

Shapiro Wilks normality test indicated that the data is not normally distributed. Hence, Kruskal Wallis H test was used to compare the trend of the performance of the teams in each quarter.

RESULTS

The result of the trend analysis using Kruskal Wallis H test is summarised in table 1

Table 1:

Kruskal Wallis H that shows the trend of performance of the employees in the four quarters

Terms	Performance		Teams participated	Mean Rank	*H*
	>Median	<Median			
Quarter 1	34	19	38	123.01	9.032*
Quarter 2	27	26	29	112.92	
Quarter 3	20	33	33	98.8	
Quarter 4	20	33	33	91.26	

The result of the trend analysis shows that the performance of each quarter differed ($H = 9.032$, $p < .05$) significantly. Comparing the mean rank of each quarter with the process of the deliverance of token reinforcement, the performance, which was high in the first quarter (Mean rank = 123.01, when there were detailed awareness sessions as well as the regular distribution of various rewards), got reduced in the second quarter (Mean rank = 112.92, when the awareness sessions were stopped, but the reward distribution continued), became weaker in the third quarter (Mean rank = 98.8, when the reward distribution was limited to few teams), and then the weakest in the fourth quarter (Mean rank = 91.26, when no rewards were distributed). Participation of the teams also gradually decreased from quarter 1 to quarter 3 but became stable after that. In quarter 1, performance of 34 teams went above the median. In quarter 2, performance of 27 teams went above the median. In quarter 3 and 4, only 20 teams went above the median in their performance. Results designate the importance of consistent token reinforcements in gamification.

DISCUSSION

Findings show that regular and continued reinforcements play a critical role in work motivation and employee performance. Hence, any gamification intervention needs not only to be planned carefully but strictly and rigorously followed up throughout the execution. The performance data shows a decreasing trend from quarter 1 to quarter 4. This observation can be related the importance and the role; regular reinforcements play to bringing in the desired behaviour change and sustaining it. During quarter 1, there were awareness sessions as well as the regular distribution of various rewards. This motivated team members and resulted in better performance outcomes. There was a healthy competition building up among the team members and various teams, which encouraged them to score more (Sonawane 2008, Boniecki 2003).

During quarter 2, awareness sessions were stopped. However, the reward distribution continued. The teams who received the rewards were motivated to contribute more to achieve better performance outcomes (Ryan 2000). During quarter 3, the reward distribution was limited to

few teams. This caused team members to lose focus and interest to continue the momentum since they did not see the value and recognition of accumulating credits. During quarter 4 no rewards were distributed. The performance outcomes of teams reduced further (Baron 2005). The variation during each of the four quarters gives an interesting insight into the importance of reinforcements in keeping up the motivation level high to achieve better performance outcomes. As the level of reinforcements is either decreased or discontinued, employees lose the motivation to achieve more performance outcomes (Baron 2005).

The performance data was shared with all team members every week through the mail. This was consistently done for the complete duration of the intervention, which served the purpose of the performance data being available to all team members. When team members saw their contributions to the performance data being shared, it encouraged them to either continue or improve their performance outcomes (Sonawane 2008, Droe 2012, Grant & Dweck 2003). Learning is one of the parameters considered for performance outcomes. Team members who attended regular training and shared knowledge among themselves had higher performance outcomes as measured during the intervention (Plass, Homer & Kinzer 2015). It was observed that teams who were consistent across the duration of the intervention had emphasised on training and sharing knowledge among the team members. The teams who contributed towards continuous improvements also had better performance outcomes when compared to other teams who did not score on performance outcomes. Hence, the detailed analysis of data shows the importance of praise, learning and continuous improvements to enable the teams to improve their performance outcomes.

CONCLUSIONS AND RECOMMENDATIONS

The study showed the role of reinforcements in gamification to improve work motivation employee performance. Trend analysis conducted over the data collected during the intervention which spanned over twelve months period provided a clear indication how critical reinforcements are to keep the workforce in an organisation motivated. The study gave an insight into the importance of praise, learning and continuous improvement for maintaining a motivated workforce who can provide better performance outcomes. For the organisations that attempt to introduce gamification to enhance work motivation employee performance, the findings are insightful.

It has to be noted that some probable extraneous factors also have influenced the results. Patterns and behaviours of the team leaders might have brought an impact on the team performance outcomes. Further, one of the parameters considered for measuring the performance outcome was recognition regarding praise provided by stakeholders when the employees contributed above and beyond their role (Droe 2012). Praise from stakeholders might have played a critical role in keeping the work motivation. A future study that controls these factors is recommended to derive a perfect relationship between reinforcements in gamification and employee performance.

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ABOUT THE AUTHORS

VINEESH U SATHIANATHAN

M.Sc. Behaviour Science, Department of Psychology, Christ University, Bangalore, Karnataka

SANTHOSH KAREEPADATH RAJAN, PhD

Assistant Professor, Department of Psychology, Christ University, Bangalore, Karnataka

THE EFFICACY OF BRIEF PSYCHOTHERAPIES IN CHILHOOD AND ADOLESCENCE

Lareina Randolfina D'Souza &
Mr. Joyson Elton D'Souza

ABSTRACT

Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, and can work productively and fruitfully (WHO, 2014). Mental Health is a crucial facet in any stage of the human lifespan. Mental health problems affect about 1 in 10 children and young people. Children are often fathomed to be immune to mental problems and illness, and to the evils of the world. However children too may face the same adversities as adults do and may be victims of abuse. Adolescence is the age when individuals explore the world and themselves, and may face problems such as drug abuse, depression and anxiety as a result of their experiences. Alarmingly, however, 70% of children and young people who experience a mental health problem have not had appropriate interventions at a sufficiently early age.

Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults (MHF, 2017). Providing children with an environment that demonstrates love, compassion, trust, and understanding will greatly impact a child so that they can build on these stepping stones to have a productive lifestyle (KMH, 2017). Schools are not only a place for academics, but may be a place where children and adolescents may share their problems in a safe environment and learn to deal with them effectively. This paper explores the use of effective psychosocial interventions such as Solution Focused Therapies, Group Therapies, Interpersonal Therapies, Family Therapies and Cognitive Behavioral Therapies in helping adolescents and children to cope with problems.

INTRODUCTION

Gamification is considered as a solution for enhancing work motivation and employee performance. The basic idea behind the application of gamification as a performance-enhancing intervention process is our love, as human beings, to play games. And, since time immemorial, gaming is a popular form of recreation (Nicholson 2013). As per the findings of Bright, Harvey and Wheeler (1985), people enjoy being involved in one or other forms of games. Games merge fun with challenges and sometimes include components that are difficult to learn, explore and master. There are games which challenge our cognition, and that will provide opportunities to persevere. Further, each game has the potential to givem experiences of success and thereby to feel right about them.

A game board which can be dated back to approximately 5870 +/- 240 BC verifies that Neolithic people had leisure time to win or lose at games of chance or skill (Rollefson 1992). Puddephatt (2003) has explored on how people engage in strategic activity in the context of a chess game, where he posits that serious players often view, experience, and enact various aspects of the game in different ways than their casual counterparts. He argues that life is usually very much like a game, as the processes of strategic interaction often associated with gaming activity are adopted widely throughout everyday life.

Childhood may be thought of the early years of human development, while adolescence is considered to be the transitional stage from childhood to adulthood. Good mental and physical health supports young people in managing the challenges they encounter during their development (SHE, 2014).

The Word Health Organization estimates that around 10-20% of children and adolescents around the world experience mental disorders, and around half of all mental illnesses start by the age of 14. Unless these children are treated, such problems may greatly affect children's development, their education and their potential to live satisfying and productive lives (WHO, 2013). NMHS studied the mental morbidity among adolescents in the age group of 13 to 17 years old in India and found that the overall prevalence of any mental morbidity was 7.3% (NMHS, 2016).

The World Health Organization also estimates that 150 million girls and 73 million boys under 18 are victims of sexual violence. A study by the Ministry of Women and Child Development (MWCD) in 2007 indicated that Children between the ages of 5-12 are at the greatest risk for abuse and exploitation in India - 69% children reported physical abuse and 50% children reported emotional abuse with 83% children indicating that their abusers were their parents (Childline, 2017).

Mental health should also be a feature of all school health promotion initiatives. Schools can play an important role in the mental health and well-being of their students and staff. Obtaining the skills needed for academic success can contribute to a better life quality in students. A positive school environment can promote good mental health in students and staff; in turn, good mental health of students and staff can promote academic performance in students and reduce staff absenteeism. Bullying and feelings of not being accepted by peers and teachers contributes to poor mental health in students (SHE, 2014).

Thus, it is evident that children and adolescents are not immune to adversity and mental health problems. They too can greatly benefit from psychosocial intervention.

Objectives

1. To create awareness on the need of child and adolescent mental health.
2. To suggest time effective psychosocial interventions.
3. To highlight the effectiveness of brief therapies with children and adolescents.

Background and Rationale

Traditional psychotherapies have functioned on the view that individuals are doomed to the consequences of their early childhood experiences. Therapy involved an unrestricted number of sessions mainly exploring the client's past, focusing on what went wrong and the unconscious mind. Thus, in this view the client has little control over bringing about big changes in their lives.

The key aspects of Brief Therapies may be summarized as follows:

1. The client and the therapist focus on working on a certain aspect of a person's life that is contributing to their distress.
2. The therapist directly and actively promotes client functioning and also shows a positive belief in the client's ability to change.
3. The client is assigned activities to complete outside the therapeutic session, emphasizing client activity rather than passivity.
4. Therapy is time limited which fuels the process of change in the client.
5. The client is encouraged to act towards change rather than suffer.

The use of short term therapy with children and adolescents is not novel but can be traced back to its use with the first child psychotherapy patient, Little Hans. Schmidt (1996), states that researchers usually attribute plasticity in developmental process as the key to making childhood and adolescence an ideal time for short term therapy. According to Phillips and Johnston (1954), "Children are highly amenable to psychological treatment; because they are growing and changing, the forward surge can be used to heighten participation, lessen pathology, and shorten treatment (Schmidt, 1996).

SOLUTION FOCUSED BRIEF PSYCHOTHERAPY: SOLUTIONS THROUGH STRENGTHS

The rationale behind Solution Focused Brief Psychotherapy (SFBT) has its origins in Milton Erickson's view that humans possess the capability to solve their own problems though they may not be aware of what causes it, and that little changes in behavior can lead to big changes, while solving the problem (Gladding, 2016).

Teachers frequently use some form of behavior management therapy for children, particularly with special needs children in order to bring about some change in their behavior (Bender, 1998). Though highly effective, it also has its drawbacks – it is time consuming, requires great effort to control variables that are a part of the intervention, and requires the teacher to possess adequate training, however many a times the training requirement is not met (Quigney & Studer, 1999).

Solution Focused Brief Psychotherapy focuses on the child finding a solution or reaching a goal, rather than the problem and helps reduce stigmatizing labels by reframing them using more positive terms. For example, an angry child may instead be called a child who is passionate.

Quigney and Studer (1999), have suggested the use of Solution Focused Brief Psychotherapy in the classroom in a four step process to counter the drawbacks of Behavior Management

1. *Goal Setting:* The student takes responsibility for his behavior and sets a goal that focuses on a positive solution rather than the problem. Thus, instead of the child stating his goal as "I don't want to be mean" he may say "I want to be kind."
2. *Tracking Exceptional Times:* Rather than focusing on the times the child displays problem behavior, the teacher focuses on all those instances wherein the child has displayed goal behavior. This shows the child that his goal is not impossible, it is already occurring in some instances and he has the capability to meet his goals.
3. *Envisioning the Future:* This involves asking the child about a hypothetical situation that may occur in the future, and how they can resolve it with a positive behavior. The question should use the future tense. This allows the child to think about positive behavior that he can use and shows him that his behavior is not static but can change.

4. *Tasks:* The child is given tasks to complete in contexts other than the class. Caution should be taken to assign only those tasks that the child has previously achieved.

Cepukiene and Pakrosnis (2011) evaluated the effect of Solution focused brief psychotherapy among foster care adolescents in Lithuania, where a large number of minors are becoming orphaned due to violence and neglect. These children often face mental health issues such as depression and drug abuse. The research assessed two components, behavior difficulties which involves conflicts with others, and perceived somatic and cognitive difficulties which included perception of physical health difficulties, pains, sleep and appetite difficulties, dissatisfaction with one's ability to comprehend new information, bad memory, and attention difficulties.

The research was conducted at seven foster care homes in Lithuania, and consisted of a treatment group and a control group. Participants could attend a maximum of 5 sessions of therapy. Pre treatment and post treatment evaluations were made. The behavior and perceived somatic difficulties and cognitive difficulties were assessed by using Standardized Interview for the Evaluation of Adolescents' Problems. Between group comparisons; effect size, reliable and clinically significant change methods were used to assess the outcome of the therapy

Results indicated the effectiveness of Solution Focused Brief Psychotherapy wherein 31% of the treatment group participants reached reliable and clinically significant change in the area of behavior and 29% in the area of perceived somatic and cognitive difficulties. Thus, solution focused brief psychotherapy in this study was more effective in treating behavioral difficulties than cognitive and perceptual difficulties (Cepukiene & Pakrosnis, 2011).

COGNITIVE BEHAVIOR THERAPY: MANAGING THOUGHTS

Cognitive behavioral therapy (CBT) is a short-term therapy technique based on the idea of cognitive patterns and the way events are interpreted influence how individuals feel and behave. Accordingly, distorted thinking leads to misery and behavioral problems, while realistic and more positive thinking realistically enables individuals to deal effectively with problems that come their way.

Martin and Thienemann studied the outcomes of Group Cognitive Behavior Therapy with family involvement in Middle School Children with Obsessive Compulsive Disorder (OCD). The participants composed fourteen children in the age group of 8- 14 years old who had a primary diagnosis of OCD. The children along with their parents participated in a group CBT program on a weekly basis. The duration of each session was 90 minutes and the total number of sessions was 14.

The children met with a therapist for an hour, while parents simultaneously met with another therapist in every session. Both, children and parents learnt the same skills. Group leaders involved a child and adolescent psychologist as well as a child and adolescent psychiatrist, each with cognitive-behavior therapy training and experience treating pediatric OCD.

The protocol used included psycho-education, use of a fear thermometer and development of a symptom hierarchy, cognitive therapy encompassing constructive self-talk, cognitive restructuring, and cultivating detachment, trial exposure-re-exposure (E/RP) tasks in a collaborative atmosphere, and joint decision-making about parents' participation in OCD rituals. During weeks 8 through 13, E/RP continues, with movement up the symptom hierarchy, addressing individual concerns of family, wrap-up session and party. Each session also included checking homework, completion of brief questionnaires, and planning of new homework.

The Children's Yale-Brown Obsessive-Compulsive Scale (CY-BOCS), National Institute of Mental Health-Global Obsessive-Compulsive Scales and Clinical Global Impression of Improvement (NIMH-GOCS; NIMH-CGI-I), Child Obsessive Compulsive Impact Scale—Child and Parent versions (COIS-C/P), Children's Depression Inventory (CDI), Multidimensional Anxiety Scale for Children

(MASC), and the Child Behavior Checklist (CBCL) were used as pre-treatment and post- treatment measures to assess the severity of the children's behavior. T-tests and eta square statistics were used as statistical methods.

Results of the study indicated that there was a reduction in symptoms of anxiety, depression, parent rated problem behaviors, and internalizing problems. Though the researchers expected children to help each other during the group CBT sessions, this was not the case; rather, children tended to focus on their own problem. Getting the children to complete their therapeutic homework was a hurdle, however greater parental involvement showed greater adherence. A major limitation of this study was the absence of a control group (Martin & Thienemann, 2005).

Research by Benazon, Ager and Rosenberg studied the effects of CBT in children and adolescents with OCD who had never received any treatment for the disorder. Participants included 16 patients, in the age group of 8-17 years. A number of scales were used to assess the severity of the disorder, including The Schedule for Affective Disorders and Schizophrenia for School-Age Children-Lifetime version. A licensed psychologist confirmed the presence of OCD in the participants as per the criteria laid down by DSM-IV. Participants received twelve 60 minute sessions of CBT over a span of three to four months.

The goals during the sessions included psycho education, cognitive training, mapping OCD, exposure and response prevention and relapse prevention. A number of statistical methods such as paired t-tests and Cohen's d were used. Patients with OCD showed a major decline in OCD symptom severity.

The study provides evidence in favor of the proposition that CBT in the absence of medication is a feasible means of treating childhood OCD. Parents are usually hesitant to agree to treating children with medication, thus CBT may serve as an effective alternative to psychopharmacology. The study was unable to conclude whether the efficacy of CBT extends to more severe patients, and was limited by the absence of a non-randomized and non-medicated group (Benazon, Ager, & Rosenberg, 2002).

Studies have also shown the effectiveness of Trauma-Focused Cognitive Behavior Therapy (TF-CBT) in helping children and adolescents cope with particularly stressful situations. O'Callaghan et at assessed the efficacy of TF-CBT in reducing mental health issues such as depression and anxiety in war affected , sexually exploited girls in Congo. The sample consisted of fifty two girls in the age groups of 12 to 17 years, assigned to either a TF-CBT treatment group or a wait-list control group. The TF-CBT group experienced considerably larger reductions in trauma symptoms as well as symptoms of depression and anxiety, conduct problems, and pro-social behavior (O'Callaghan et al., 2013).

Research by King et al (2000) sought to assess the efficiency of child and caregiver participation in the cognitive-behavioral treatment of sexually abused children with posttraumatic stress symptoms.

The participants comprised of thirty-six sexually abused children in the age group of 5–17 years who were randomly assigned to a child-alone cognitive-behavioral treatment condition, a family cognitive-behavioral treatment condition, or a waiting-list control condition.

According to the findings, children who received treatment showed significant improvements in posttraumatic stress disorder symptoms and self-reports of fear and anxiety as compared to the controls. There was also considerable improvement in parent-completed measures and clinician ratings of global functioning. Parental involvement did not ameliorate the effectiveness of cognitive-behavioral therapy. Improvement was seen at the 12 week follow up assessment (King et al., 2000).

FAMILY THERAPY: BASIC UNIT TOWARDS HEALING

Family therapy or family counseling is a form of treatment that is designed to address specific issues affecting the health and functioning of a family. It can be used to help a family through a difficult period of time, a major transition, or mental or behavioral health problems in family members ("Family Therapy", 2014). Behavioral or emotional problems in children are common reasons to visit a family therapist. A child's problems do not exist in a vacuum; they exist in the context of the family and will likely need to be addressed within the context of the family (Herkov, 2016).

Diamond et conducted a study to find out the efficacy of Attachment-Based Family Therapy (ABFT). The main objective was to design a treatment manual and adherence measure for attachment-based family therapy (ABFT) for adolescent depression and to collect pilot data on the treatment's efficacy.

The duration of research was 2 years, 32 adolescents who met DSM-III-R criteria for major depressive disorder (MDD) were randomly assigned to 12 weeks of ABFT or a 6-week, minimal-contact, waitlist control group. The sample was 78% female and 69% African American; 69% were from low-income, inner-city communities.

The results of the study suggested that at post-treatment, 81% of the patients treated with ABFT no longer met criteria for MDD, in contrast with 47% of patients in the waitlist group. Mixed factorial analyses of variance revealed that, compared to the to waitlist group, patients treated with ABFT showed a significantly greater reduction in both depressive and anxiety symptoms and family conflict. Of the 15 treated cases assessed at the follow-up, 13 patients (87%) continued to not meet criteria for MDD 6 months after treatment ended. Thus ABFT appears to be a promising treatment and worthy of further development (Diamond et al., 2002).

Another study was conducted by Family Acceptance Project (FAP), a research and intervention initiative to study the influence of family reactions on the health and mental health of LGBT adolescents and young adults.

The measure of family acceptance was developed based on individual in-depth interviews of 24 hr each with 53 socioeconomically diverse Latino and non-Latino white self-identified LGBT adolescents and their families in urban, suburban, and rural communities across California. Interviews were conducted in English and Spanish, audio-taped, translated, and transcribed. Each participant provided narrative descriptions of family interaction and experiences related to gender identity and expression, sexual orientation, cultural and religious beliefs, family, school and community life, and sources of support and described instances or examples of times when parents, foster parents, caregivers, and guardians had shown acceptance and support of the adolescent's LGBT identity.

From these transcripts, a list of 55 positive family experiences (comments, behaviors, and interactions) was generated. 55 close-ended items were created that assessed the presence and frequency of each accepting parental or caregiver reaction to participants' sexual orientation and gender expression when they were teenagers (ages 13–19). At least three close-ended items were generated for each type of outwardly observable accepting reaction documented in the transcripts. (Ryan et al., 2009).

The findings showed that family acceptance did not vary based on gender, sexual identity, or transgender identity. Family acceptance in adolescence is associated with young adult positive health outcomes and is protective for negative health outcomes and the influence of family acceptance persists, even after control for background characteristics (Ryan et al., 2010).

The study was limited as the sample was not representative of the LGBT population (Russell, 2003).

INTERPERSONAL THERAPY: RESOLVING INTERPERSONAL PROBLEMS

Interpersonal therapy is a structured, time-limited therapy that typically works intensely on established interpersonal issues. The underlying belief of interpersonal therapy is that psychological symptoms (such as depression) are often a response to difficulties we have interacting with others. The resulting symptoms can then also affect the quality of these interactions, causing a cycle. The thought process behind the therapy is that once a person is capable of interacting more effectively with those around them, the psychological symptoms can improve.

The time-limited or 'brief' aspect of IPT therapy means that this type of therapy will always have an end date (around 12-16 sessions is considered the norm) and will focus on just a couple of key issues. For this reason, this therapy is best suited to those with identifiable problems (Limited, 2009).

Mufson et al studied the efficacy of Interpersonal Therapy in a controlled, 12-week, clinical trial of Interpersonal Psychotherapy for Depressed Adolescents (IPT-A). 48 adolescents who in the age group of 12 to 18 years and met the criteria for Major Depressive Disorder as per DSM III-R were assigned in a random manner to either weekly IPT-A or clinical monitoring. A "blind" independent evaluator assessed their symptoms, social functioning, and social problem-solving skills on a biweekly basis. Results indicated that Participants who received IPT-A reported a significant reduction in depressive symptoms and made much progress in overall social functioning, functioning with friends, and specific problem-solving skills

The study contained certain limitations, 32 out of 48 participants completed the research, and participants were mainly Latino and low socio-economic adolescents.(Mufsom et al., 1999)

Tang et al evaluated the outcomes of intensive interpersonal psychotherapy for depressed adolescents with suicidal risk (IPT-A-IN) as opposed to with treatment as usual (TAU) at schools. Adolescents aged 12–18 year completed the Beck Depression Inventory-II, the Beck Scale for Suicide Ideation, the Beck Anxiety Inventory and the Beck Hopelessness Scale for screening for suicidal risk. 73 who received a screening of depression with suicidal risk were randomly assigned to the IPT-A-IN or TAU group. Analysis of covariance (ANCOVA) was used as a statistical measure. Results showed that school-based IPT-A-IN was more effective at reducing severity of depression, suicidal ideation, anxiety, and hopelessness in depressed adolescents with suicide risk in schools as compared to TAU (Tang et al., 2009).

FUTURE DIRECTION

Many of the researches discussed are limited due to their small sample size, thus generalizations cannot be made. A few of them lack a control group and follow up assessment. Hence further research is needed to assess the effectiveness of brief psychotherapies.

However, through the researches discussed, it is evident that brief psychotherapies are effective for use with children and adolescents, who can easily adapt to change. These therapies provided a relatively quick and short term solution to a problem, rather than the long winding route that traditional therapies take. Children and adolescents world over are in need of assistance with mental health, thus brief psychotherapies may be used with them to help them reach the fullest of their potential and lead a satisfying life, that will help them become competent adults. The application of these brief psychotherapies can be well applied in school settings where children and adolescents spend most of their time. Schools can provide the students and staff with adequate professional help. Family can also be involved in this process. This in turn would enhance the mental health of children and adolescents and help them remain healthy.

CONCLUSION

Children and adolescents may face many adversities and challenges, and if left untreated, this could cause adverse effects for them throughout life. Children and adolescents adapt easily, and thus Brief therapies are beneficial for them as they can bring about change in themselves in a short time. In instances wherein parents are uneasy with giving their child medication, Brief Therapies serves as a solution with no or very little harm.

Solution Focused Brief Psychotherapies can help children focus on goals and positive behavior, and show them that what they want to achieve is possible, rather than focusing on what is wrong with the child. Cognitive Behavior Therapy can be used to help children understand how maladaptive thoughts negatively affect one's life, and instead use strategies to change their cognition. Family Therapy can tap on the child receiving support from the basic unit of his or her environment by providing the parents with education on the child's difficulty. Thus support, acceptance and guidance from parents can have positive impact on the treatment process. Interpersonal therapy could deal with current relationships more effectively. It also helps in learning to express emotions in an appropriate and healthy manner thus reducing the conflict and improving interactions with others.

However an important aspect to be noted is that every child or adolescent is unique and different from the other. The experiences and trauma faced by one may not be the same as the other. Hence the use of a specific therapy or an eclectic view can be considered accordingly. This would help a child or an adolescent to deal with situations, may help schools enhance mental health of the students and also help abused children to reduce trauma and overcome it.

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ABOUT THE AUTHORS

LAREINA RANDOLFINA D'SOUZA

MR. JOYSON ELTON D'SOUZA

Students of MA PART I, Child Development and Child Psychology. Department of Psychology, Parvatibai Chowgule College Margao

PSYCHIATRIC SOCIAL WORK IN PERINATAL MENTAL HEALTH CARE SETTINGS IN INDIA

G. Ragesh,
Ameer Hamza &
K. Sajitha

ABSTRACT

Women with perinatal psychiatric disorders and their family members may face multiple psychosocial issues. Psychiatric Social Work (PSW) is a specialized filed of social work which is capable to address perinatal mental health issues. PSW has preventive, promotive, curative and rehabilitative functions in perinatal mental health settings. Knowledge and skills in psychiatric diagnosis; reproductive health and child health; skills in psychosocial assessment and interventions; and sensitivity to sociocultural aspects are essential for psychiatric social workers (PSWs). A PSW works as a clinician, case worker, group worker, case manager, psychotherapist, counselor, trainer, researcher, coordinator, an advocate of the patient and family etc. There is vast scope for psychiatric social work practice, training and research in perinatal mental health care settings in Indian scenario.

Key words: perinatal psychiatry, clinical social work, maternal mental health, perinatal social work, psychosocial interventions

INTRODUCTION

In many of the low and lower-middle-income countries, the major focus is on preventing or reducing maternal mortality rate and pregnancy related complications than the mental health of mothers. Recently the perinatal mental health of women has become subject of research and mental health interventions for mothers have been started at least in few lower-middle-income countries. Pregnancy and postnatal periods are very crucial and maternal mental health may get affected during this period and mothers may develop anxiety, mood and psychotic disorders during this period which has both biological and psychosocial etiology and this psychiatric disorders may cause even for maternal mortality (Howard et al., 2014; Kumar, 1994; O'Hara & Wisner, 2014; Oates, 2003). Perinatal psychiatric disorders impair mothers' function and are associated with suboptimal development, ill health and may result in increasing infant mortality rate (O'Hara & Wisner, 2014; V. Patel, DeSouza, & Rodrigues, 2003; V. Patel & Prince, 2006). Fathers also can experience difficulties associated to their partner's pregnancy and the birth of a new baby as a stressful life event filled with new challenges and adjustment to new roles and responsibilities (Condon, 2006; Goodman, 2004; Massoudi, Hwang, & Wickberg, 2016; Paulson & Bazemore, 2010). These findings indicate that the

mental health problems of mother may affect the whole family and all the family members require health care providers' attention.

The first Mother-Baby Unit in India was established in July 2009 at the National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, as a five bedded facility for admitting mother-infant dyads, managed by a multidisciplinary team consists of psychiatrists, psychiatric social workers, psychologists and nurses (Chandra, Desai, Reddy, Thippeswamy, & Saraf, 2015). Studies in Indian settings found high prevalence (9.18%- 48.5%) of perinatal depression and other psychiatric disorders (Ajinkya, Jadhav, & Srivastava, 2013; Chandra et al., 2015; Gupta, Kishore, Mala, Ramji, & Aggarwal, 2013; Hegde et al., 2012; A. R. Johnson et al., 2015; H. L. Patel et al., 2015; Shrestha, Hazrah, & Sagar, 2015). Women with perinatal psychiatric disorders and their families face multiple psychosocial issues during this period. Economic deprivation, poor marital relationships, presence of gender preference (preference to have male baby) either in mother or in a family member, domestic violence, lower levels of practical help and emotional support, relationship difficulties with in-laws and own parents, adverse life events during pregnancy are the few psychosocial risk factors associated to perinatal mental health complications in India (Chandran, Tharyan, Muliyil, & Abraham, 2002; Rodrigues, Patel, Jaswal, & De Souza, 2003; Supraja, Varghese, Desai, & Chandra, 2016). A study conducted by Anu et.al, (2015) in Bangalore, has found multiple psychosocial issues among women with perinatal psychiatric disorders and their family, those are;

- poor understanding about illness in patient and family members
- stigma related to mental illness in patient and family members
- difficulties in activities of daily living and impaired occupational functioning
- duress from family members to have another baby within short gap of last delivery and family planning related issues
- mothers with unhealthy coping strategies
- inadequate social support
- anxiety related to pregnancy and child birth
- impaired mother-baby bonding
- separation from baby due to interpersonal issues with family members
- domestic violence against mothers
- interpersonal relationship issues among family members of both patient and spouse
- marital discord and separation
- early marriage
- poverty and financial issues
- care giver burden in spouse and other family members
- legal issues related to property, domestic violence etc.
- housing related issues
- high negative expressed emotions in spouses and family members
- issues related to gender of baby
- seeking magico-religious help for curing psychiatric disorders and complication followed by it (e.g. getting delayed treatment, abuse etc.)
- abortion and grief related issues
- inadequate parenting skills in both parents
- mothers with intellectual disabilities and associated difficulties
- mental health issues or substance use disorder in spouses
- developmental delay in babies and associated disturbances in parents etc. (Anu et al., 2015)

Apart with these issues; women and family may come up with problems related decision making on pregnancy, adoption, child protection etc. All these findings show that mental health issues of women during perinatal period have direct and indirect impact on all family members. As perinatal mental illness has both biological and psychosocial etiology; a multidisciplinary team consists of psychiatrists, nurses, psychologists and social workers is required to address this complex issue.

PSYCHIATRIC SOCIAL WORK PRACTICE IN PERINATAL MENTAL HEALTH CARE SETTING IN INDIA

Social work, as a profession committed to enable and empower to achieve optimum level of functioning at the individual, family and community realms. It is defined as a "practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing" (IFSW, 2014).

Psychiatric social work is a specialty practice area of social work (NASW, 2016). The magnitude of psychosocial issues associated to perinatal psychiatric disorders in India, demands psychosocial interventions from psychiatric social workers. Psychiatric social worker helps individuals, families, and communities respond to psychosocial issues that emerge during the period from pre-conception through an infant's first year of life and performs services in a variety of settings including private practice, hospitals, community mental health, primary care, and other agencies (NASW, 2016).

A psychiatric social worker should have adequate knowledge in psychiatric illnesses and; skills in making psychiatric diagnosis; knowledge in reproductive health and child health; skills in psychosocial assessment, psychosocial interventions especially in psychotherapeutics. The knowledge base of psychiatric social work includes theories of biological, psychological, and social development; diversity and cultural competency; interpersonal relationships; family and group dynamics; mental disorders; addictions; impacts of illness, trauma, or injury; and the effects of the physical, social, and cultural environment. Knowledge of the Diagnostic and Statistical Manual (DSM) or International Classification of Diseases (ICD) - Classification of Mental and Behavioral Disorders is critical so that social workers can be conversant with other mental health clinicians (APA, 2013; Ragesh, Hamza, & Sajitha, 2015; WHO, 1992).

Psychiatric social worker is notable for the variety of his or her roles, including that of team member and team leader in a multi-disciplinary setting. In perinatal mental health care setting; psychiatric social worker works as a clinician, case worker, group worker, psychotherapist, counselor, trainer, researcher, coordinator of some clinical and psychosocial services, an advocate of the client and family, case manager etc. Social case work, social group work, community organization as methods of social work and case management approach gives better result (Laken & Ager, 1996; Ragesh, Sajitha, & Hamza, 2016; G. Ragesh et al., 2015). Psychiatric social worker in the perinatal mental health settings, he or she extends his or her services not just for the mother but with her spouse, baby, other family members and the community at large; for preventive, promotive, curative and rehabilitative purposes.

PSYCHIATRIC SOCIAL WORK ASSESSMENT

In perinatal mental health care setting - whether it is mother-baby psychiatric unit or in intensive care unit or general hospital or clinic or community setting or inpatient and outpatient division; the psychiatric social worker starts interventions with psychosocial assessment. The psychosocial factors have two fold effects. The first one is as reasons or triggering or maintaining factor for developing mental health complications and the other one is the impact of mental illness in individual, family and community (G Ragesh et al., 2015). All these factors should be seriously taken care for preventive, promotive, curative, developmental and rehabilitative interventions. Assessment should cover individual aspects of mother; infant; mother-infant dyad; marital and familial; financial and all other social milieu (G Ragesh et al., 2015). Bio-psycho-social framework may be adopted in perinatal setting for the psychosocial assessment and psychiatric social worker should address the rights and social justice of persons with illnesses and their family for comprehensive understanding of the problems and interventions followed by (Engel, 1980; G Ragesh et al., 2015). Based on the assessment, a psychosocial diagnosis and the psychosocial intervention plan could be made. Case

theory approach also provides a framework to formulate assessments that are clear and directly related to the real-world problems clients present (Bisman, 1999). Understanding cases in a family perspective may widen the scope of interventions in psychiatric social work.

PSYCHIATRIC SOCIAL WORK INTERVENTIONS

Authors have briefed the psychiatric social work interventions for the mother, mother-baby dyads, baby, family and in community.

Interventions for mother

Helping pregnant mothers and her family to connect with maternal health programmes and referring to Integrated Child Development Services (ICDS) are important (GOI, 1975). This may help to reduce maternal and infant mortality rate and to provide a happy pregnancy and post delivery period. Helping the mother to cope up with pregnancy loss and other reproductive trauma are also important.

Vulnerable mothers should be supported by a health care provider during the perinatal period for preventing the onset of illness during the period and psychosocial and psychological intervention may be helpful to prevent perinatal mental illness (Brugha et al., 2000; C.-L. Dennis, 2005). Identifying vulnerable mothers and providing promotive and preventive interventions such as enhancing more support from family members, counseling, early identification and early interventions are important in reducing maternal mental health complications.

Once the psychiatric illness is diagnosed, depends on the nature of illness, the psychiatric social worker provides psycho education about mental illness, insight facilitation and adopt relapse prevention strategies. Different modalities of psychological therapies such as interpersonal psychotherapy, cognitive behavior therapy, trauma focused therapy, supportive psychotherapy and other psychosocial interventions may be considered to treat psychiatric disorders in both outpatient and inpatient settings (Berardelli et al., 2015; Cooper, Murray, Wilson, & Romaniuk, 2003; Cuijpers, Cristea, Karyotaki, Reijnders, & Huibers, 2016; C. L. Dennis & Hodnett, 2007; Dimidjian et al., 2016; Green, Haber, Frey, & McCabe, 2015; J. E. Johnson et al., 2016; Tyano, Keren, Herrman, & Cox, 2010). Breast feeding education is essential for all mothers. If the mother is with maternal-foetal attachment difficulties, the psychiatric social worker has to consider interventions to address the same.

Providing 24/7 telephonic helpline for managing emergency would be a great help for mothers with perinatal psychiatric disorders. Mothers may be referred for disability assessment to avail welfare measures are also may be considered. Some mothers may face crisis in terms of abandonment and lack of support due to interpersonal issues with family members. Crisis intervention has to be considered and both mother and baby may require shelter or placement services. Networking and advocacy with various organizations may require helping mothers in this situation.

Interventions for Mother-infant dyad

In many cases, mothers may develop poor bonding with their new born. Both objective and subjective bonding assessment would give better understanding of mother-infant relationship. Structured assessment is required for this. Mother-baby bonding interventions are required when impaired bonding develops. A psychiatric social worker may consider video feedback intervention as a mode of intervention to enhance mother-infant relationship, along with other mother-baby bonding interventions (Reddy et al., 2014).

Recently, the child welfare and child rights movement has become stronger in India. In this context, the parenting competency or right to child custody of the mother with mental illness or intellectual disability may be questionable. Psychiatric social workers can help the family, treating team, child welfare and other legal machinery to answer the question of whether the mother can take care of the baby or not. Here, the psychiatric social worker may do an in-depth structured

assessment of the mother-baby bonding (both objective and subjective bonding), safety of the child. Incompetent mothers may be recommended for parenting skills training. If the mother is not competent and not amenable for parenting skills training or not improved with the parenting skills training, in the absence of a surrogate mother in family and the if the safety of the baby is questionable; the child may be sent for legal adoption or foster care after discussion with the family members and with their consent.

If there are legal problems related to domestic violence or marital or family matters, the psychiatric social worker may refer the case to appropriate centers for legal aid. Also, psychiatric social worker may provide rehabilitation services; women and child protection services; advocacy and networking for availing social welfare services or benefits and other services for mother and baby.

Interventions for baby

Babies of mothers with perinatal psychiatric disorders exposed to psychotropic medication during pregnancy and during lactation period; and if babies are suffering from nutritional deficiency may develop neurodevelopmental problems (Chambers, Johnson, Dick, Felix, & Jones, 1996; Gentile & Galbally, 2011; Jones, Lacro, Johnson, & Adams, 1989; Nulman et al., 1997; K Yoshida, Smith, Craggs, & Kumar, 1998; Keiko Yoshida, Smith, Craggs, & Kumar, 1997). Doing development screening for babies and appropriate referrals for further evaluation and interventions may help in addressing the developmental problems in babies and may prevent or reduce disabilities. The baby may be referred to appropriate centers under ICDS and health care systems for early childhood care, health care and development services whenever required (GOI, 1975). If the baby is found to be a victim of violence or abuse in any manner, a psychiatric social worker should take necessary action to protect the baby and may consider separation from mother and may refer to child welfare committee for further protection services (CHILDLINE, 1996).

Working with spouse and family

Psycho education about mental illness for spouses and family members are essential to improve their understanding about illness which helps to develop a positive attitude among them towards the patients and enhance support and better care.

Spouses also may experience difficulties during the perinatal period. Special focus has to be given for spouses' emotional health. Separate individual sessions with spouses addressing their concerns, knowledge about illness etc. will help to enhance their support to mother and baby as well as may help to improve their emotional health. The role of spouses in caring of mother with psychiatric illness and babies has to be discussed and ensure their adequate involvement in care for both mother and baby. They may require continuous education on individual basis on the use of contraceptives. Sometimes spouses and other family members involved in caregiving may require individual counseling or referral for psychiatric evaluation and interventions.

If the couples face marital issues during the perinatal period, it may worsen mental health of the mother. Marital therapy or counseling may help to strengthen the cupules subsystem. In some cases, couple may require preconception counseling. If the couple cannot have babies due to physical or psychiatric complications, they may require adoption counseling and guidance if they are planning for adoption or foster care. Contraception counseling is important for all couples to ensure birth spacing and it should be provided regularly. In case of abortion or death of new born, grief counseling or therapy may be required for both mother and spouse. Pre-discharge counseling to all family members including the mother has to be given. This will ensure treatment adherence as well.

Family counseling or therapy may be considered by including other family members when family discord is present which may help to solve the family issues such as domestic violence and interpersonal difficulties and which also enhances family support. Non-biomedical explanatory

models are common in women and families with postpartum psychosis (Thippeswamy, Dahale, Desai, & Chandra, 2015). It is observed that the family members seeking magico-religious solutions for perinatal psychiatric disorders. Magico-religious beliefs and related practices may harm the health of the mother and baby and this issue has to be addressed on time. Reporting of the exploitation to the appropriate legal system may be considered after consultation with the family.

Group interventions

As group interventions have showed better results in managing many psychiatric disorders, psychiatric social worker may conduct group intervention for mothers, care givers (mother or siblings or in-laws of patient) and spouses (Green et al., 2015; G. Ragesh et al., 2015; Tirado Muñoz, Gilchrist, & Torrens Melich, 2015). This will help to enhance knowledge about illness, support and to improve hygiene practices.

In Indian context it is very commonly found that spouses are not actively involved in sharing responsibilities in providing care to mother and babies. In this situation group intervention specifically for spouses will help to increase their knowledge about illness and enhance support to mother and babies as well as attending group session would be a support for spouses themselves (G. Ragesh et al., 2015).

Parenting education and parenting skills training can also be provided in group or individual basis. Group interventions can be conducted in both outpatient and inpatient settings. Information on services for women and children and family welfare services also may be provided in the group session. Group interventions may be considered to address specific problems of pregnant and delivered mothers (Itkovics et al., 2007).

Community interventions

Developing and distribution of information, education and communication (IEC) materials and other public health education strategies to may enhance knowledge about the perinatal psychiatric disorders in community. Training programmes for health workers, screening of pregnant ladies and recently delivered mothers etc. may help in prevention and early identification of perinatal mental health issues (Chandra et al., 2015; Ragesh et al., 2016; G. Ragesh et al., 2015; Rahman et al., 2013; Reddy et al., 2014; Tyano et al., 2010). Home care programme may be considered for mothers with significant psychosocial disadvantages; severe medical or psychiatric complications and if their children are also with developmental challenges.

PSYCHIATRIC SOCIAL WORK TRAINING IN PERINATAL MENTAL HEALTH

Social work as a profession itself is in infancy stage in India. Perinatal mental health care facilities are very minimal in India. Psychiatric social work training opportunities in Indian subcontinent is also very minimal. Currently, psychiatric social work training in perinatal mental health is available only in few institutes such as National Institute of Mental Health and Neuro Sciences (NIMHANS), Bangalore and Institute of Mental Health and Neuro Sciences (IMHANS), Calicut. The training involves outpatient and inpatient care for women and their family members as part of pre-doctoral course (Master of Philosophy) in psychiatric social work. They are trained to provide all the above mentioned interventions under live supervision of trained and experienced psychiatric social workers along with other trainees from psychiatry, clinical psychology and psychiatric nursing. Trainees are encouraged to take up brief descriptive and interventional research projects related to psychosocial aspects of perinatal mental health.

CONCLUSION

Perinatal mental health is a neglected area in Indian mental health setting. Availing maternal mental health services are rights of mothers. Many mental health issues during pregnancy and after child birth are left unattended or unidentified which will adversely affect the mother and the baby in many ways. It is the duty of a psychiatric social worker to ensure rights based care for all. Multi-disciplinary team work gives better outcome. Treating team has to ensure comprehensive care for women with perinatal psychiatric disorders, their babies, spouses and other family members.

Psychiatric social workers have preventive, promotive, curative and rehabilitative roles in perinatal mental health settings considering the magnitude of psychosocial issues related to pregnancy and child birth in India. Individual work with mother, mother-baby bonding, involvement of spouses in mother and baby care, enhancing family support and developmental problems of babies are the areas in which the psychiatric social worker should give special focus. Regular follow-up with perinatal mental health care team has to be ensured. If the psychosocial issues are severe, psychiatric social worker should extend psychosocial intervention even beyond the typical perinatal period. Understanding the sociocultural, familial beliefs or custom and practices during perinatal period among Indian families is very important and psychiatric social worker has to be sensitive to these factors during the assessment and giving interventions for the mother, baby, spouse, family members and in community. Primary methods of social work have major application in perinatal mental health care setting. Psychiatric social work practice, training and research in perinatal mental health field are yet to be flourished in Indian scenario.

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ABOUT THE AUTHORS

G.RAGESH

Psychiatric Social Worker, Dept. of Psychiatric Social Work, Institute of Mental Health and Neuro Sciences (IMHANS), Government Medical College Campus, Calicut-8, Kerala, India. Phone (Mob): +919964494585. Email: rageshpsw@gmail.com

DR. MD. AMEER HAMZA

Additional Professor, Department of Psychiatric Social Work, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru, Karnataka State, India. PIN-560029. Email: drameerhamza@gmail.com

K.SAJITHA

Psychiatric Social Worker (freelance practitioner) Email: sajikvn@gmail.com

SIGNIFICANCE AND FEASIBILITY OF SOLUTION-FOCUSED BRIEF THERAPY IN THE INDIAN CONTEXT

Hamza. Hansi &
Subramanian. Lalitha

ABSTRACT

With the advancement in mental health treatment, people are now increasingly aware of non-pharmacological interventions. However, in today's fast paced life, conventional therapies may be time consuming and hence people tend to choose brief psychotherapies. Solution focused brief therapy (SFBT), an approach to psychotherapy is future-focused, goal-directed and focuses on solutions rather than problem-solving. Since its inception, a number of studies have documented the importance of SFBT in different conditions such as depression, anxiety, deliberate self-harm, obsessive compulsive disorder, schizophrenia, marital issues, caregiver burden and adolescent parenting. This article seeks to find out the significance and feasibility of SFBT in Indian settings through review of literature from over the past decade.

Keywords: Solution Focused Brief Therapy, Brief Psychotherapy, Indian setting

INTRODUCTION

Solution-Focused Brief Therapy (SFBT) is a postmodern approach to psychotherapy and is based upon the social constructivist view of reality. It implies that an individual's reality is developed through interactions and conversations with others. That is, language can be used as a tool for creating change in therapy by bringing up new descriptions or meaning for the client. The fundamental assumptions in SFBT are that clients have the skills to act effectively, but they often need help in identifying and developing those skills. Hence, solution-focused therapists work to help clients clarify their goals and work collaboratively to develop a series of steps that will help them achieve those goals.

SFBT has more than three decades of history ever since Steve de Shazer and his colleagues at Brief Family Therapy Centre in the USA developed it through inquisitive approach towards existing practice. It is briefer than other conventional therapies and it applies specific solutions to the client based on the context. The number of sessions may usually vary, but many authors have reported it takes about six sessions with a client and many at times it can be less as well as more than six. According to de Shazer et al (1986), solution-focused therapists believe that it is not important to know the details about the problem in order to start exploring possible solutions with the clients. Moreover, they believed that clients possess knowledge and resources about the solutions but

they just are not aware of their own knowledge. The solution-focused therapist's role is to open the client's eyes to a range of existing alternatives. As solution-focused therapists view the clients as an expert it makes SFBT a client-centered and collaborative process.

Unlike many other therapies, the focus of SFBT is not diagnosis or to look for negative aspects of the client but aim at finding workable solutions. Clients approaching the therapy often have a deterministic view where they believe that they are stuck with their problem and that will determine their future. Solution-focused therapists help the client redirect from problem-focused to solution-focused modality by assisting the client to focus onto the achievable goals and challenging clients to write different endings to their stories (O'Hanlon, cited in Bubenzer & West, 1993).

The interests of the solution-focused therapist are about the client's motivation to change, their knowledge about what they want to change and the methods to bring about this change. Hence, SFBT provides the therapists with a framework for assessing and utilizing client's motivation for change in order to establish, build, and maintain therapeutic progress and to help therapists know how they can begin and proceed in therapy with individuals. According to Gingerich & Eisengart (2000), the main therapeutic task in SFBT is to help clients to imagine how he or she would like things to be different and what takes it to make that happen.

The therapists practicing SFBT need to acquire minimum competence with the non-traditional questioning of their clients which includes exception questions, miracle questions, scaling questions, and coping questions in looking beyond past and present problems, to identify goals, and to foster and build on the client's current resources. The therapist's role is to stimulate and encourage the change through allowing the client to see how their life can be different if they take the step towards changing.

STAGES OF SFBT

According to Linda Seligman (2004) the practice of SFBT usually involves seven stages. They are:

Identifying a solvable complaint - involves clarifying the desire for the change and acknowledging the problems by providing an explanation of the formation of the problem to the client. It not only facilitates the development of goals in the intervention but also promotes the necessary change. This is done by using *Phrase questions* (e.g., What led you to make an appointment now?). The therapists use empathy, summarizing, paraphrasing, open-ended questions and other active listening skills to understand the client's situation in specific terms. In order to establish a baseline and identify the progress, the therapists use *Scaling questions* (clients are asked to rate on a ten-point scale how things are for that specific day). Using this technique, the client continually evaluates their progress, and this information also serves as a form of feedback. It is often used in outcome research as a measure of therapy effectiveness.

Establishing goals - According to O' hanlon & Weiner Davis (1989), goals are typical of three forms - Changing the doing of the problematic situation, Changing the viewing of the situation or the framework and Accessing the client's strength and resources. In establishing goals, the therapist uses two types of questioning – *Miracle question* ("If a miracle happened and the problem you have was solved overnight, how would you know it was solved, and what would be different?") and *O'Hanlon's videotape Question* (If you and I were to watch a videotape of your life in the future, what would you be doing on the tape that would show that things were better, 1987). This technique helps the client to imagine that the problem can be solved and facilitates hope. It also helps the therapist to discuss with the client how to make the miracle a reality. It provides therapist an idea of potential solutions to the client's concerns.

Designing and intervention - It helps the client to recognize that some changes have already been achieved. *Platform Questions* (what are the changes that have been already occurred? How did you make that happen?), *Coping questions* (how do you cope with the difficulties? What keeps you going? How do you manage day-to-day activities?), and *Exception questions* (tell me about the times when (the complaint) does not occur, or occurs less than at other times) are used in this stage. One of the main purposes of amplifying exceptions is to help the client identify how different they feel when they have a problem and when they do not.

Strategic tasks - are used to promote change in the client. The tasks are generally clearly written for client's understanding and agreement. Three types of task/client have been identified by De Shazer - *a visitor, a complainant or a customer*.

In a visitor-relationship, the client is sent or referred by others and has not come forward in search of help and is not suffering emotionally. Here the client is given no tasks. In a complainant-relationship, the client is suffering emotionally along with awareness of a problem, but does not see self as contributing to the problem and/or the solution. As the client generally expects change in others, the therapist gives an observation task to the client to help them to be aware of their own self and the situation. In a customer-relationship, the client has an insight into the problem and is willing to make changes in themselves. The clients are given behavioural tasks that involve actions to be completed.

Positive new behaviors and changes – As the solutions have taken effect, they are reviewed with the client. Therapist helps in highlighting the areas of strength and competence in the client and encourages them to find more solutions independently.

Stabilization - The client and therapist re-evaluate the problem and goal, considering the extent of progress and education about coping with any disappointments if they do not achieve or experience change as expected. Client and therapist review the necessity of continuation or termination of therapy.

Termination - initiated by the clients who have now accomplished their goals of finding solution to their problems.

EFFECTIVENESS OF SFBT IN CLINICAL POPULATION

Over a period of time solution focused approach has gained much importance among the other brief therapies in various settings. A systematic qualitative review of 43 controlled studies on the efficacy of SFBT reveals that 74% of studies reported significant positive benefit from SFBT. Even though a number of outcome studies have documented the effectiveness of SFBT in variety of clinical and non-clinical settings, in India, fewer studies have documented the treatment outcome of solution-focused therapy. Globally, the solution-focused brief therapy is practiced with clients diagnosed with depression.

In India the following studies on SFBT was done and was found to be effective. Koorankot & Shabnam (2017) in a case study, demonstrated the effectiveness of SFBT in reducing the depressive symptoms and also in addressing the therapeutic application in helping the bisexual client with related behavioural problems. Results revealed that the therapy helped the client gain insight into sexual orientation by becoming aware of their problems and by accepting them. It also helped the client to control impulsive and undesirable acts. Moreover, it helped him have better knowledge of his limitations. All these helped him come out of his depression.

Reddy et. al, (2016) evaluated the effectiveness of SFBT on moderate depression and demonstrated significant differences in single subject research outcome design with baseline and treatment phase on Hamilton Depression Rating Scale (HAM-D). Considerable improvement were reported in symptoms such as difficulty in attention, concentration, memory, irritability and sad

mood, guilt feelings, lethargic, anhedonia, decreased sleep, decreased appetite and in scholastic performance.

Baijesh (2015) examined the effect of SFBT treatment program for adolescents with Social Anxiety Disorder. Results revealed significant improvement from pre-treatment to post- treatment on self-report measures of social anxiety symptoms, self-efficacy and clinician rating of anxiety among participants.

Koorankot, Mukherjee and Ashraf (2014), examined the outcome of SFBT in the context of a tribal community in India, to find out the applicability of solution focused practice in Indian community mental health settings. Results revealed significant differences in pre-post test scores on the Beck Depression Inventory-II (BDI-II), indicating improvement in domains of affect, work, and satisfaction.

BENEFITS OF SOLUTION FOCUSED BRIEF THERAPY

Often clients drop out of the therapeutic process while on long term as they do not see any expected improvements in the stipulated time frame and structural barriers such as financial constraints, loss of work hours, loss of motivation.

While both the problem and solution focussed therapeutic approaches are aimed at resolving client problems, the difference between these approaches lies in the manner in which clients change. Solution focused therapy focuses on the client's competence, possibilities and attempted solutions whereas the Problem focused therapy focuses on the client's problems, deficits, weaknesses, limitations.

In Solution-Focused therapy, the talk is focused on possible solutions, client's future and change whereas in Problem focused therapy, the talk is focused on client's problems, client's past & present stability.

In Solution-Focused approach, therapy is structured, time limited and therapists look for exceptions and possible solutions. The solutions are present within the client whereas in Problem focused approach, therapy is open ended, time unlimited and therapists look for enduring traits and causes of the problem. The solutions are outside the client.

CHALLENGES TO PSYCHOTHERAPY IN INDIAN SETTING

SFBT is specifically relevant in Indian context due to various factors such as limited time - demand of clients to solve their problems quickly within the stipulated time frame; financial constraints of clients to access long term therapies; shortage of appropriately trained and experienced experts and professionals - availability of less than 1 licensed clinical psychologist per 1 million population (as per Central Rehabilitation Registry, Rehabilitation Council of India, 2015).

In Indian clinical scenario, the type of clients that often seek help from psychotherapy are of the visitor or compliant relationship. Less than 40% are customer-relationship client which is more predominant in western scenario. Solution focused therapists believe that it is not important to know the details about the problem in order to start exploring possible solutions with the clients (de Shazer et al, 1986). Therefore, SFBT becomes more relevant and feasible that it is not necessary for the client to be aware of their problem because the only goal is the find a solution.

Solution-focused brief therapy can be a promising therapy for counsellors who want a practical and time-effective approach in school settings (Sklare, 2005). Franklin et al. (2001) examined the effectiveness of SFBT with children in a school setting and results revealed that the students showed positive changes in various behavioural problems and academic difficulties. Many

adolescents struggle with academic problems, personal problems or both, as they pass through various stages of life where SFBT appears to be ideally appropriate. It helps students enhance their self-esteem and belief in their own abilities.

Overall, we have limited resources to meet high demand and hence, the need for using time-limited and effective alternatives becomes more relevant.

CONCLUSION

The solution focused approach provides therapists with a framework for exploring and utilising clients' existing resources; their strengths, ideas and theories of how change occurs. It helps the client to redirect their thinking from being problem-focused to solution-focused. This can often be a difficult task for the clients who have lived with a particular concern for many years. Techniques such as the miracle question and exception questions can serve as useful tools for inspiring new ways of thinking and generating ideas for solution building and the establishment of a preferred future. Compared to other conventional therapies, preliminary research findings of SFBT have proven to be efficacious, economical and feasible in Indian context. More research needs to be done in order to provide empirical support for the approach.

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ABOUT THE AUTHORS

HAMZA. HANSI

MPhil Clinical Psychology Student, Department of Psychology, Sri Ramachandra University, Chennai. Contact: hansihamza66@gmail.com

SUBRAMANIAN. LALITHA

Lecturer, Department of Clinical Psychology, Sri Ramachandra University, Chennai.
Contact: anarsi246@gmail.com

SOLUTION FOCUSED BRIEF THERAPY AND HEALTH PSYCHOLOGY: A REVIEW

Soumya N &
Abdul Salam

ABSTRACT

Solution Focused Brief Therapy (SFBT), a goal orient therapy focus on a person's present and future circumstances rather than past. In this therapy symptoms or issues bring a person to therapy are not typically targeted. Health psychology is the study of psychological and behavioral process in health, illness and health care. It is concerned with understanding how psychological, behavioral and cultural factors contribute to physical health and illness. Psychological factors can affect health directly.

This is a review of studies which examines the effectiveness of solution focused practice in health related issues. The relevant studies were identified from Pub Med and Google scholar data bases. This review shows that five studies were reported in application of SFBT on health related issues. Out of five studies two studies were case studies, one qualitative study and other two were pilot studies from 2003-2014 and was limited to published studies in health psychology. This paper which discuss about all these studies with respect to research methodology, conceptualization and other implications. The findings suggest that solution focused brief therapy affect the health related issues. SFBT is effective for patients when developing effective coping responses the stressors associated with chronic physical diseases and pain.

Key words: - SFBT, health related issues, chronic pain

INTRODUCTION

Solution Focused Brief Therapy (SFBT), a goal orient therapy focus on a person's present and future circumstances rather than past. In this therapy symptoms or issues bring a person to therapy are not typically targeted. SFBT, is as its name suggests, brief and focuses on solutions instead of problems. SFBT is a goal –oriented, future-oriented and solution focused models. According to Egan (2003) SFBT has moved away from focusing on clients problems. It focuses on current and future hopes rather than past causes. Solution focused therapy which emphasizes people's resources and resilience and how these can be used in the pursuit of purposeful positive change. Solution focused cognitive processing is characterized by a style of thinking that focus on the problems and their causes. Solution focused thinking style can be expected to be associated with well-being and positive affect.

In this therapy, the therapists determine the skills, abilities and resources and develop a vision of the future successfully. SFBT keeping people in therapy for longer period of time and promoted realistic solutions as quickly as possible. The therapy developed into very effectively. Today SFBT have been applied into wide variety of fields including schools, organizationsional settings and other settings and help to improve personal goals and interpersonal relationships.

SFBT aim to help identifying and developing skills in their life, which helps to people experiencing difficulty, find tools they can use immediately to manage symptoms and cope with challenges. This therapy focuses a vision of one's future and then determining how internal abilities can be enhanced in order to attain the desired outcome. Therapist who practice SFBT attempt to guide people in therapy through the process of recognizing what is working for them, help them explore how best to continue practicing those strategies and encourage them to acknowledge and celebrate success. In addition therapists of SFBT support people in therapy as they experiment with new problem-solving approaches.SFBT has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatments. Since its origins in the mid-1980s, solution-focused brief therapy has proved to be an effective intervention across the whole range of problems presentations (chris Iveson, 2002).

Health psychology focuses on how psychological, biological and social factors influence health and illness. Health psychologists study the factors that allow people to be healthy, recover from an illness or cope with a chronic condition. They are experts in the intersection of health and behavior and are in demand as a part of integrated health care delivery teams working with other doctors to provide whole person health care.

Health psychology a specialty area focuses on how bio psychosocial factors impact our physical health. Health psychologist don't treat the disease itself, but try to find ways to help the individuals who is suffering progress his or her life by better understanding how the mind and body work together.

There is devastating sign that altering people's health related behavior can have a major effect on some of the important causes of mortality and morbidity. Behavior plays an important role in people's health, for example smoking; being physically inactive or poor diet can cause a huge number of diseases. Health psychologists deliver a non-traditional method to understanding our health. One purpose of this field is to notify and teach people, helping them understand that they can take control of their overall well-being. When patients understand how and why their bodies are answering to physical problems, they are better able to accept explanations. Health psychologists can help patients like Rick manage chronic conditions or help them find ways to avoid preventable diseases by living a healthy lifestyle. Ideally, health psychology is where medicine and psychology work together to mediate the relationship between disease, thought, and behavior.

The underlying principles and techniques of solution focused practice are taken from Solution Focused Brief Therapy (SFBT). SFBT is practiced by a wide variety of practitioners from differing professional backgrounds. At the heart of this approach is sensitivity to individual differences, with what the individual brings to the work (i.e. their strengths and abilities) being placed at the center of behavior change conversations.

Until newly the mainstream of SFBT research has focused on the application and effectiveness of SFBT in family therapy and counseling in mental health and educational settings. However, there is now an emerging indication base on the use of solution focused practice in health-related settings.SFBT is an approach aimed at attaining a patient's goals or 'preferred future' through recognizing and using their expertise. SFBT may have significant efficacy in helping those with chronic physical disorders to live improved, meaningful lives.

This is a review of studies which examines the effectiveness of solution focused practice in health related issues. This is a review of studies which examines the effectiveness of solution focused practice in health related issues. The relevant studies were identified from Pub Med and Google scholar data bases. This review shows that five studies were reported in application of SFBT on health related issues. Out of five studies two studies were case studies, one qualitative study and other two were pilot studies from 2003-2014 and was limited to published studies in health psychology.

EFFECTIVENESS OF SFBT IN HEALTH RELATED ISSUES

Arvand J.et.al (2012) conducted a case study on depression in patients with chronic hepatitis B: an experience on individual solution focused therapy.Hepatitis B as a chronic illness associated with some psychological problems such as depression, anxiety, stress and impaired health related quality of life. One of the most important significances of psychiatric problems is reduced patient compliance with prolonged therapeutic regimens. Chrohn's disease patients have impaired quality of life. This study measured the feasibility and effect of psychological interventions in the management offatigue.Psychotherapy, such as solution– focused therapy, may help these patients to resolve psychiatric problems, rise quality of life and completion of therapeutic regimens. Solution-focused therapy is effective for patients when developing effective coping responses to the stressors related with chronic illnesses. In this case study, describes two patients with decreasing depression in chronic hepatitis B. They conducted solution focused therapy for 5 sessions, each session 1 hour once a week. This technique was helpful to decrease symptoms and signs of depression within 5 weeks.(Arvand J. et.al, 2012). Individual SFBT, as short term psychotherapy, is effective on reducing symptoms of depression in patients with chronic hepatitis B. So, it is recommended to take into account counseling and psychotherapy, especially SFT as a brief and short term method, in patients with chronic hepatitis B, mainly those who suffer from depression. (Arvand,J.et.al., 2012).

Viner, R.M, Christie, D. & Taylor(2003) conducted a pilot study on motivational or solution focused intervention improves HbA1C in adolescents with type 1 diabetes. This pilot study find out the motivational and solution-focused therapy group intervention to progressglycaemic control in young people 11-17 years with poorly controlled Type 1 diabetes (mean annual HbA1c >8.5%) (Viner, R.M, Christie, D. & Taylor 2003). The method of the study was Seventy-seven subjects agreed to be assessed for a pilot non-randomized controlled trial. Subjects completed psychological questionnaires and were given feedback designed to encourage entry into the intervention. Twenty-one young people opted to enter the intervention groups (cases). Two intervention groups consisting of five to six subjects were conducted in each age band 10-13 years and 14-17 years (Viner, R.M, & Taylor 2003).Twenty of those who did not opt to join the groups were randomly selected to act as controls. Cases and controls were well matched for age, HbA1c, duration of diabetes and socio-economic status. These pilot data suggest that a motivational/solution-focused group intervention is promising in improving HbA1c in adolescents and should be investigated further in a randomized controlled trial.

Vogelarr, L(2011) conducted a study on Solution focused therapy: a promising new tool in the management of fatigue in Crohn's disease patients psychological interventions for the management of fatigue in Crohn's disease.Crohn's disease patients have a decreased Quality of Life (QoL) which is in part due to extreme fatigue. In a pilot study they prospectively evaluated the feasibility and effect of psychological interventions in the management of fatigue. The method of the study was the Patients with quiescent Crohn's disease and a high fatigue score according to the Checklist Individual Strength were randomized to Problem Solving Therapy (PST), Solution Focused Therapy (SFT) or to a control group (treatment as usual, TAU). Patients finished the Inflammatory Bowel Disease Questionnaire, the EuroQol-5D, and the Trimbos questionnaire for Costs.(TheVogelarr, L., 2011).results shows that Twenty-nine patients were included (12 TAU, 9 PST, 8 SFT), of these 72% were female, mean age was 31 years (range 20-50). (Vogelarr, L.,2011).The SFT group enhanced on the fatigue scale in 85.7% of the patients, in the PST group 60% showed enhanced fatigue scores

and in the TAU group 45.5%. Although not significant, in both intervention groups the QoL increased. Medical costs lowered in 57.1% of the patients in the SFT group, in the TAU 45.5% and the in PST group 20%. The dropout rate was highest in the PST group (44%; SFT 12.5%; TAU 8.3%). The findings suggest that PST and SFT both positively affect the fatigue and QoL scores in patients with Crohn's disease. SFT seems most feasible with fewer dropouts and is therefore a promising new tool in the management of fatigue in Crohn's disease patients.

Peterson, Y. (2005) Conducted a study on Family therapy treatment: working with obese children and their families with small steps and realistic goals

Childhood obesity treatment can be discussed from several points of view, and there are many forms of treatment. Solution-focused brief therapy (SFBT) and systemic family therapy can be beneficial in a wide variety of settings and settings such as social care, education and healthcare. (Peterson.Y, 2005).They can also be used wherever practitioners occasionally feel that they have very little impression on the patient and where the patient seems to be resistant to acknowledging his/her problem(Peterson.Y, 2005). Health professionals need to assist by starting to explain main goals and medical information in terms of a single, small, tangible and significant goal, described as the beginning of a new behavior, not as the end of something (Peterson.Y, 2005). This report emphasis on some useful tools and methods taken from casework examples from multidisciplinary obesity team meetings with more than 300 families during a 3-y project approximately between 2002 and 2003 at the Childhood Obesity Unit at University Hospital, Malmö. Other casework examples are taken from supervision and training professionals who are currently working with or are going to work with childhood obesity using a solution-focused model (Peterson.Y, 2005).The main objective of this report is to discuss and think about the difference between problem-solving and solution-building interview questions when it comes to treatment concerning how best to help children and parents with serious obesity health problems. The results suggest that there is a great need for treatment models and the prevention of childhood obesity now and in future, which presents an interesting and urgent challenge for open-minded thinking and new fields of research

EFFECTIVENESS OF SFBT IN CHRONIC PAIN

Dargon, P.J, Simm,R.& Murray,C.(2014) conducted a study on chronic pain patients This study suggested that Solution-Focused Brief Therapy (SFBT) may be effective in facilitating significant change for those living with chronic pain. This study aimed to additional this understanding through exploring the experiences of people living with chronic pain, who had attended an 8-week solution-focused pain management programme. The design of this study was conducted in consultation with a service-user advisory group, and employed a qualitative and explanatory design rooted in critical community psychology, participatory research frameworks and emancipatory disability research. (Dargon, P.J., 2014). Five participants were opted-in to the study following an opportunity sampling method of persons who had attended a programme in the last 18 months. The interview was transcribed into verbatim and it analyzed into thematic analysis. The five main themes were identified inthis study, such as solution focused group, the solution focused clinician, solutions and changes, assessing the pain management programme and challenges and improvements (Dargon, P.J., 2014). At last, clinical and research implications of the findings were discussed. Five main themes were identified: 'Accessing the pain management programme', 'a solution-focused group', 'the solution-focused clinician', 'Solutions and changes' and 'Challenges and improvements' (Dargon, P.J., 2014). Clinical and research implications of the findings are discussed.

CONCLUSION

This article is aimed at reviewing the SFBT in health psychology. Five studies were considered for the review out of five studies, two were case studies, one qualitative study and other two were pilot studies. There were limited to published studies in health psychology. The findings support that solution focused brief therapy affect health related issues. SFBT is effective for patient when developing effective coping responses that stressors associated with physical disease and pain.

Future directions of the research: -

1. Very little research has still been conducted on SFBT on health psychology. It is clear that SFBT research studies on health psychology have improved the years in terms of research methods and designs.
2. The next wave of research on SFBT must continue to improve on the quality of research designs and sample size has to be increased proportionately in health psychology.

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ABOUT THE AUTHORS

SOUMYA N

Post- Graduate student, Centre for health psychology, University of Hyderabad, Hyderabad, Telangana-500046. Email address: - soumyanenmini@gmail.com

DR. ABDUL SALAM K. P

Assistant professor and Head, Department of Clinical Psychology, IMHANS, Govt. Medical College Calicut, Kerala

EXTENT OF TIME SPENT ON SOCIAL NETWORKING SITE BY SPOUSE; PARTNER PERCEPTION AND QUALITY OF MARITAL LIFE AMONG YOUNG MARRIED COUPLES

Ms. Minu William &
Ms. Jibby Varghese

ABSTRACT

The present study examined the association between the extent of time spent on social networking sites (SNS) by spouse and quality of marital life, in a sample of 150 young couples, using the conceptual frame work of Jane Lanigan'ssociotechnological family model.Three tools were used, a structured questionnaires with two parts- section A: questionnaire for demographic variable , and section B: questionnaire for assessing the time spent on SNS by spouse, a likert scale for assessing partner perception of SNS use by spouse and a rating scales (marital quality scale by Dr. Shah ,1995) for assessing quality of marital life. Pilot study was conducted and study was found to be feasible. Majority of the study participants were using more than one SNS. As per the findings, Facebook and Watsappranked first, followed by Twitter and LinkedIn, among the different SNS used by study participants, Majority of the study participants were having a positive perception regarding the SNS usage of their spouses.Very few holds negative perception. Majority of the participants said that their spouse often spent quality time with children even though they spent too much time in SNS. Almost one fourth of the study participants spent one to two hours each day on online SNS. Most of the participants spent more than 2 hours on SNS. The good quality of marital life of study participants holds a downtrend with increasing duration of time spent on SNS by spouse. Most of the study participants have poor quality of marital life. There was significant association between the time spent on SNS and quality of marital life. The increasing usage of online SNS by spouse is associated with decreasing quality of marital life. There were significant association between quality of marital life of young couples and gender, occupation of spouse and number of children.

Keywords: Social networking sites; Quality of marital life; Young married couples.

INTRODUCTION

Expeditious expansion of internet in the last decades of 20th century has changed the lives of many people worldwide. Very significantly internet has brought the world into a single room. Rapid expansion of internet also expected to increase people's leisure opportunities. While an extreme increase in leisure time has never materialized, the extended research and casual evidence suggest that the use of technology has changed our lives: our work, education, leisure time, our perception of ourselves, our families and communities (Das, 2014). Social network sites (SNS) were web-based

services that allow individuals to construct a public or semi-public profile within a bounded system, articulate a list of other users with whom they share a connection, and view and traverse their list of connections and those made by others within the system. The nature andnomenclature of these connections may vary from site to site (cited in Journal of Leisure Research, 2014 p. 205). Facebook, Whatsapp, MySpace, and Twitter were among the most often mentioned SNSs .

With over forty five million users, India has the second largest number of people on SNS in the world. Social media statistics (2013) reported that, due to their accelerated development, neither creators of SNSs nor their users were ready to face the potential dangers and issues brought by theirinvention. They included cyber bullying (CNN news online, 2012 oct13), sexual exploitation of children (Preibusch et al, 2014), issues related to privacy and identity theft (Pantic,et.al.,2012), compulsive use, loss of connection with reality (Sprecher & Felmlee,2014), attachment to online relationships, and cyber affairs and infidelity (O'Dea & Campbell ,2014) . According to Aponte (2009) in the majority of cases, negative effects were not limited to individual users, but were likely to influence their entire families. Spouses' internet use may reduce the amount of time spent on other leisure pursuits with their families or with each other, increase opportunity to reconnect with long-lost friends and romantic partners, create an escape environment for those experiencing marital problems and even lead to virtual infidelity.

Since shared quality time is considered to be one of the key factors that contribute to stability and quality of marriage and family and life satisfaction, the interplay between the use of SNS by spouse, and their marital quality should be examined. Grohol & John (2015) in a study, on the relationship between social networking and marital happiness, the researchers measured the extent to which partners in these relationships utilized social networking sites such as Facebook, Twitter, and MySpace. They found that increased use of social networking is correlated with poorer marital happiness and a higher likelihood of a troubled relationship; alongwith thoughts of divorce. Many studies prove the high positive correlation between change in the interaction pattern between couples and adoption of social networking sites in family. Excessive use of social media has been associated with compulsive use, which may create psychological, social, school and/or work difficulties in a person's life. These phenomena, in turn, may trigger marriage unhappiness and, ultimately, divorce (cited in Hindustan times, 2014)

Survey report by the American Academy of Matrimonial Lawyers (2010) found that, four out of five lawyers reported an increasing number of divorce cases citing evidence derived from social networking usage .Further, the hike in divorce rates in India also accounts to the increasing use of social networking sites. Among the thirty seven percentage hike in the divorce rate of Kerala, at Kozhikode among one thousand and three hundred divorce petitions registered in the family Court, 20 percentage accounts to the infidelity and other problems related to social networkingusage. Middle-aged partners' when compared to the young couples identifies successful problem-solving strategies contribute to the sense that they have control over their relationship (Hirschberger et.al., 2009). Hence, the researcher selected young couples for the study. A good quality of marital life contributes to a better harmonious living and a positive mental health. Since family is the basic unit of society a better family contribute to a better society. The growing popularity of social networking sites SNS is shown to have impact on the quality of marital life, hence it will be worthwhile to study the effect of SNS on the quality of marital life as perceived by the partner.

Objectives

- Assess the partner's perception of social networking sites use by spouse
- Determine the extent of time spent on social networking sites by spouse as perceived by partner.
- Assess the quality of marital life of spouse, whose partner is active in social networking sites.

- Find out the association between extent of time spent on social networking sites by spouse and quality of marital life.
- Find out the association between quality of marital life and selected partner variables.

MATERIALS AND METHODS

Non experimental research approach with descriptive design was used. The research variables were extent of time spent on SNS by spouse, perception of the partner and quality of marital life as perceived by the partner. The screening and demographic variables were age in years, marital status, whether user of social networking site and whether partner is a regular user of social networking sites , gender, religion, educational status, educational status of spouse, occupational status, occupational status of spouse, duration of marital life, number of children, type of family, and place of stay . Through non probability convenience sampling, 150 young couples who were present at the railway station during the time of data collection who met the inclusion criteria at Kozhikode were sampled for the study. Tools used were Screening questions, Tool 1: section A: Self prepared structured questionnaire for demographic variable and section B: Self prepared structured questionnaire for assessing the time spent on SNS by spouse with total 6 items , Tool 2: Self prepared 21 items likert scale for assessing partner perception of SNS use by spouse. Each of the items have 4 options as; often, sometimes, rare and never. Among those items there were 11 negative statements and 10 positive statementsand Tool 3: a standardized four-point rating scale,Dr. Shah's marital quality rating scale for assessing quality of marital life(MQS). MQS is a 50-items, 12-factor, self-report scale developed to assess quality of marital-life and standardized on normal population in India. The` 12 factors understood, rejection, satisfaction, affection, despair, decision-making, discontent, dissolution-potential, dominance, self-disclosure, trust, and role functioning. There were 50 items in the tool of which 28 were the positive statements.

The formal permission for the study was obtained from the Kozhikode railway authority, southern railway and informed consent was obtained from the subjects. The investigator administered the tool and collected the responses. The ethical aspect of the research was maintained throughout the data collection.

RESULTS

Description of the pattern of use of social networking sites by young couples

The frequency and percentage distribution of pattern of social network use of young couples were summarized in the following tables.

Table 1: Distribution according to most frequently used SNS by study Participants (n=150)

Rank	Type of SNS	*f*	%
I.	Facebook &Watsapp	127	84.7
II	Twitter	27	18
III	LinkedIn	17	11.3

Facebook and Watsapp shares first rank in most frequently used SNS. Among the 150 study participants 127 (84.7 %) were using Facebook and Watsapp.Twitter with 27 (18%) users and Linkedin with 17 (11.3%) users, holds second and third rank respectively.

Table 2: Distribution according to most frequently used SNS by spouses of study Participants (n=150)

Rank	Type of SNS	*f*	%
I.	Facebook	129	86
II	Watsapp	114	76
III	Twitter	23	15.3

Facebook holds first rank in most frequently used SNS. Among the spouses of 150 study participants, 129 (86 %) were using Facebook Watsapp with 114 (76%) users and Twitter with 23 (15.3%) users holds second and third rank respectively as reported by study participants

Table 3: Distribution according to time spent on SNS by spouses of the study Participants (n=150)

Duration	*f*	%
Less than 1 hour	55	36.7
1 to 2 hour	33	22
More than 2 hour	62	41.3

Among the study subjects the duration of SNS use is said to be 1 to 2 hours per day and it constitute of 56(37.3%), 51(34%) says that they spent only less than 1 hour in SNS.

Analysis of the perception of young couples regarding the spouses ofthe study participant's social networking site usage

Perception means interpretation regarding social networking use of the partner by spouses of the study participants as measured by self-prepared likert scale

Table 4: Perception of study participants regarding their spouses SNS usage (n=150)

Perception	*f*	%
Positive (20-50)	92	61.3
Negative (51-80)	58	38.7

The majority 92 (61.30%) study subjects perceive the spouses of the study participants SNS usage positively, while 58 (38.7%) of subjects negatively perceive their spouses of the study participants SNS usage.

Assessment of quality of marital life of study participants, in comparison with time spent on SNS by their spouses.

The quality of marital life is computed by the Dr. Shas rating scale score,(50-99) range indicate good quality of marital life and ,(100-200) indicate poor quality of marital life

The results were presented in the following table

Table 5: Time spent on SNS by spouses of the study participants (n = 150)

Marital quality	< 1 hour		1 to 2 hour		>2 hour	
	f	%	f	%	f	%
Good (50-99)	33	60	20	60.6	21	33.9
Poor (100-200)	22	40	13	39.4	41	66.1

The good quality of marital life of study participants downtrend with increasing duration of time spent on SNS by spouse Majority of study participants 41(66.1%) whose spouses of the study participants were active in SNS greater than two hours per day have poor quality of marital life, when compared to the majority of study participants 33(60%) have good quality of marital life whose spouses of the study participants is active in SNS less than 1 hour per day.

Exploration of the Association of extent of time spent on social networking site by spouses of the study participants and the quality of marital life

The association between the extent of time spent on social networking site by spouses of the study participants and quality of marital life were determined by using Pearson's Chi square. The individual scores for extent of use of SNS were used for computation. The quality of marital life is computed by the Dr. Shas rating scale score.(50-99) range indicate good quality of marital life and ,(100-200) indicate poor quality of marital life .The results were presented in the following table

Table 6: Distribution of the participants based on the Association of extent of time spent on social networking site by spouses of the study participants and the quality of marital life (n = 150)

Variable	$\chi 2$ (df = 2)
MQS score and Extent of time spent on SNS by the spouses	10.112*

*Significant at 0.05 level

This indicates that there exists significant association between extent of time spent on social networking site by spouses of the study participants and the quality of marital life.

Determination of the association between the quality of marital life with the selected variables produced the following findings: The variables gender (p =.004), occupation of Spouses of the study participants (p = 0.37), number of children (p = 0.025) were significantly associated with quality of marital life of couples whose spouses were active in SNS.

DISCUSSION

Facebook and whatsapp were the SNS used by majority of the respondents and their spouses. The results are consistent with the social media statistics compiled by Wat Consult social media statistics (2012), which reports that Facebook, whatsapp, LinkedIn and Myspace cater to about 90 per cent of the users in the social media space. Raymore& et .al.,(2014) in their quantitative and qualitative research report into attitudes, behaviours and use of social networking sites, data indicated that, an average user of online SNS were seen to use it for approximately one hour to 2.5 hours per day. This finding were reflected in the present study, with the majority users used SNS for a timeperiod of one to two hours per day. The study result of declined quality of marital life among participants whose spouses are active in SNS is consistent with the study results of Correlation between Facebook and divorce by James Katz (2014). The study found a correlation between using social network sites (like Facebook), spousal troubles, and the divorce rate.

In a study titled family and marital satisfaction and the use of social network Technologies conducted by Iryna and Sharaievska (2012) to explores family and marital satisfaction and the use of social network technologies ,the results showed that using SNS is negatively correlated with marriage quality and happiness, and positively correlated with experiencing a troubled relationship and thinking about divorce. Similar findings of negative correlation between quality of marital life and SNS usage was found in the present study also. These correlations hold after a variety of economic, demographic, and psychological variables related to marriage well-being were taken into account. On analysis the correlation of various demographic variables its shows that marital satisfaction is positively correlated with age, economy, and efficacy oflife and associated with many psychological factors. This were comparable to the present study in which there were seen to be significant association between the occupation of spouse, gender, number of children and quality of marital life.

In the present study it's found that there is no significant relationship between duration of marital life and quality of marital life which were contrary to the result found in a study (Hirschberger et.al., 2009) saying, the penetration of SNS among the middle aged partners is not resulting in harmful outlooks whereas an increase in divorce rates, negative psychological impactsand poor quality of marital life, among the young couples.

CONCLUSION

This study concludes that:

- The study participants were having profiles in at least one online SNS. Majority of the study participants were using more than one SNS.
- Almost one fourth of the study participants spent one to two hours each day on online SNS. While the majority of spouse of study participants spent more than 2 hours on SNS
- Majority of the study participants were having a positive perception regarding their spouses SNS usage and very few holds negative perception
- Majority of the study participants were having poor quality of marital life.
- There was significant association between the time spent on SNS and quality of marital life which indicated that as the increasing usage of online SNS is associated with decreasing quality of marital life.

RECOMMENDATIONS

Author of this study recommend

1. A similar study with a larger sample size and including study participants from different areas.
2. The comparative study by selecting those couples who don't have profiles in any online SNS, and enrolling them in an SNS during the study period after which their marital quality can be assessed. A comparative group consisting of those who already were using SNS too can be maintained.
3. A similar study using Qualitative research approach. To better evaluate the lived experience, behaviour, and emotions etc, of the subjects using SNS.

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ABOUT THE AUTHORS

MS. MINU WILLIAM

Psychiatric Nursing Tutor, Institute Of Mental Health And Neuro Sciences, Kozhikode

MS. JIBBY VARGHESE

Associate Professor, Baby Memorial College Of Nursing, Kozhikode

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RISK FACTORS OF POOR ACADEMIC PERFORMANCE IN INDIAN CHILDREN: A PSYCHOSOCIAL PERSPECTIVE

Akhil. P

ABSTRACT

Poor scholastic performance is a major challenge faced by some students, their school teachers and parents in our society. There are several risk factors associated to the scholastic backwardness. Children usually fail in examination or become school dropouts if they are untreated for their academic backwardness and this will have a lifelong impact on their functioning. Early identification and remediation will make a huge difference in children's future.

INTRODUCTION

Education is essential for a person in this competitive world as academic achievements are considered as a measurement tool to evaluate one's life. Stress related to scholastic backwardness has a negative effect on the children and it has great impact on their future life. Many school going children are affected with scholastic backwardness and many of these children may not get sufficient attention and interventions to overcome their difficulties.

There are many risk factors which have significant role in scholastic backwardness such as family, environment, school, child, financial aspects, psychological, disease and medical factors (Aneja, Duhan, & Sangwan, 2016; Dev, 2016; Rutter & Madge, 1976; Satapathy, 2012). It is important to identify the risk factors for scholastic backwardness so that these children can be identified and the remedial measures be implemented. (Aneja et al., 2016; Dev, 2016; Rutter & Madge, 1976; Satapathy, 2012). The main objective of this paper is to describe the different factors causing scholastic backwardness in children from a psycho social perspective. The chief factors of scholastic backwardness are:

Intelligence and motivation of children: children with below average intelligence and children with poor Motivation to study and temperamental factors are also contributing (Johnson, 2017).

Family related factors: Few Indian studies emphasize that children perform well when there are facilities such as separate room to study, availability of electric power at home, separate table and other necessary items particularly for the child (Satapathy, 2012; Srinivas & Venkatkrishnan, 2016). Mothers' help will provide a significant positive growth in the school going children's

academic performance. So it is recommended that parents take care of academics at least in the lower classes (Srinivas & Venkatkrishnan, 2016). Broken family is one of the major issues in causing scholastic backwardness when there is parental disharmony, the child would have impaired study environment. This shows that family disharmony has adverse effect on scholastic performance of the children (Satapathy, 2012; Srinivas & Venkatkrishnan, 2016). Also the financial constraints are also a risk factor (Satapathy, 2012; Srinivas & Venkatkrishnan, 2016). When alcohol dependence is present in the family, scholastic performance of the children may be affected as they may not get proper guidance or attention from the family members (Gopakumar & Johns, 2017).

Influence of school and teachers: Teachers influence will affect the performance of the children in a positive way and also it will encourage the students to achieve the academic targets (Srinivas & Venkatkrishnan, 2016).

Environmental: When the children are living in war area or in a community where recurrent violence is happening, it may result in inadequate educational facilities.

Conflict with law: Children who are in conflict with the law may suffer from behavioural, emotional problems and educational issues (Luschei & Chudgar, 2017).

Financial aspects: Children from poor financial background appear to be backward in academics due to lack of facilities (Haneesh, Krishnakumar, Sukumaran, & Riyaz, 2013).

Illness or medical factors: Children with chronic and disabling illness are seen with academically challenged (Haneesh et al., 2013).

REMEDIES

Some remedial measures which may be considered are given below.

1. Awareness creation among parents and teachers
2. Early identification and referral to mental health professionals for assessment and early interventions
3. Treatment of medical causes
4. Intervention in family level to treat the pathology in the family
5. Behavioural interventions for children
6. Measures to avail adequate facilities in schools
7. Ensure adequate nutrition to the children
8. Additional support from teachers
9. Necessary changes in the policies and programmes of the government
10. Treatment for medical illness

CONCLUSION

Educational backwardness is an important issue in the current scenario. There are multiple factors contributing to it. Emergence of poor scholastic performance can be catastrophic to the children and also for the family. And scholastic backwardness can be a triggering point for many of the inappropriate behaviours and have a long-lasting impact on their growth. Remedial measure on time may help the children to achieve their best. Proper guidance to the parents and teachers and early identification can reduce the risk to a minimal level and can contribute to the development of the country as we are running short of competent human resources in the Indian context.

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ABOUT THE AUTHOR

AKHIL.P

is doing his Master of Philosophy course in Psychiatric Social Work at Institute of Mental Health and Neuro Sciences, Calicut, Kerala.

RESIDENTIAL EXPOSURE WITH RESPONSE PREVENTION: A TIME-EFFECTIVE INTERVENTION FOR A SEVERE AND CHRONIC CASE OF OCD

Sheetal Rose Jose &
Babu Paikkattu

ABSTRACT

Obsessive-Compulsive Disorder (OCD) is marked by persistent preoccupations and repetitive behaviors that correspond to obsessions. The primary treatment for OCD—exposure with response prevention (ERP)—directly targets psychological factors through two elements: exposure to triggers of compulsive rituals and prevention of ritualized response. Majority of clients undergo ERP on an out-patient basis, with a caregiver being assigned the role of a co-therapist to implement the treatment plan at home. This case study of a severe and chronic OCD patient opens doors to provide insights regarding time-effectiveness of ERP without any psychiatric medications, when administered by a qualified therapist co-residing with the client round the clock. The client, 'SV', presented with obsessions of contamination regarding masturbation and associated compulsions of cleaning everything directly or indirectly in contact with the act since 6 years. A single case-study design was employed, and information about presenting complaints, past, family, and personal history, premorbid functioning, and mental status were collected through a clinical interview. Severity of symptoms was assessed through Yale-Brown Obsessive-Compulsive Scale. ERP was done intensively, with a co-therapist residing with him on a daily round-the-clock basis. Obsessions were dealt with through intensive psychoeducation and cognitive restructuring. As part of relapse prevention, activity scheduling was done to enhance quality of time spent daily. After eleven sessions, the client reported that that his obsessions of contamination had reduced, and repetitive washing and cleaning were no longer an issue. Post-therapy scores on Y-BOCS indicated subclinical level of obsessions and compulsions, compared to the pre-therapy extreme severity of symptoms. This case study suggests that the outcome of ERP in treatment of OCD would be extremely favorable, even for treatment- resistant OCD, if done on a daily, round-the-clock basis with the client residing with the therapists. It sheds light on time-effectiveness of ERP when done as described.

Keywords: Obsessive- Compulsive Disorder, Exposure with Response Prevention, Cognitive Behavior Therapy

INTRODUCTION

Obsessive-Compulsive Disorder (OCD) is marked by persistent preoccupations and repetitive behaviors that correspond to the obsessions (Rosenberg & Kosslyn, 2014). The recommended treatment of choice for OCD is Cognitive-Behavioral Therapy (CBT; National Collaborating Centre for Mental Health, 2006) which refers to Exposure and Response Prevention (ERP) with or without

the inclusion of cognitive therapy strategies. ERP directly targets psychological factors through two elements: exposure to the triggers of compulsive rituals and prevention of the ritualized response.

There are several variants of ERP that are employed in treatment of OCD. In a meta-analysis of 24 outcome studies by Abramowitz (1996), the differences in outcome across variations in ERP procedures were reviewed. The four dimensions upon which ERP procedures varied throughout the OCD treatment literature were: (1) whether exposure sessions were supervised by the therapist or conducted by the patient on his or her own, (2) whether the evocative medium was real-life in-vivo presentation of stimuli, or imagined situations, (3) whether gradual exposure or flooding procedures were used, and (4) the totality of response prevention. Therapist-controlled exposure was associated with better outcome than self-controlled exposure. Using in-vivo and imaginal exposure together was superior to using in vivo alone. Combining complete response prevention with exposure was associated with better treatment gains than when partial response prevention was used. Also, therapy sessions that lasted longer were predictive of more improvement in symptoms.

This case-study proposes that intense therapist-controlled ERP done on a residential basis is time-effective, even in severe and chronic cases of OCD. Self-controlled ERP also needs to introduced gradually in the treatment sessions, and has to be complemented with psycho-education and cognitive restructuring techniques. Insight into the irrationality of obsessions is an important step towards a positive treatment outcome.

Significance of the Study

There are several outcome studies about the efficacy of ERP in the treatment of OCD. However, the number of treatment sessions (M=2.80 sessions per week, range= 1-5 sessions per week; M=14 sessions, range=4-24 sessions; M=7.54 weeks, range=2-28 weeks) recommended by studies conducted outside India (Abramowitz, 1996) may not contribute to the time-effectiveness of treatment. This study proposes a way to work around this. Conducting therapist-controlled complete response-prevention, which is not confined to the treatment sessions, may serve to enhance the time-effectiveness of the intervention (Foa et al., 2012).

Duration of the exposure is also a major factor in treatment outcome. Prolonged continuous exposure is more effective than short interrupted exposure (Rabavilas et al., 1976). This study proposes that ERP would be time-effective if administered continuously on a daily basis. The pairing of cognitive strategies is also postulated to contribute to a positive treatment outcome (Whittal et. al., 2005). This study provides insights into the time-effectiveness of ERP when paired with cognitive strategies, where the therapist has maximum control over response-prevention.

METHOD

Case Report: SV, a 24 year old unmarried Hindu male, discontinued MBBS after failing to pass the first year final exams. He is the only child of his parents and lived with them. He presented with complaints of repeated washing and cleaning following sexual urges and masturbation since 6 years, with insidious onset, continuous course, and deteriorating symptoms.

He was maintaining well till August 2010. When he joined for MBBS, there was a ragging incident in college, where his seniors asked him to demonstrate sexual intercourse with another roommate of his. When he refused saying he did not have any knowledge regarding the same, they showed him porn videos, and coerced him into imitating the same with his roommate. He gained sexual knowledge only at this time when he was aged 18 years, and started frequent masturbation. He would get sexual urges 3-4 times a day, and masturbate by watching porn on his phone. The frequency increased to 5-6 times in the following month. He felt contaminated after masturbating and started washing everything associated with it. He would wash the phone which he used to see the videos. He would wash his bedsheet and mattress repeatedly. He also washed his laptop. This reduced his concentration in studies, and he could not pass his first year exams. He left the hostel and came back home, where he attempted to write and pass his first year exams. He made two attempts, but failed at both.

He has been staying at home since 2011. The frequency of his masturbation reduced from 5-6 times to 4 times in a day. Following this, he would wash everything in the vicinity repeatedly. According to his parents, they have observed him taking several baths during a day, which lasted for more than an hour each. He was also seen washing clothes, bedsheets, pillow covers, doormats, etc. throughout the day. He would wash everything including the laptop after masturbating. His whole day involved only these activities.

Since 6 months, the frequency of masturbation has reduced from 3-4 times to 2 to 1 time a day. However, washing and cleaning has become more repetitive. He started washing even the car repeatedly whenever he drove it. He would change his clothes several times in a day. He used to wash the clothes of his parents as well if they came into contact with anything that was associated with his masturbation. He started becoming aggressive when anyone would stop him from washing. He stopped going out and would remain at home to wash and clean. He reported that he had severe disgust towards himself for masturbating, and that he was having sexual urges which are not normal. His appetite and sleep were normal. He has had several visits to psychiatrists, counsellors, and faith healers, but with no success. There is no history of head injury, brain trauma, epilepsy, mental retardation, psychotic symptoms, and persistent elated mood.

His father is a 52 year old general physician, and his mother is a 46 year old homemaker. Both parents are openly critical of the client. There is a history of seizure disorder in the paternal uncle.

Client attained sexual knowledge at the age of 18 years through his seniors, and has a negative, guilt-ridden attitude towards sex. His parents have not educated him in this regard and forbidden him from speaking about his sexual matters to them. Premorbidly, even though he was overprotected and pampered by his parents, he was adaptive and functional premorbidly.

On MSE, he seemed tensed and anxious. In possession of thought, obsessions and compulsions were elicited. In content of thought, preoccupation with sex, disgust with semen and masturbation, and ideas of helplessness regarding masturbation were found. Mood and affect were congruent (anxious), with cognitive functions intact and Grade III insight. He was provisionally diagnosed as having *Obsessive-Compulsive Disorder (Mixed Obsessional Thoughts and Acts)*.

The *Yale-Brown Obsessive Compulsive Scale* was administered to assess the severity of his obsessions and compulsions. The total score was 32, indicating *extreme severity of obsessions and compulsions.*

Case Conceptualization: The client's symptoms were precipitated by the ragging incident in his college. His lack of sexual knowledge further perpetuated his symptoms. His parents' unwillingness to discuss sexual issues and their complete ignorance in sexually educating him are other perpetuating factors. His unawareness about what is normal and what is not in terms of sexual health led him to explore his sexuality, and gratify himself through frequent masturbation, which served in maintaining his symptoms. This finally gave rise to his disgust with his bodily fluids and a subsequent obsession of contamination, which he tried to neutralize with his repeated washing and cleaning of any objects or people associated with his masturbation. The washing behavior was reinforced by an abating of his intrusive thoughts about contamination, until the time he next masturbated, and the cycle began again.

Exposure and Response Prevention was considered ideal, and the following assessment was done for formulation:

Cues	Feared consequence	Rituals	Avoidance
Masturbation	'Since it is a dirty act, anyone or anything that comes into contact will become dirty'	Repeated washing and cleaning of any object that comes in contact	No avoidance

Table 3.1: Formulation for ERP

Therapy Package: Two therapists (female and male) chose Cognitive Behavior Therapy as the mode of intervention. This was carried out on a residential basis (male co-therapist resided with the client). The therapy package is described as follows:

- Since his feared consequence was a result of a lack of accurate sexual knowledge, psychoeducation was the first step.
- To weaken the association between the obsession and dissipation of anxiety following the neutralising act of washing and cleaning, Exposure and Response Prevention would be used.
- To prevent relapse, the client's daily activities were structured through Activity Scheduling was recommended.
- Socratic questioning and guided discovery was instrumental in helping him carry on with his future pursuits, and the following goals were formulated.

The therapy was carried out in 11 sessions over 1 month. Pre-therapy scores were recorded, and at a three month follow-up, assessment was done to ascertain the post-therapy score.

Therapy Procedure: In the first three sessions, the therapist proceeded to work on the Case History and Mental Status Examination, and establish a therapeutic relationship. Yale-Brown Obsessive Compulsive Scale was administered for diagnostic clarification. Therapy was formulated, and the cues, rituals, feared consequences, and avoidance was identified. Cognitive Behavior Therapy (Exposure and Response Prevention combined with cognitive strategies) was chosen as the mode of intervention. His parents decided to let him reside with the co-therapist for a few months for therapy.

In Session 4, he was psycho-educated about his disorder and Exposure and Response Prevention. His unhelpful thoughts were challenged through the three-question technique. For homework, the client was asked to keep a diary recording his daily activities and how much time he spent in each of it.

In Session 5, he was psycho-educated about the concept of contamination, and the co-therapist engaged in a thorough education regarding sexual matters and what was considered normal and healthy in sexual matters. For homework, his activities were scheduled, and he was asked to follow the schedule.

In Session 6, the therapist asked him to identify the instances of washing and cleaning. The co-therapist psycho-educated him about the reality of contamination and tried to challenge his thoughts. Since the client showed no signs of acceptance, the co-therapist commenced with ERP proper, where he was exposed to the lesser contaminated cue ('contaminated' phone).After exposure, the client was told not to wash (the phone or his hands) repeatedly when he left the session. People who lived with him were assigned to check for unnecessary washing instances. For homework, he was given material to read on OCD, and asked to explain it for the next session. He was asked to follow the activity schedule strictly, and also to maintain a thought diary.

In Session 7, the client reported that even though he was getting the urge to wash, the co-therapist tried to engage him in other activities and prevented him from washing and cleaning till the end of the day. However, the washing and cleaning at the end of the day was rigorous. The co-therapist continued ERP with the client on a daily basis for one week, and there was a gradual reduction in his urge to wash and clean repeatedly. Challenging the authenticity of the contamination beliefs was also done regularly. For homework, he was asked to maintain the diary and the schedule of activities.

In Session 8, the client reported that he was not feeling an urge to wash or clean unnecessarily anymore. His anxiety about continuing his education in medicine was targeted. By Sessions 9 and 10, there were no instances of unnecessary washing or cleaning. The therapist and client worked on his study habits, and assigned homework accordingly.

In the concluding session, a summarization of all the sessions was done. The progress of the client was clearly shown to him, and he was asked to maintain the same and report to the therapist or co-therapist if he felt that he was on the verge of relapse. Y-BOCS was done to assess the post-therapy change.

RESULTS

The client, SV, who presented with obsessions of contamination following masturbation and compulsions of consequent washing and cleaning, was treated intensively with Exposure with Response Prevention as the main mode of intervention. His change over the sessions is noted as follows:

Session No.	Mood Check (0-100%)	Changes in Symptoms
4	10%	• Masturbated that morning followed by repetitive washing and cleaning • Irregular sleep patterns • Poor sexual knowledge
5	25%	• No masturbation • Busied himself with daily activities • Washing and cleaning frequencies unchanged
6	30%	• No masturbation • Engaging in daily activities reportedly helpful • Washing and cleaning frequencies unchanged
7 (After ERP proper)	50%	• No masturbation • Reduced washing and cleaning frequencies • Renewed insights about contamination • Regular sleep patterns
8-11	80-90%	• No unnecessary washing and cleaning • Reduced anxiety • Better informed on sexual matters

Table 4.1: Changes over Sessions in Mood and Symptoms

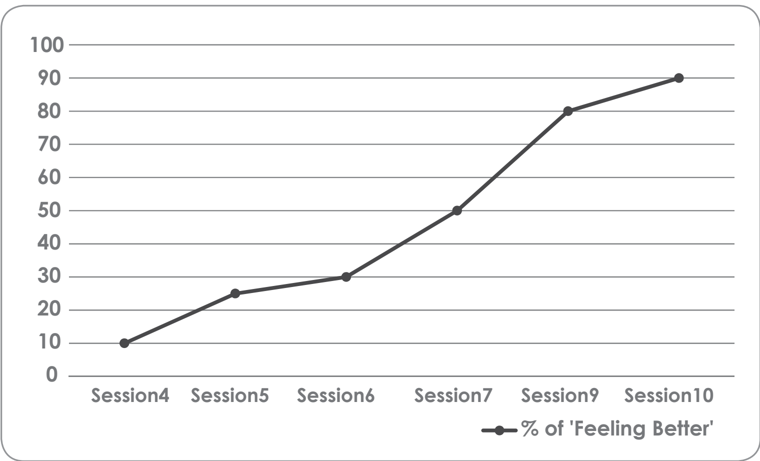

Fig 4.1: Self-reported Improvement in Mood over Sessions

Pre-therapy score on Y-BOCS was 32, indicating extreme severity of obsessions and compulsions. Post-therapy score on Y-BOCS was 6, indicating subclinical level of obsessions and compulsions.A follow-up done after 3 months revealed the client was not having any of the symptoms with which he presented for treatment.

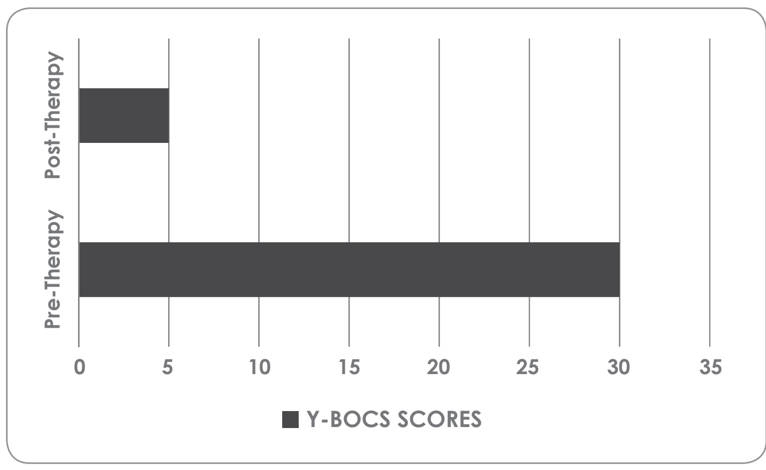

Fig. 4.2: Pre- and Post-Therapy Scores On Y-BOCS

DISCUSSION

Traditionally, Exposure with Response-Prevention is the evidence-based psychotherapy recommended for treatment of Obsessive-Compulsive Disorder. While the efficacy of ERP is already established, its time-effectiveness has been under-investigated.

The client, SV, who presented with obsessions of contamination following masturbation and compulsions of consequent washing and cleaning, was treated intensively with Exposure with Response Prevention as the main mode of intervention. When he first presented for treatment, his parents reported that they had visited several psychiatrists, counsellors, and faith healers for his condition. He regularly practiced yoga for mind control for 2 years, but with no avail. The therapist and co-therapist endeavored to use ERP in the most intensive way possible, as the client's condition was severe and chronic. Medication was not considered, as the precipitating factor of the condition was majorly psychological. The emphasis in this severe and chronic case is on the fact that the client was treated without medication and on a residential basis, where he resided with the co-therapist who was present round-the-clock to carry on the treatment continuously.

After administering ERP for 3-4 weeks, the client reported that that his obsessions of contamination had reduced, and repetitive washing and cleaning were no longer an issue. Post-therapy scores on Y-BOCS indicated subclinical level of obsessions and compulsions, compared to the pre-therapy extreme severity of symptoms. A follow-up done after 3 months revealed the client was not having any of the symptoms with which he presented for treatment. These facts imply the time-effectiveness of ERP when administered in such a manner.

There were several salient findings of the study. First, the client was psycho-educated by two different therapists (male and female) about his symptoms and its management. In this way, he could corroborate what he learned and what he was expected to do. It enhanced his confidence, as he perceived that he was being helped by two credible therapists, with whom he had a strong therapeutic alliance (Grayson et al., 1982, 1986).

Second, the client was under the supervision of a co-therapist, who resided with him round-the-clock. This co-therapist kept a strict check on the activities of the client, and implemented response prevention in a timely manner, which speeded the process of remission (Abramowitz, 1996; van Oppen et al., 2010). It is implied that the activities of the client outside the therapy setting require more supervision, and if supervised successfully, could lead to an alteration of the daily schedule.

In most cases, a family member is assigned as the co-therapist, and is written into the therapeutic contract to implement the therapy outside the therapy sessions. However, this may be highly unreliable, as the implementation directly depends upon the caregiver's attributes and their relationship with the client. It is observed frequently that family members may not be successful in implementing ERP in majority of the cases (Gillihan et al., 2012). In such cases, a trained co-therapist is considered a necessity to ensure successful implementation of the intervention. Residential treatments may be a more effective way of carrying out ERP; this is in line with the finding that continuous ERP is superior to interrupted ERP (Abramowitz, 1996).

Also, the therapy was implemented on a daily basis. In most cases, weekly sessions are held, leading to a delay and hindrance in remission (Abramowitz, 1996). In this case, gaps were not encouraged, and the client was made to attend sessions 4-5 days a week, while being subjected to ERP even where he resided. This seems to be the optimal arrangement to enhance the time-effectiveness of the intervention.

Cognitive strategies were included to help the client discover the rationality of his obsessions. It is also thought to further help in relapse prevention. The use of cognitive techniques further helped in maintaining the improvement in the client, as found in the reviewed literature (Solem et al., 2009; Whittal et al., 2005; Fisher and Wells, 2005; van Oppen et al., 2005).

These findings make it optimistic to recommend intense, continuous, and residentially-implemented Exposure with Response Prevention as an effective mainstream treatment modality, even in severe and chronic cases of OCD. It can also be recommended for clients who are reluctant to use pharmacotherapy for their symptoms.

CONCLUSION

When the therapy began, the client was having obsessions of contamination and disgust with bodily fluids and associated compulsions of washing and cleaning. A ragging incident at college and his lack of sexual knowledge were major factors contributing to his symptoms. Cognitive Behavior Therapy was chosen as the mode of intervention. The package was a combination of Exposure with Response Prevention and cognitive strategies. The client was educated about his disorder and symptoms. Exposure and Response Prevention was done intensively on a daily and residential basis to deal with his obsessions and compulsions. His fears about contamination were dealt with through intensive psychoeducation and three-question technique. His activities were scheduled to enhance the quality of time spent. He had difficulties with his study methods, and new ways of studying were suggested. The client adhered to the homework and treatment plan. By the concluding session, the client reported that that his sexual urges were controllable, his urge to masturbate had reduced drastically, and that repetitive washing and cleaning were no longer an issue for him. He also reported that he was better informed on sexual matters. His confidence in his abilities was slightly improved. His daily schedule was much more regular.

Implications: This case study suggests that the outcome of ERP in treatment of OCD would be extremely favorable, even for treatment- resistant OCD, if done on a daily, round-the-clock basis with the client residing with the therapists. It opens doors to provide insights regarding the time-effectiveness of ERP when implemented in an in-patient setting, with a qualified therapist co-residing with the client round the clock. It has strong implications for positive outcomes in treatment-resistant OCD cases. This also adds to the literature on the effectiveness of ERP, even when drug treatments are not administered.

LIMITATIONS AND FUTURE DIRECTIONS

- ERP was commenced abruptly without making an explicit hierarchy. The effectiveness of ERP with an explicit hierarchy can be studied in future.
- Family communication, which could not be targeted due to the unavailability of the family members, needs to be targeted. Family accommodation and expressed emotion are areas that need to be worked on in this case. This treatment variant of ERP can be applied to a larger sample of clients in order to extend into the efficacy literature.
- It can be paired with third-wave therapies, and the effect can be studied in order to ascertain if it can be more time-effective as compared to CBT alone.

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ABOUT THE AUTHORS

MS. SHEETAL ROSE JOSE

Psy.D. Trainee in Clinical Psychology (2015-2019), Sweekaar Academy of Rehabilitation Sciences, Secunderabad, Telengana

DR. BABU P

Assistant Professor, Department of Clinical Psychology, Sweekaar Academy of Rehabilitation Sciences, Secunderabad, Telengana)

Corresponding author Email address: antobabuclpsy@rediffmail.com

Phone number: 09700927417

Mailing address: Dr. Babu P., Assistant Professor, Department of Clinical Psychology, Sweekaar Academy of Rehabilitation Sciences, Upkaar Complex, Upkaar Junction, Secunderabad, Telengana- 500003

PSYCHOSOCIAL INTERVENTIONS FOR PTSD IN WAR-EXPOSED CHILDREN AND ADOLESCENTS: A REVIEW OF LITERATURE

Nishita Ravindra Tikekar,
Shyamoli Sarah Ivanka Menezes Sousa &
Eshani Chamdrashekhar Bakhle

INTRODUCTION

War is defined as a state of usually open and declared armed hostile conflict between states or nations as by land, sea or air ("Definition of WAR", n.d.). War and terrorism are man perpetrated acts of violence. The impact of war-related stressors may occur as the direct result of physical and visual impact, media exposure and social disruption (Purwar, Dhabal & Chakravarty, n.d.). In the armed conflicts children and adolescents are the ones who are most affected. The exposure to such events increases the chances of post-traumatic stress disorder, anxiety and depression in adolescents and children (Thabet, EL-Buhaisi & Vostanis, 2014). The impacts of war on a child are unimaginable as war displaces families from their home, some become orphans and some become physically disabled. The physical and emotional security that a child needs from parents is lost in the constant struggle of parents in wartime. Some children recover, some are traumatised for life and others rebel by accepting violence as the right way to live life and discover the power of weapons to terrorise and subjugate the weak (Menon, 2016).

POST-TRAUMATIC STRESS DISORDER

Post-Traumatic Stress Disorder (PTSD) is a trauma and stress related disorder that may develop after exposure to an event or ordeal in which death, severe physical harm or violence occurred or was threatened. Traumatic events that may trigger PTSD include violent personal assaults, natural or unnatural disasters, accidents, or military combat ("Cognitive Behavioral Therapy (CBT) for Treatment of PTSD", 2017). PTSD is diagnosed when the stress symptoms following exposure persist for over a month ("Narrative Exposure Therapy (NET)", 2017). Children and adolescents who are exposed to armed conflicts often tend to become violent and aggressive and losing their parents can results fewer sustainable resources which prevents them from growing in a safe and healthy environment (Thompson, 2014).

PSYCHOSOCIAL INTERVENTIONS

Psychosocial interventions are used to help guide the person back into a healthy state of being. That is the use of non-medicinal means to alter a person's behaviours and relationship with society in order to reduce the impact of the person's disorder or condition (Airth, n.d.). The following are psychological interventions.

Cognitive behavioural therapy was invented by a psychiatrist, Aaron Beck, in the 1960s. It is a form of psychotherapy which focuses on changing an individual's thoughts in order to change his or her behaviour and emotional state. CBT is based on a model which state that it's not events themselves that effect but the meaning we give them. If thoughts are too negative, it can block us from seeing things or doing things that don't fit. CBT is used to treat a wide range of issues in a person's life which include sleeping disorders, relationship problems, drug and alcohol abuse, anxiety and depression. It works by changing people's attitudes and behaviour by focusing on the thoughts, images, beliefs and attitudes that are held and how these processes relate to the way they behaves, as a way of dealing with emotional problems (Martin, 2016.)

Therapists who employ CBT for PTSD may encourage patients to re-evaluate their thinking patterns and assumptions to identify unhelpful patterns in thoughts. These are intended to help the person redefine their understanding of traumatic experiences, understanding of themselves and their ability to cope. Exposure to the trauma narrative and reminders of the trauma or emotions associated with the trauma, are often used to help the patient reduce avoidance and maladaptive associations with the trauma. This exposure is done in a controlled way. The goal is to create a sense of control, predictability to the patient, self-confidence and reduce escape and avoidance behaviours ("Cognitive Behavioral Therapy (CBT) for Treatment of PTSD", 2017).

In Narrative exposure therapy the patient constructs a narration about his whole life from birth till the present situation, while focusing on the detailed exploration of the traumatic experiences and traumatic memories. It is frequently used in community settings and with individuals who experienced trauma as result of political, cultural or social forces such as refugees. The story a person tells himself or herself about their life influences how the person perceives their experiences and wellbeing. The therapist asks the patient to describe his or her emotions, thoughts, sensory information and physiological responses in detail. The patient is asked to narrate the traumatic experience and relive the emotions experienced without losing connection to the present. Staying present is achieved by utilizing permanent reminders that the emotions and physical responses that occur in response to memories are linked to episodic facts. while narrating their whole life story, the patient does not need to choose one particular traumatic occurrence from numerous ones experienced across the lifespan. NET allows the patient the freedom to reflect on their entire life, cultivating a feeling of personal identity ("Narrative Exposure Therapy (NET)", 2017).

KIDNET is a narrative exposure therapy which aims at treating refugee children who are suffering from PTSD, in which children build a chronological narrative which include all trauma related events in their lives and is guided by the therapist ("KIDNET - Child Trends", 2011).

RATIONALE OF THE PAPER

Psychological distress from war is harmful to refugee children and adults regardless of racial or cultural background. Refugees may experience a sense of helplessness and despair. The most common mental health issue for refugees is post-traumatic stress disorder and related symptoms of depression, anxiety, inattention, sleeping difficulties, nightmares, and survival guilt (María Vargas, 2007).

Wounds from war are not just confined to the battle field. Refugees from conflict zones often continue to experience trauma from persecution, imprisonment, torture and resettlement for a long time (María Vargas, 2007).

The physical, sexual and emotional violence that children from war-zones experience ruins their innocence and impairs the very the foundations of their lives. It is important to address these issues as the children in war-zones suffer from severe psychological trauma which attenuates future perspectives and leaves a grave impact on their perception of the world.

OBJECTIVE

To determine time effective psychosocial interventions for PTSD in war-exposed children and adolescents.

METHOD

During the entire process the team read through twelve articles but included 8 in this review since it suited our criteria. The articles were then filters and only the key interventions used. These articles have been taken from journals like Researchgate and other information directories.

REVIEW OF LITERATURE

Most interventions that restore the mental health amongst children are categorised into two broad categories: psychological, psychiatric or psychosocial. The psychiatric approach aims to help the individual rather than the community as a whole. One major hurdle faced by many mental health professionals are the large cultural discrepancies. But since disorders are faced by people of most cultures psychiatric instruments are applied from one culture to another. These psychological and psychosocial interventions should be aimed at mass disasters by being realistic, short, focused, and services of local professionals can be used as well as extensive educational requirements. This is important as some interventions could be harmful in certain circumstances or might not be reliable and easy to apply (Analyti, 2012).

Amongst the psychiatric approach is the Cognitive Behavioural Behaviour Therapy (CBT) that generally has better results with adults. CBT was found to be more effective than CCT, non-directive supportive therapy (NST), and time-limited dynamic therapy (TL-DT) (Sagle, 2013). Significant reductions in post-traumatic stress, depressive and grief symptoms were reported (Ehntholt & Yule, 2006).

Narrative Exposure Therapy (NET) is based on CBT. It is a standardized short-term approach for the treatment of survivors of wars and torture, in which the participant constructs a detailed chronological account of the child's own bibliography into a coherent narrative. It emphasises life as a continuum including traumatic events, it creates a familiarity with these events and makes children confront the feelings it brings up (Ehntholt & Yule, 2006). KIDNET is the adapted child version of NET, with the assistance of play and visual aids to help children construct their story. KIDNET is claimed to be a successful approach for the treatment of traumatized child survivors. During this therapy children are encouraged imagine the future using colourful objects, paintings and flowers to project their hopes and goals. This teaches them that life events are continuous and can lead to a better and more hopeful future. Children drew scenes they remembered from their traumatic experiences and were encouraged to speak about their feelings and traumatic experiences. It is found to be very effective in reducing PTSD symptoms, emotional and behavioural symptoms

showed an increase in self-esteem and quality of social connections in children and adolescents (Jordans, Tol, Komproe & de Jong, 2009). Narrative exposure therapy is particularly beneficial in cases where individuals are suffering from repeated exposure to a variety of traumatic events (Sagle, 2013; Niaz, 2015) KIDNET when combined with MED RELAX therapy was found to significantly lower PTSD symptoms. Eighty-one per cent of the children in the KIDNET group improved at the six-month follow-up, while 71% of the children in the MED-RELAX group improved (Analyti, 2012; Sagle, 2013).

Rumination-focused Cognitive and Behavioural Interventions had high results with adolescent genocide survivors in Rwanda. However the drawback of this therapy is that one to one interaction might not be practical and economical in some situations. Its short and pragmatic method is preferred especially in war and disaster areas. Care must be taken however, not to inflict further harm by exposing patients to traumatic memories and not allowing them enough time, or treatment, to deal with these memories (Thabet, EL-Buhaisi & Vostanis, 2014; Smigelsky & Aten, 2014).

Creative-expressive approaches include storytelling, drawing, writing, playing, role-playing, and singing, dancing, playing music and performing psychodrama.

Role playing or dramatic play gives excellent results as well, as it encourages children to express themselves through the roles they undertake whilst facing their traumatic experiences and feelings that are mostly suppressed. It helps in defusing feelings, dealing with them, relieving stress and reducing anxiety reactions. Children are encouraged to express their anxieties and insecurities through their roles learn to externalise them which is usually extremely hard to achieve using words. These techniques seem to have much higher results on children below 14 years. Teenagers seem to respond better to more 'adult' interventions like group or individual psychotherapy. It was also conducted in traditional environments with the main aim of talking about ones experiences. (Thabet, Tawahina, El Sarraj & Vostanis, 2008; Analyti, 2012; Smigelsky & Aten, 2014)

The Developmental Trajectory for Refugees was another intervention used on children traumatised by way. It was based on a similar principle of imaginative play. The central part of the programme consists of working groups in Collective Centres for refugees; groups for children, adolescents and adults operated concurrently. No attempt was made to advise the participants, but simply a platform was created for social interaction, and tools were given with which they could build on their own resources. Individual and group expression was facilitated by a variety of media such as movement, human sculpting, performances, and creative and expressive games. Drawing exercises, rating scales and questionnaires with participants resulted in positive outcomes. On a basic level the programme provided friendship and recreational activities, at a deeper level it promoted the development of coping skills. Young participants developed cognitive, social and emotional competence and improved their self-esteem, which in turn enhanced resilience. However, the open-ended nature of the programme and the need to deploy experienced professionals raised questions of sustainability.

The Theatre Action Group is based on a similar concept. It creates a therapeutic space where children can express their emotions and discuss their problems. The members of TAG listen with care and respect and offer emotional support. Striking changes have been observed in some of the children's behaviour; timid children have become more assertive, aggressive children have become more reasonable. Once contact has been established with children and teachers, TAG slowly starts spending time in the village. A drama may be performed, based on themes of children, whereupon spectators are involved in discussion. As a result, in some communities, members have acted and started to bring about changes (Kalksma-Van Lith, 2007).

CONCLUSION

Interventions are subdivided into psychological, psychiatric or psychosocial. It is observed that young refugees were frequently subjected to multiple traumatic events and severe losses. Even though young refugees are resilient they do experience mental health difficulties, which include PTSD, depression, anxiety and grief.

Cognitive Behavioural Therapy (CBT) was the most common and the most effective at reducing Post-traumatic Stress Disorder (PTSD) and Post-traumatic Stress Symptoms (PTSS) in children and adolescents. Every research article that we referred to mentioned CBT and its advantages.

Rumination-Focused Cognitive and Behavioural Therapy was rarely used and was proven to have the least significance in terms of treatment.

Some of the other promising interventions treating symptoms of war related PTSD are creative-expressive approaches which include storytelling, drawing, writing, playing, role-playing, and singing, dancing, playing music and performing psychodrama. The interventions that proved to be effective based on this approach were role playing or dramatic play, developmental trajectory for refugees and Theatre Action Groups.

Knowledge of the particular needs of unaccompanied asylum-seeking children, cross-cultural differences, medico-legal report writing, self-report measures and the importance of clinician self-care is also necessary.

LIMITATIONS

There were a number of limitations to this research. The paper being theoretical in nature has to rely on research articles available online. These articles can sometimes have unreliable self-reports, lack important information about the families perceptions of factors like financial situations, work, separation from relations and harassment.

The interventions mentioned above could be effective in a particular type of circumstance and or culture. Thus it is unclear whether it works for all children and adolescents with PTSD exposed to war.

A meta-analysis could be conducted, thereby reviewing more research articles. This would make the paper more precise and accurate.

SCOPE OF THE STUDY

The physical, sexual and emotional violence that children from war-zones experience ruins their innocence and impairs the very foundations of their lives. It is important to address these issues as the children in war-zones suffer from severe psychological trauma which attenuates future perspectives and leaves a grave impact on their perception of the world.

Individuals generally believe that stress and trauma will be forgotten as time passes by. This isn't true in all cases. We need to create awareness about these interventions so that children and adolescents can make use of the resources available around them. They can be tried and tested in the Indian context, on children living in conflict areas like Kashmir. The effectiveness of these interventions differ from culture to culture depending to various factors (for eg, collectivistic or individualistic cultures). It would help them come to terms with their traumatic event/s and use it to grow as a person.

Outreach programs need to be organised focussing on these interventions by local or national NGO's. Experienced counsellors can provide these services at an individual or group level.

Further, these interventions can be implemented as a part of the curriculum in schools. The quality of a child's education would give the child some hope for the future. This would help the child develop emotionally as well as socially. Since war would be a major crisis faced by a lot of children in the area, a number of children would be affected by it. When individuals have similar life events and experiences that they've been through they tend to bond better.

FUTURE DIRECTION

The literature available in this field is extremely limited. It highlights the interventions done across various cultures. The results could differ from each other due to these various cultures.

Researches should be checked for validity and reliability.

Longitudinal studies would understand the seriousness of trauma and stress on children and adolescents while also checking the effectiveness of the interventions over time.

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ABOUT THE AUTHORS

NISHITA RAVINDRA TIKEKAR.
SHYAMOLI SARAH IVANKA MENEZES SOUSA.
ESHANI CHAMDRASHEKHAR BAKHLE.

Authors are Students of Psychology at Parvatibai Chowgule College of Arts and Science, Goa.

WOMEN A SUBJECT OF OFFENSE: A REVIEW OF LITERATURE

Roma Prabhudessai,
Jumana Khan &
Mariah Dias

RATIONALE OF THE PAPER

Crime against women are on the rise and is evident due to the frequent spectacle of this in the daily news. Thus, there was a keen interest in studying this topic and we mainly focused on rape and domestic violence as this crime is very much on the rise and more so as it may not have been recorded due to various circumstances such as social, economic and legal issues that the victim faces. This study not only aims at understanding the violence women face but also contribute in developing interventions that will help reduce these types of violence.

INTRODUCTION

In our society, violence is bursting. It is present almost everywhere even right behind the doors of our homes. Behind closed doors of homes all across our country, people are being tortured, beaten and killed. "any form of physical, sexual or emotional abuse which takes place within the context of a close relationship It is caused by a biological relative, but typically it is violence suffered by a woman by male members of her family or relatives. It is happening in rural areas, towns, cities and in metropolitans as well. It is crossing all social classes, genders, racial lines and age groups (Bhartwaj, 2014; Kumar, 2010).

DEFINITION OF VIOLENCE

"Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development, or deprivation" defined by World Health Organization (Saferspaces, 2017). Violence is the use of physical force to injure people or property. Violence may cause physical pain to those who experience it directly, as well as emotional distress to those who either experience or witness it. Individuals, families, schools, workplaces, communities, society, and the environment all are harmed by violence (WHO; Human Diseases and Conditions, 2017).

Violence is a global phenomenon which leads to deaths of more than 1.6 million people each year, making it one of the leading causes of death worldwide. While no country is untouched by violence, the vast majority of its resultant deaths occur in low to middle income countries (Saferspaces, 2017).

Violence against women also known as gender based violence mainly refers to violent acts directed towards women. It is not just physical violence but it also includes sexual, emotional, psychological and financial abuse. It knows no social or economic boundaries. Gender-based violence is a reality in both developing as well as developed countries, affecting women of all socio-economic backgrounds (The World Bank, 2017; Womensheath, 2012; Australian Govt., 2017).

Violence strikes women from all kinds of backgrounds and of all ages. It can happen at work, on the street, or at home. Some forms of violence against women are dating violence, domestic and intimate partner violence, emotional abuse, same-sex relationship violence, rape, stalking, violence against immigrant and refugee women, violence against women at work, violence against women with disabilities etc. Mostly they are hurt by people who are close to them, such as a husband or partner. (PCI; Womensheath, 2012).

FACTORS INFLUENCING VIOLENCE

Some social and cultural aspects which would help us in understanding why violence is so prevalent in our country, is the fact that a country like India is a patriarchal society. The term ‘patriarchy’ refers to the system of male domination over women in society, in which the male head of the household had absolute legal and economic power over his dependent female and male family members. Patriarchy in its wider definition means the manifestation and institutionalization of male dominance over women and children in the family and in society as well (Imran, 2008; Times of India, 2013; Shiva, 2013; Bhartwaj, 2014).

Male superiority over women has been a norm in the past societies. Even women got use to believe and accept that view. According to these ideologies, women are regarded as inferior and weak human beings for whom being victim of male violence are natural and acceptable in society. This very factor is contributing to a great extent to the amount of violence taking place against women. The attitudes of people in society predominantly men’s toward violence against women supports the view that violence against women is not a very great problem for some people1 in 5 young men and 1 in 10 young women think that abuse or violence against women is acceptable (The Hindu, 2013; Imran, 2008; Nijhawan, 2017).

Besides this the other factors that play an important role in promoting the violence against women are cultural definitions of appropriate sex roles, expectations of roles within relationships, customs of marriage (bride price/dowry) and acceptability of violence as a means to resolve conflict (Kumar, 2010; Kumar et al., 2009).

The important economic factors responsible for violence against women are women’s economic dependence on men; limited access to cash and credit; discriminatory laws regarding inheritance, property rights, use of communal lands and maintenance after divorce or widowhood; limited access to employment in formal and informal sectors; and limited access to education and training for women (Kumar, 2010; Kumar et al., 2009).

The important legal factors are lesser legal status of women, either by written law and/or by practice; laws regarding divorce, child custody, maintenance and inheritance; legal definitions of rape and domestic abuse; low levels of legal literacy among women; and insensitive treatment of women and girls by police and judiciary (Kumar, 2010; Kumar et al., 2009).

The important political factors are under-representation of women in power, politics, the media and in the legal and medical professions; domestic violence not taken seriously; notions of family being a private sphere and beyond control of the state; risk of challenge to status quo/ religious laws; limited organization of women as a political force; and limited participation of women in organized political system (Kumar, 2010; Dang, Kulkarn, Gaiha, 2017; Kumar et al., 2009).

PREVALENCE

Crime against women has more than doubled over the past ten years, according to latest data released by the National Crime Records Bureau (NCRB).A total of 327,394 cases of crime against women have been reported in 2015, 26 crimes against women are reported every hour, or one complaint every two minutes (Jana, 2017; Kiran, 2015).

The four important principles that should guide all strategies and interventions in dealing with violence are Prevention, Protection, Early intervention and rebuilding the lives of victims/survivors (Kumar et al., 2009).

INTERVENTIONS

Raising awareness in every section of the society is the most important factor. Educational therapy would play an important role in building a culture of non-violence. Nonviolence, conflict resolution, human rights, women rights and gender issues such topics should be taught at different levels in an institution from elementary school to other training settings (Goodtherapy, 2017; Kumar et al., 2009).

Victims who faced violence struggle with self-esteem, anxiety, fear, and posttraumatic stress which hampers their everyday normal functioning. Therapies should be used to administer to help victims express and process difficult emotions associated with the traumatic experience and also help them build upon their strengths and minimize negative beliefs about themselves. Group therapy benefits survivors as listening to other people's experiences helps them normalize their feelings and provide them with a network of support. Practices like art therapy and music therapy can provide survivors with a creative outlet for their feelings, and many people learn to trust again through animal-assisted therapies (Stopvaw, 2006; Goodtherapy, 2017).

Many other therapeutic approaches like narrative therapy, eye movement desensitization and reprocessing (EMDR), cognitive behavioral therapy, cognitive processing therapy can be beneficial in helping victims/survivors in rebuilding their life and learning to trust again (Stopvaw, 2006; Goodtherapy, 2017).

DEFINITION OF RAPE

"Rape is a type of sexual assault usually involving sexual intercourse or other forms of sexual penetration carried out against a person without that person's consent". The act may be carried out by physical force, coercion, abuse of authority, or against a person who is incapable of giving valid consent, such as one who is unconscious, incapacitated, has an intellectual disability or is below the legal age of consent. The term rape is sometimes used interchangeably with the term sexual assault (The Human Disease Forum; Scarleteen, 2010).

According to law, Rape can happen to anyone regardless of age, gender, sexual orientation or ethnicity. Rape is when someone puts their penis into (penetrates) the vagina, anus or mouth of another person without their consent (The Heavens, 2017).

In India a women is reportedly raped every 15 minutes and there a number cases which are not even reported for a number of reasons. In India, rape cases and cases of violence against women have increased over the years. The National Crime Records Bureau (NCRB) reported 10,068 rape cases in 1990, which increased to 16496 in 2000. With 24,206 cases in 2011, rape cases jumped to incredible increase of 873 percent from 1971 when NCRB started to record cases of rape. And Delhi has emerged as the rape capital of India, accounting for 25 percent of cases.

One explanation for the ongoing rape problem is the skewed sex ratio. India has a massive imbalance in its sex ratio. According to the Indian census, the sex ratio in the 6 and below age group has risen from 102.4 males per 100 females in 1961 to 108.9 in 2011 (Khan, 2016).

The incidence of rapes is determined by interplay of several factors like the economic, demographic, social, efficiency of the police and judicial systems, and exposure to mass media (Dang, Kulkarn & Gaiha, 2017).

DEFINITION OF DOMESTIC VIOLENCE

The term used to describe the exploding problem of violence within our homes is Domestic Violence. This violence is towards someone who we are in a relationship with, be it a wife, husband, son, daughter, mother, father, grandparent or any other family member. Anyone can be a victim and a victimizer. This violence has a tendency to explode in various forms such as physical, sexual or emotional (Kumar, 2010; Kumar et al., 2009).

Domestic violence has been an intrinsic part of the society we are living in. The contributing factors could be the desire to gain control over another family member, the desire to exploit someone for personal benefits, the flare to be in a commanding position all the time showcasing one's supremacy so on and so forth. On various occasions, psychological problems and social influence also add to the vehemence (Kumar, 2010; Kumar et al., 2009).

Domestic violence against women is most common form of all. One of the reasons for it being so prevalent is the orthodox and idiotic mindset of the society that women are physically and emotionally weaker than the males (Kumar, 2010).

According to United Nation Population Fund Report, around two-third of married Indian women are victims of domestic violence and as many as 70 per cent of married women in India between the age of 15 and 49 are victims of beating, rape or forced sex. In India, more than 55 percent of the women suffer from domestic violence, especially in the states of Bihar, U.P., M.P. and other northern states.

HEALTH CONSEQUENCES OF VIOLENCE ON WOMEN

The injuries sustained by women as a result of violence are extremely serious. It has been increasingly recognized that all forms of violence can have devastating physical, emotional and health effects. Many incidents result in injuries, range from bruises and fractures to chronic disabilities. The physical and emotional strain at times leads to suicide. Women who are abused suffer an increased risk of unplanned or early pregnancies and sexually transmitted diseases, like HIV/AIDS (Stopvaw, 2013).

Women endure enormous psychological suffering because of violence. Many are severely depressed or anxious, and show symptoms of post-traumatic stress disorder. They may be chronically fatigued, but unable to sleep, they may have nightmares or eating disorders. They turn to alcohol and drugs to numb their pain or become isolated and withdrawn (WHO, 1997).

OBJECTIVES

To focus on psycho-social interventions for women who are subjected to offenses such as rape and domestic violence in India.

REVIEW OF LITERATURE

A study was conducted by Swapnil Sudhirkumar Agarwal et al., on the legal and ethical complexities in the examination of victims of sexual assault in India. Sexual assault cause immense damage to the victims not only physically but also psychologically thus the Indian law has added various sections of the Indian Penal Code for example several amendments of Penal and Criminal Procedure Codes, Evidence Act along with Protection of Children from Sexual Offenses Act. Though, these amendments have put medical practitioners as well as the victim in conflicts of ethical and legal issue such as mandatory reporting to police even when the victim is not in consent; mandatory examination, treatment and rehabilitation by any medical practitioner and that too free of cost. It was found that apart from medico-legal purposes, the victim receives sufficient treatment including that for physical injuries, sexually transmitted diseases, emergency contraception as well as psychological counseling and rehabilitation. (Agarwal, 2017)

Kamdar (2017) examined rape and tried to understand if it was a lifestyle or behavioral problem. They studies the attitude and myths toward rape among college going students of Surat City. 332 participants from three different colleges participated in the survey and the 'The Attitude Towards Rape Scale' (21 items) and updated 'Illinois Rape Myth Acceptance Scale' (22 items) was used. Data analysis was done with the SPSS version 19. It was found that Almost two-third (73%) of female participants and 42% of the male participants disagreed with the myth that "When a woman says "no" she really means "yes". Around 30% of the participants were uncertain about the myth that "A woman cannot be raped by someone she previously knew or had sex with." While almost 35% of participants believed that "Most rapes are carried out by strangers." Strong sexual desire of guys, drunkenness, and girl's clothes were reported to be factors that provoke rape by 50%, 40%, and 33% of respondents, respectively, around 95% of female and 92% of male participants think that 7-year imprisonment for rape is not enough. Thus, in conclusion rape myths were found to be highly prevalent especially among youth and even higher among males.

A study was led by Daruwalla (2017) on the changing gender norms in the prevention of violence against women and girls in Mumbai. Records of 1653 survivors of violence were reviewed anonymously. 5 focus group discussions and 13 individual interviews with 71 women and men representing a range of age groups and communities were also conducted additionally. It was found that descriptive and injunctive norms were relatively similar with regard to femininity, masculinity, the need for marriage and childbearing, resistance to separation and divorce and disapproval of friendships between women and men. Some constraints on women's dress and mobility were relaxing, but there were more substantial differences between descriptive and injunctive norms around women's education, control of income and finances, and premarital sexual relationships.

Bhadra (2017) examined women in disasters and conflicts in India. The study shows that the vulnerability of women in disasters and conflicts is higher than that of men and women are significant victims of post-disaster situations. Thus, an important development challenge in rehabilitation is the need to enhance the social status and capability of women belonging to different sociocultural

groups. The cultural, social, and mental strengths of women should be explored for disaster interventions. Gender roles should be matched with post-disaster interventions that build on the strengths of the individual, family, and community where men and women are complementary for each other.

Rob Stephenson et al., did a study on the Domestic Violence and Abortion Among Rural Women in Four Indian States. Data from two linked data sets, India's 1998-1999 National Family Health Survey (NFHS-2) and a follow-up survey in 2002-2003, were analyzed. The analysis examined how the experience of physical violence affects the subsequent uptake of abortion following subsequent experience of physical, sexual, and verbal violence. Women who experienced physical violence have significantly higher odds of reporting a subsequent induced abortion, whereas women who had an induced abortion have significantly higher odds of reporting subsequent sexual and verbal violence. (Stephenson, 2016)

de Lima, et al., (2016) examined Domestic Violence in Pregnant Women. The study aimed to estimate the prevalence of domestic violence in adolescent and adult mothers who were admitted to obstetrics services centers in Brazil and to identify risk factors of domestic violence and any adverse obstetric and perinatal outcomes. Researchers used standardized interviews, the questionnaire Abuse Assessment Screen, and a review of patients' medical records. Descriptive statistical analyses were also used. The prevalence of domestic violence among all participants totaled 40.1% (38.5% of adolescents, 41.7% of adults). Factors associated with domestic violence during pregnancy were as follows: a history of family violence, a greater number of sexual partners, and being a smoker. Results showed that, in Vitória, Espírito Santo, Brazil, pregnancy did not protect a woman from suffering domestic violence.

Ghosh(2015) examined The Political Economy of Domestic Violence in a Mumbai Slum. This paper studied the structural violence contributes to domestic violence and also systematically disadvantages women by forcing them to drop out of school, reduces labour force participation and prevents women from leaving abusive marriages. This article uses an ethnographic approach and, including two pairs of mothers and daughters as case studies, offers an intergenerational perspective that underscores the transmission of violent life trajectories, highlighting the limited possibilities for mitigation. In the results it was found that programmes that aim to reduce domestic violence need to go beyond the family as a site of intervention, to account for the role that systemic violence plays in the production of domestic violence in marginal spaces, such as slums.

Indupalli & Giri (2014) examined the sexual violence among married women. Internets based popular search engines were used to explore data from literature, which includes PubMed, PubMed Central, Google Scholar and Medknow. Search was done using the key-word combinations sexual violence within marriage" and 'intimate partner violence". A total of 51 publications were evaluated for this article. Results indicated that there is a substantial level of sexual violence among women especially young recently married.

Kimuna (2012) did a study on Domestic Violence in India. The study used the 2005-2006 India National Family Health Survey-III (NFHS-III) and focused on the 69,484 ever-married women ages 15 to 49 from all regions, who were administered the domestic violence module. The results showed that 31% of respondents experienced physical violence in the past 12 months before the survey; the corresponding figure for sexual violence was 8.3%. The multivariate logistic regression results show key determinants of physical and sexual violence. Moreover, respondents who believed that wife-beating was justified under certain circumstances were more likely to experience domestic violence. These results and significant regional differences observed in this study suggested that gender role conditioning and cultural norms both contribute to domestic violence.

A study was conducted by Bhatia (2012) on the Domestic Violence in India. It was based on a preliminary study using questionnaire-based interviews of litigants in Delhi. Primary data, taken from all the Delhi Metropolitan Magistrates Courts at that time, concern the background of those who used the law, the litigation process, implementation of the law and the forms of violence addressed. The

objective of the study was to find the effectiveness of the new legislation and examine specifically what kinds of people bring actions under this new gender-specific law. This qualitative assessment of the perceptions of different kinds of violence by complainants and respondents provided deeper insights into ongoing and potential contestations over gender-based violence.

Simister (2008) conducted a study on 'Domestic Violence in India. They studied domestic violence and the attitudes between husband and wife in India The data was collected from the Demographic and Health Survey 1998–2000 and the survey included women in the ages of 15 to 49, in 26 Indian states. It was found that gender-based violence is very prevalent in India. Violence is less common if women and men are well educated and education must be prioritized for both boys and girls.

A research was conducted by Sahoo & Raju (2007) on Domestic violence in India on working women and their experience of domestic violence situating. The analysis was done using the data from the National Family Health Survey II (1998-99). The results showed that working women face more violence as compared to the rural counterparts because of economically active being and relatively better informed about their rights which on one hand, threaten male dominance and on the other, results in better reporting of incidences of domestic violence although it is extremely difficult to sift the independent contribution of these outcomes. It was also found that working urban women were more susceptible to violence than working women in rural India suggesting that urban women are in a more direct confrontation with established and coded gendered domains vis-à-vis men.

Stuart, et al., (2006) examined Psychopathology in Women Arrested for Domestic Violence. Results revealed that high rates of posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder (GAD), panic disorder, substance use disorders, borderline personality disorder, and antisocial personality disorder. Violence victimization was significantly associated with symptoms of psychopathology. Logistic regression analyses showed that sexual and psychological abuse by partners were associated with the presence of PTSD, depression, and GAD diagnoses. Results highlighted the potential importance of the role of violence victimization in psychopathology. It also suggested that Axis I and Axis II psychopathology should routinely be assessed as part of violence intervention programs for women and that intervention programs could be improved by offering adjunct or integrated mental health treatment.

A study was done by Bacchus (2006) on domestic violence in pregnancy .The study consists of 16 women who had experienced domestic violence in the previous 12 months. The violence was perpetrated by a current or former partner in all but one case. Ten of the 16 women had experienced domestic violence during their recent pregnancy, of whom four women had also been assaulted in at least one previous pregnancy. Three women had been assaulted by their partners in a previous pregnancy but not during their recent pregnancy, and three had experienced domestic violence outside of pregnancy only. Some women reported increased feelings of insecurity, jealousy, and possessiveness in their partner during their pregnancy. Abuse within the relationship centered around the arrival and care of the new baby: financial worries, the woman's lessening physical and emotional availability during pregnancy, the lack of practical and emotional support from the male partner, and doubts about paternity.

A study was conducted by Cohen (2006) on psychosocial interventions for maltreated and violence-exposed children in the study they reviewed randomized controlled studies that have assessed child mental health outcomes for maltreated and violence-exposed children. The highlights of their study were (1) maltreated and violence-exposed children typically experience more than one of these types of traumas; (2) effective psychosocial treatments are available to address Posttraumatic Stress Disorder (PTSD), depression, anxiety, and behavioral problems in these children; (3) it is likely that treatments which effectively reduce mental health symptoms in children exposed to one type of child maltreatment or violence exposure will also be effective for other or multiple types; and (4) mental health outcomes are not the only important outcomes to address in future treatment or intervention efforts.

McFarlane (2000) did a research on Indicators of Intimate Partner Violence in Women's Employment : Implications for Workplace Action . The study examined the indicators and consequences of intimate partner violence on women's employment and associated types and levels of violence. Interviews were conducted with a consecutive sample of 90 women seeking a protective order. Actual and threatened violence was measured with the Severity of Violence Against Women Scales (46 items). The Findings indicated lost productivity and reduced performance. The researchers concluded poor work performance, tardiness, and absenteeism may indicate an employee is suffering from intimate partner violence.

CONCLUSION

Evidence from the above study indicated that a set of prejudicial, stereotyped or false beliefs about rape, rape victims, and rapist exist in the community and are found to be very much prevalent amongst youth and higher among males. Studies have found a link between the behaviour of some Indian men and the 'machismo' values gender-specific socialization, cultural definitions of appropriate sex roles, values that give men proprietary rights over women and girls, customs of marriage (bride price/dowry) and acceptability of violence as a means to resolve conflict, as conveyed in the culture to crimes against women. Studies show that violence is less common if women and men are well educated and thus, acceptance of domestic violence seems to be related to the respondent's education level. Another important economic factor is the women's economic dependence on men. Majority of women are likely to avoid reporting these experiences due to associated shame, retaliation or gender inequity. This also includes sexual violence among married women in a silent suffering. Psychological interventions such as CBT, PTSD interventions, counseling, and exposure therapy have shown positive results. Finally, the government should include educating students regarding this in their education curriculum as well as more stringent laws and bring about awareness to help women who are victimized.

Finally, it could be stated that though there is evidence of some interventions to help women who are victims of domestic violence and rape, further research is needed, especially on high-quality with quantitative data outcome.

A meta-analysis could be conducted for this study as it would increase the power and also the effect that we are interested in showing. Research in this field could be done to bring about awareness amongst the Indian population especially males. Research ought to be conducted to understand the correlation between violence and patriarchal societies in India.

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ABOUT THE AUTHORS

ROMA PRABHUDESSAI

Student, Dept. of Psychology, Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.

JUMANA KHAN

Student, Dept. of Psychology, Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.

MARIAH DIAS

Student, Dept. of Psychology, Parvatibai Chowgule college of Arts and Science Autonomous, Goa-India.

MOTIVATION ENHANCEMENT THRAPY IN POLY SUBSTANC ABUSE

Aleena George,
Anitha S &
Seema P Uthaman

ABSTRACT

Motivation enhancement therapy is a treatment approach that helps individuals to resolve their ambivalence about engaging in treatment and stopping their substance use. This tries to evoke a rapid inner change in client through motivational interviewing followed by teaching relapse prevention strategies and coping skills. The present case study is an attempt to provide a psychosocial oriented therapeutic intervention for a 19 year old boy, diagnosed with poly substance abuse and anti-social personality traits. Condition of the client at the time of referral, assessment findings and therapeutic interventions are discussed in detail. The interventions included motivational interviewing, assertiveness skill training, decision balance exercise, environment modification and psycho education. The outcome included abstinence of the client from the substance, better bond between the family members and an initiation of a career oriented course.

Keywords: Motivation enhancement therapy,poly substance abuse

INTRODUCTION

Substance abuse disorders are one among the major topics of discussion among mental health professionals. Research evidences support the effectiveness of various psychosocial interventions in the treatment of substance abuse disorders. Along with medications, behavioral and family based interventions seem to have best treatment outcome. Recent research substantiates that psychosocial intervention for substance dependence can promote behavior change[1].

Case Introduction

Mr. S 19 year old single male, studied up to plus two, hailing from middle socio-economic status from rural background, was brought to us on 15/01/2017 by the counselor of Juvenile justice board, with the complaints of aggressiveness, stealing, obstinacy, anger outbursts and lying for the last one year and cigarette smoking, cannabis use, use of benzodiazepine tablets for the last three years.

The history revealed that the client was using the substance out of his curiosity during the initial phase. But as he developed tolerance, he was in need of money to procure the substance. For this, he started to steal money and indulged in robbery. At the age of 18 years, following a robbery, he was arrested and sent to Juvenile home. The case is going on and he is under trial. On his release from Juvenile home, he continued to use substances and involved in petty thefts. He was again arrested and imprisoned for a period of 4 months, for setting fire to a shop and two vehicles under intoxication. On release from the prison, he was bought to the Psychiatry out Patient Services of IMHANS and a diagnosis of cannabis dependence syndrome, poly substance abuse with anti-social personality traits was made. The client was then referred to the psychiatric social work trainee for detailed evaluation and psychosocial interventions.

Case Conceptualisation

The psychosocial assessment of the client reveals inconsistent patterns of parenting and over- involvement of the parents leading to disobedience and aggressiveness in the client. Client lacked concerns regarding the moral and religious norms of the society. Parents were yielding to his demands and were less concerned about his maladaptive behaviors and gang activities. The influence of his peers, easy availability of the substances and the huge pocket money he got from parents made him vulnerable to the frequent use of substance, which soon developed into dependency. As he had strong craving for the substance, he was ready to involve in any gang activity, despite its consequences. Even after the imprisonment he tried to access substances. Though he was good at studies, he lacked motivation and ambition at the time of intake session he was very distressed and was worried regarding his future.

Course Of Treatment And Assesment Of Progress

Along with pharmacotherapy, psychotherapy sessions were planned after the psychosocial assessment. Within a span of four months, thirteen sessions were conducted individually and three sessions were done with family members. The primary focus of the sessions were on developing the relapse prevention skills, ensuring treatment adherence, and developing assertive skills in the client. On subsequent sessions, the therapist monitored change, reviewed cessation strategies to be used, and continued to encourage commitment to change or sustained abstinence.

Treatment Implications of the Case

Along with pharmacotherapy, psychotherapy sessions were planned after the psychosocial assessment. Within a span of four months, thirteen sessions were conducted individually and three sessions we

Motivation enhancement therapy

Motivation Enhancement Therapy was given in six sessions. The patient was on pre-contemplation stage at the time of intake. Through regular sessions of psycho education and supportive therapy, clinical social work trainee could build a therapeutic alliance with the client. Furthermore, motivational counseling helped the patient to take a decision of change. Then a decision balance exercise was given to encourage him to identify the pros and cons of substance use. During the sessions, the client had raised many worries regarding withdrawal symptoms and peer pressure. Repeated motivational interviews were given in each session with the client to yield better outcomes. It helped in increasing client's motivation in treatment and reinforced his commitment to change.

Assertiveness skill training

With the discussion of patient and family members, hierarchies of high risk situations were made. Then role play sessions were done during therapy on demonstrating how to respond to such high risk situations. This helped to improve confidence in the client as he developed skills. The major risk situations were hangouts with his peers. Role play included different simulated situations through which the various strategies to improve his internal strength were demonstrated.

Environmental modification of patient

The patient had easy accessibility to cannabis and other substances in his home town. Also, he had a powerful network of friends of similar habits. Since he was less assertive and vulnerable to peer pressure, clinical social work trainee suggested environment modification. In conjoint sessions with his parents, they were guided to take a decision of shifting their stays to a different town where they could join with their extended family.

Career counseling

The client was found to have instability in taking and implementing decisions in academic career. Also, during the session client reported lack of concrete plans about his career. The clinical social work trainee explained various career opportunities which the client could attain with his educational qualification. This was also discussed with his parents and they expressed their readiness to send him for such courses or job. Patient decided to join for IT diploma after his case trials, and also made a short term plan of working in a textile shop.

Family Level

Supportive therapy was given to the parents and elder brother. It helped them in alleviating their worries emerging from client's substance use and the consequences. A therapeutic alliance was built through reflective listening and positive regard. The sessions with elder brother explained the expressed emotions and its implications to the outcome. These sessions helped the father to reduce expressed emotions towards the client.

OUTCOME

Personal level

Patient got awareness about his current situation and realized the need to take a "U'' turn in his life. He took initiative to avoid his peers and drugs. Also, he was willing to continue medication and was on regular follow-ups. Client reported confidence in facing the high risk situations. Client could modify his interaction pattern and noise level towards parents, which in turn reflected some positive signs in their family life. Of late he joined a diploma course so as to develop a future career.

Family level

Family got an awareness regarding the client's illness and they decided to bring him in regular follow-ups. They started to cope up with the situation and provided support and reinforced the patient for his desired activities. Family dynamics improved.

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S Jhanjee-Indian journal of psychological medicine,2014-ncbi.nlm.nih.gov

ABOUT THE AUTHORS

ALEENA GEORGE

MPhil Scholar, Institute Of Mental Health And Neuroscience Calicut

ANITHA S

MPhil Scholar, Institute Of Mental Health And Neuroscience Calicut

SEEMA P UTHAMAN

Assistant Professor & Head department of Psychiatric Social Work

A CLINICAL CASE STUDY OF OBSESSIVE COMPULSIVE DISORDER WITH EXPOSURE RESPONSE PREVENTION THERAPY

Anitha.S,
Aleena George &
Seema.P.Uthaman

ABSTRACT

Exposure Response Prevention Therapy [ERP] is one of the interventions for treating OCD [Obsessive Compulsive Disorder] which exposes the clients to the cues of the compulsive rituals and prevention of the ritualized response. The present case study is an attempt to provide therapeutic intervention to a 23 year old lady suffering from OCD and Undifferentiated Schizophrenia. The lady was treated with pharmacological and non-pharmacological interventions. The presenting complaints and modes of intervention given are explained in detail. After 14 sessions of intervention, significant improvements were found in the client. The interventions included assessments, psycho-education, Exposure Response Prevention Therapy and activity scheduling.

Keywords: Obsessive Compulsive Disorder, Exposure Response Prevention Therapy

INTRODUCTION

"Obsessive-compulsive disorders are characterized by obsessional thinking, compulsive behavior and varying degrees of anxiety, depression and depersonalization"[1]. Exposure therapy is usually coupled with response prevention. This component of treatment is especially used for people who have developed repetitive ritualized behaviors called compulsions. This compulsive behavior seems to neutralize the anxiety that occurs during the distressive thoughts. Since compulsive behaviors serve to eliminate anxiety, they are intrinsically rewarding. Response prevention prevents these compulsions from being rewarded. As per learning theory the behavior which is no longer rewarded gets faded gradually. The combination of exposure to anxiety provoking stimuli and prevention of rituals leads to the effective treatment response. Research evidences show that exposure and response prevention therapies require complete participation of participants to tolerate the discomfort until habituation develops. At times therapist need to motivate patient for treatment and to switch various approaches for effective treatment outcome. The therapy seems to be more effective when it is coupled with home work assignments.

Brief Clinical History

Ms. A is 23 year old divorced female, educated up to plus-two (failed) unemployed, from middle socio economic status hailing from rural background of Malapuram district, Kerala. She was first presented to the adult psychiatry out-patient services of Institute of Mental Health and Neurosciences (IMHANS) during December 2016, with three years history of illness characterized by decreased initiation, withdrawal, increased time for doing activity, unwanted distressing thoughts of contamination, repeated washing, and repeated stamping of the foot on the ground. She was diagnosed with Undifferentiated Schizophrenia and Obsessive Compulsive Disorder and was referred to clinical social work trainee for the psychosocial management.

Case Conceptulisation

The psycho social assessment of the client reveals that she was anxious in nature and she used to get upset easily during stressful situations. She had intermittent poor adherence to treatment which could be attributed to the factors such as fear of stigma, poor knowledge and understanding about the illness and misconceptions about treatment. Just before her marriage, the client stopped medication which in turn led to the exacerbation of symptoms resulting in the disharmony among couple and divorce. Further, the symptoms caused impairment in socio occupational functioning as evidenced by disruption in the areas of day to day activities, participation in household chores and social interaction. The client subsequently became home bound. The family dynamics revealed over involvement of parents which significantly affected the client's coping skill and adaptation pattern .She became highly dependent and reluctant in taking decision even in simple matters. All these factors together contributed to patient's current condition.

Course of Treatment and Assesment of Progress

Along with pharmacotherapy, psychotherapeutic interventions were initiated from December 2016. Total of 14 sessions were seen on a weekly basis. An obsessive compulsive check list of Yale Brown and severity scale were used. Along with that subjective distress scale was used to assess the progress. In addition to that an activity schedule was also given to measure the functional outcomes of client.

Client was a known case of Undifferentiated Schizophrenia and the persistence of negative symptoms sometimes hindered the therapy sessions. Though adequate primary support system was a protective factor, repercussions associated with marriage affected the prognosis of OCD.

TREATMENT IMPLICATIONS

Cognitive Behavior Therapy Assessment

An obsessive compulsive check list of Yale Brown was used to identify the symptoms at periodic psychiatric consultations in order to generate a list of target symptoms. Yale brown obsessive compulsive scale was used to measure the frequency and severity of target symptoms. The scale was administered to the patient during the first session and after one week of intervention. First assessment of severity of symptoms showed a higher score where as during the second assessment; a significant improvement from severe to moderate range was reported by the client.

Psycho Education

Four sessions were conducted focusing on psycho education. The first session emphasized on the nature of obsessive compulsive disorder in which the patient was educated on prevalence rate of the disorder and symptoms of obsessive compulsive disorder. Second education session consisted of the causes and treatment of OCD and the importance of behavior therapy. Also the session enumerated on the implementation of exposure and response prevention therapy. The patient was continuously educated and motivated for regular follow up with psychiatrist and therapist.

Exposure Response Prevention

The exposure and response prevention sessions were done by exposing the client to the cues of the compulsive rituals and prevention of the ritualized response. As the first step of intervention, a list was prepared on the client's obsessions and compulsions identified through checklist and measured subjective unit distress of the symptoms. Based on the distress scale, a hierarchical list of symptoms was developed followed by development of graded exposure tasks. The grade ranged from less anxiety provoking cues to high anxiety provoking cues and the exposure was done according to the grade. Before and after each exposure, the SUD (Subjective unit discomfort) was measured. This exposure to triggering situation prolonged for 45 minutes and the session held on a weekly basis.

While exposing to the cues, the client was observed to be highly distressed and anxious. Gradually she became relaxed. After the exposure therapy at clinic, the client was assigned with homework tasks and the mother was educated to act as co-therapist. The mother was asked not to be involved in any rituals of the client such as washing, dusting etc. She was provided with an activity schedule in which home work task were incorporated and some ground rules were established for each task. The subjective unit distress was measured after the session and client received regular feedback and reinforcement for her efforts.

Activity Scheduling

During the initial sessions, while discussing about the activities at home, it was understood that client was sitting idle at home spending time for sleeping and having food. Since she refused to do household activities this process became a daily routine. The mother never persuaded to change this daily routine as she was afraid of her anger outburst.

The client had received a structured schedule of activity to follow on a regular basis. Initially it was given weekly with baseline activities and monitored during weekly sessions. The clinical social work trainee reinforced the client for her attempt to do the activities and motivated her to develop an initiation and to do more activities. Gradually the schedule was restructured from baseline activities to more complex activities and entrusted the mother to monitor and reinforce from time to time.

OUTCOME

Within a span of three months intervention period, the client acquired adequate knowledge regarding the course and treatment of her illness. The client learned to experience reduction in her distress following repeated exposure to triggering factors and significant reductions in the time spend for compulsion was noticed. The family members acquired adequate knowledge regarding the client's illness, the ways to manage it and the factors in the family that maintains the illness behavior.

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ABOUT THE AUTHORS

ANITHA.S

MPhil scholar, Department of Psychiatric Social Work, Institute of Mental Health and Neuro Sciences, Calicut

ALEENA GEORGE

MPhil scholar, Department of Psychiatric Social Work, Institute of Mental Health and Neuro Sciences, Calicut

SEEMA.P.UTHAMAN

Assistant Professor and Head, Department of Psychiatric Social Work, Institute of Mental Health and Neuro Sciences, Calicut

SOLUTION-FOCUSED BRIEF THERAPY FOR MILD DEPRESSION IN A PRIVATE PSYCHIATRY SETTING

Baijesh A. R.,
Sonu S. Dev,
Liya Ajayan &
Rithika Alladi

ABSTRACT

People living with mild depression and mostly goes both undiagnosed and untreated. Untreated depression is a grave concern, researches indicate that it can lead to significant distress, functional impairment and can cause psychological suffering along with worse medical outcomes, including immunosuppressive effects. The present study is a preliminary investigation, evaluating the efficacy of SFBT in the management of Mild Depression among individuals who are undergoing therapy. A total of 11 individuals who were diagnosed with mild depression in a Psychiatric Hospital Setting were recruited for the study. There were 2 drop-outs, and the remaining 9 participants subjected to 10 weeks SFBT treatment program for mild depression. The participants were assessed by Beck Depression Inventory- II (BDI) and Solution Focused Inventory, pre- and post intervention. The assessment scores, pre- and post intervention, were compared and was found as statistically significant at 0.05 level on both BDI (z= 2.67) and SFI (z= 2.67). Post- intervention, all 9 participants were interviewed by an independent clinician for mild depression, and only one person met the ICD- 10 diagnostic criteria for depression. The findings of the study indicate a preliminary efficacy of SFBT in treating depression among people infected with mild depression.

INTRODUCTION

Solution-focused brief therapy is an approach to psychotherapy focusing on solutions rather than the problems. It investigates current situations and future hopes rather than present problems and past causes and typically involves only three to five sessions. It has great value as a preliminary and often sufficient intervention and can be used safely as an adjunct to other treatments. Developed at the Brief Family Therapy Centre, Milwaukee (de Shazer et al, 1986), it came in an interest in the inconsistencies to be found in problem behaviour. From this came the central notion of ‘exceptions’: however serious, fixed or chronic the problem there are always exceptions and these exceptions contain the seeds of the client’s own solution. The founders of the Milwaukee team, de Shazer (1988, 1994) and Berg (Berg, 1991; Berg & Miller, 1992), were also interested in determining the goals of therapy so that they and their clients would know when it was time to end! They found that the clearer a client was about his or her goals the more likely it was that they were achieved. Finding ways to elicit and describe future goals has since become a pillar of solution-focused brief therapy.

Since its origins in the mid-1980s, solution-focused brief therapy has proved to be an effective intervention across the whole range of problem presentations. Early studies (de Shazer, 1988; Miller et al, 1996) show similar outcomes irrespective of the presenting problem. In the UK alone, Lethem (1994) has written on her work with women and children, Hawkes et al (1998) and MacDonald (1994, 1997) on adult mental health, Rhodes & Ajmal (1995) on work in schools, Jacob (2001) on eating disorders, O'Connell (1998) on counselling and Sharry (2001) on group work.

There are lot of studies that have documented the general effectiveness of SFBT in different clinical and non clinical settings, and various studies showing that SFBT is an effective treatment for depression. Moreover, the studies suggest that SFBT produces positive results in a relatively short period of time (Estrada & Beyebach, 2007). A comparative study between a single session of SFBT versus interpersonal psychotherapy among 40 college students indicated no significant difference between the two treatments, demonstrating that single session SFBT was effective in reducing depressive mood (Sundstrom, 1993). Studies conducted by Lee, Greene, Mentzer, Pinnell, and Niles (2001) and Hanton (2008) show significant improvement in depressed clients after SFBT. In the case of specific populations, a study conducted by Estrada and Beyebach (2007) demonstrated significant differences in pre-post test scores on the Beck Depression Inventory-II (BDI-II), indicating that the SFBT treatment was effective in reducing the depressive symptoms of people with hearing impairment. Studies also show that SFBT is effective and applicable in tribal community in treating the depressive symptoms (Koorankot, Mukherjee and Ashraf, 2013). Depressive disorders have been listed among the most prevalent psychiatric issues. They are some of the most common mental illnesses and one of the leading causes of morbidity and mortality in the world today. They place profound economic burdens on society (Greenberg, Kessler, & Birnbaum, 2003; Lynch & Clarke, 2006).

Koorankot, Mukherjee and Ashraf (2014) studied the efficacy of SFBT in the context in the treatment of depression among a Tribal community mental health setting in India. As there were no reported studies on SFBT in India, and especially not in tribal communities, the study made an attempt to explore the outcome and the application of a time-limited, solution-focused therapeutic approach in treating clients with depression. The findings indicate that SFBT is an effective therapeutic approach in treating depression also in this very specific context. The findings also give a scope for further research in SFBT on this and in other populations and also with other psychiatric conditions in India.

Reddy et. al,(2016) evaluated the effectiveness of SFBT on moderate depression. Ms. S, 19 year old female failed in SSLC diagnosed with depression. An intervention using SFBT with 6 sessions, resulted in a positive change on self report by the client and HAM-D scores as well.

METHOD

Aim

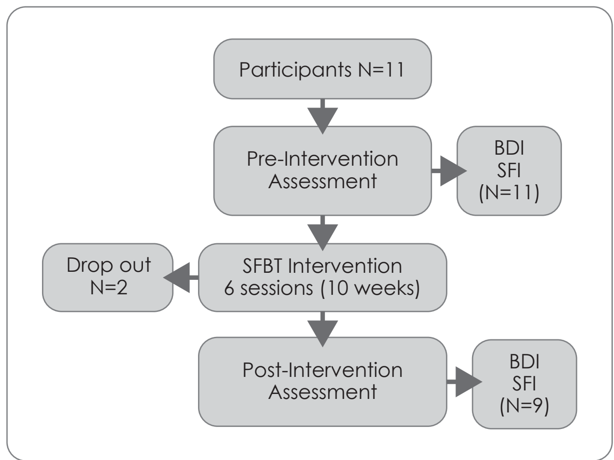
The aim of the present study is to evaluate the efficacy of SFBT in the management of Mild Depression among individuals seeking treatment in a private psychiatric hospital setting.

Participants

The sample consisted of clients referred by a Psychiatrist from a private psychiatry setting who were diagnosed with mild depressive episode by the by the Psychiatrist as well as the Clinical Psychologist as per International Classification of Diseases-10 (ICD-10) criteria. Clients with co-morbid psychiatric conditions were excluded from the study. 11 clients who gave consent to participate in the study were recruited. Out of 11, five of the participants were male and six were female. All the clients had formal education up to graduation or/and above, all of them belonged to middle socioeconomic status, living in an urban locality. Four of participants were under psychiatric medication for the mood problems while others preferred a non pharmacological intervention.

Design

A single group pre-post test design was used in the study to examine the outcome of SFBT with regards to reducing symptoms of depression among individuals. Figure 1 shows the study design.



Tools

The Beck Depression Inventory- II (BDI- II) is a widely utilized 21-item self-report scale in both clinical and research studies (Beck et al.,1996). The scale was originally developed in 1961 as an interviewer-assisted format but has undergone several revisions over the last 35 years from the BDI-1A(1978), to the most recent version The Beck Depression Inventory-II (1996) which is a completely self-administered format. The Beck Depression Inventory-II is a depression rating scale that can be used in individuals that are ages 13 years and older, and rates symptoms of depression in terms of severity on a scale from 0 to 3 based on the 21 specific items. Patients that endorse multiple items on the questionnaire(i.e. sadness, pessimism, past failure, loss of pleasure, guilt feelings, punishment fears, self-dislike, and so forth) typically have higher scores with a maximum score of 63 compared to others.

Solution-focused Inventory (SFI), developed by Grant (2011) is a 12 item scale with three subscales: Problem Disengagement, Goal Orientation and Resource Activation. Reverse scoring should be done for the items numbered 1, 2, 4 and 5. Total scores for the SFI are calculated by simply summing all 12 items (after reverse scoring relevant items). The use of a total 12-item SFI composite score and also the use of individual 4 item subscale scores (PD, GO and RA) are supported by the Grant et al (2012) validation study. Test–retest reliability over 16 weeks was 0.84. Cronbach's for the 12-item scale was 0.84.

Procedure

The patients were assessed on SFI and BDI pre- & post- intervention a by an independent rater. Therapeutic program: The therapeutic program consisted of 6 sessions for each client over a period of ten weeks. The sessions were conducted individually; every treatment had the same format. Each session lasted for approximately 60 minutes with session break of five minutes. The treatment followed the Solution Focused Brief Therapy (SFBT).

Dropout

Though 11 individuals were recruited for the program, two of them did not complete the program due to various person reasons. One person shifted to different cities for treatment and care. One person did not show up after the first session and he took appointment after two weeks but he excluded from the study

Analysis

Statistical analysis was carried out on the five patients. The Wilcoxon signed-rank test was used to analyse the data. The pre-treatment BDI & SFI scores were compared with post-treatment scores to evaluate the outcome of SFBT intervention. For analyzing the data GNU PSPP statistical software version 0.7.9. was used. The comparison of pre and post intervention BDI- II & SFI scores were also analyzed using Wilcoxon Signed Rank Test.

RESULTS AND DISCUSSION

The aim of the present study was to evaluate the efficacy of SFBT in the management of Mild Depression among individuals.

Table 1 shows the pre- & post intervention assessment scores on SFI & BDI for nine patients who completed the treatment.

Table 1

Sl No	BDI		SFI	
	Pre	Post	Pre	Post
1.	16	9	18	35
2.	18	7	22	52
3.	19	11	27	44
4.	14	11	19	43
5.	15	5	31	60
6.	19	18	18	22
7.	16	6	27	45
8.	17	8	17	39
9.	19	12	19	28

BDI- Beck Depression Inventory II; SFI – Solution Focused Inventory.

Table 2 shows the comparison of pre and post intervention mean scores on BDI & SFI scores using Wilcoxon Signed Rank Test.

Table 2

Measure	z
BDI	-2.67*
SFI	-2.67*

BDI- Beck Depression Inventory II; SFI – Solution Focused Inventory; * $p<0.05$

After completion of the intervention, clinical interview by an independent Clinical Psychologist indicated that only one client met the criteria for depression indicating significant improvement in all the other clients. Table 1 demonstrates the post treatment reduction in the scores of BDI, in the self reported depression levels of eight participants. The analysis (Table 2) shows a a significant difference between pre and post intervention groups ($p<0.05$) on both self report measures. It is also to be noted that there was a significant change in the solution focusede thinking in majority of the clients post treatment. Further studies can also investigate the possibility of solution focused thinking as a mediating factor in the change process.

In conclusion, the findings of this investigation indicates the efiicacy of SFBT in the management of mild depression. The findings are in consistent with the previous studies (Koorankot, Mukherjee and Ashraf, 2014; Reddy et al., 2016). Considering there was no control group for the present study, limitations in the recruitment, systematicity and small sample size may suggest that the data cannot be used to generalize results to a larger population. Four participants were on antidepressant medications and it could be argued that the changes can be attributed to the medications. Considering the effects of medications, it is also to be noted that the significant improvement was seen also among those who were not undergoing medical management. Thus the present study provides a promising insight of using SFBT in the management of mild depression and scope for futher more systematic, large and randomized researches.

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ABOUT THE AUTHORS

BAIJESH A. R

Consultant Clinical Psychologist, Chetana Hospital, Hyderabad

SONU S. DEV

MPhil Clinical Psychology trainee, Sweekaar Institute of Mental Health, Secunderabad

LIYA AJAYAN

MPhil Clinical Psychology trainee, Sweekaar Institute of Mental Health, Secunderabad

RITHIKA ALLADI

Clinical Psychologist, Physitrix De Care, Hyderabad

RECONCEPTUALIZATION OF SELF-DEFEATING HUMOR: IMPLICATIONS FOR HUMOR INTERVENTION PROGRAMS

Pearlene Helen Mary D,
Shefaley Phebe K &
Mary Ann S

ABSTRACT

The theoretical focus of humor intervention is to increase positive emotions to overcome negative emotions through the development of emotional resilience. In the 7-humor habit program (7HHP) one of the key humor habits is the integration of humiliating self-directed jokes in everyday life to promote effective coping. Self-defeating humor helps to switch thoughts effectively by playfully laughing at perceived flaws both within and outside the person's sensitive interests. But, long term benefits of the intervention are found to be negligible. Existing literature suggests that even though humor in general is a healthy coping mechanism the use of self-defeating humor may be maladaptive. This humor style may accentuate the emotional element but may not necessarily develop only positive emotions. The present paper addresses the stagnant negative emotions highlighting the discrepancy in experiential affect. This puts the use of self- defeating humor in the 7 Humor Habits Program (7HHP) in question. The current study posits a comprehensive conceptual model of self-defeating humor, the mechanisms by which this form of humor develops and operates in an individual. In this model, early maladaptive schemas operate in association with humor, resulting in both behavioral expression (e.g., laughter) and negative emotional experience, paradoxically perpetuating negative self-evaluative beliefs. Furthermore, the model suggests pivotal implications of self-defeating humor.

Keywords: Self-defeating humor, coping strategies, negative self-beliefs

A Novel Perspective on Humor

Humor is a ubiquitous facet of the human affairs (Lefcourt, 2001). It is a psychological reaction of mirth in a social context that is caused by the awareness of a playful dissonance that takes place in many forms (Martin, 2010). From various psychological perspectives, although humor has been extensively established as a beneficial coping mechanism; pertaining literature in terms of its positive effects on psychological wellbeing is inconclusive (Ruch, 1998). One explanation for such inconsistency is attributed to the presence of different types of humor itself (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003). Martin et al., (2003) conceptualized humor based on its function: to enhance oneself or to enhance one's interpersonal relationships. Cutting across these functions of humor is the capacious difference in its very essence. They distinguished between benign, adaptive

use of humor (e.g., self-enhancing humor, affiliative humor) and destructive, maladaptive use of humor (e.g., aggressive humor, self-defeating humor) as having contrasting effects (Martin et al., 2003). Self-defeating humor is considered to be of prime importance owing to its strong detrimental impact on psychological wellbeing (Martin, Lastuk, Jeffery, Vernon, & Veselka, 2012; Samson & Gross, 2012; Schermer et al., 2015; Vrabel, Zeigler-Hill, & Shango, 2017; Zeigler-Hill, McCabe, & Vrabel, 2016).

Self-Defeating Humor

Humor that is used to improve one's social relationships at the expense of one's own self is termed 'self-defeating humor' (Martin et al., 2003). It involves saying or doing funny things about one's own faults and incapacities in an attempt to gain approval from others. Self-defeating humor serves as a means of defensive denial, wherein one's honest underlying feelings are repressed in an attempted to earn social approval (Kubie, 1971). Although individuals who employ self-defeating humor are perceived as charming or witty, there are compelling factors of psychopathology associated with it (Martin et al., 2003; Zeigler-Hill, McCabe, & Vrabel, 2016). Furthermore, it is important to acknowledge the influential role of 'strength of self-defeating humor'. Some forms of benign humor may sometimes involve mild mockery, such as gently making fun of one's own mistakes. However, this may not be potentially dangerous to one's well being. The degree of self-disparagement involved in humorous behavior decides the extent of its negative impact (Martin et al., 2003; Warren & McGraw, 2015). The presence of such overlap between adaptive and maladaptive use of humor has not been sufficiently addressed. Therefore, a lack of structured conceptualization pertaining to the nature of self-defeating humor constrains an in-depth understanding of its implications in psychological wellbeing.

Functions of Self-Defeating Humor

In order to understand the association between self-defeating humor and psychological wellbeing, it is important to understand its functions, both intrapsychically and interpersonally. Intrapersonal benefits of humor is evident in Relief Theories, which suggest that people engage in humorous behavior in order to relieve stress and psychology tension (Goldstein & McGhee, 2013; Kuiper, Martin, & Olinger, 1993). The psychological unease accompanying unpleasant thoughts exceeds the mental capacity of controlled thinking. This in turn results in a strong emotional experience, which is unleashed by humorous behavior (Goldstein & McGhee, 2013). In case of self-defeating humor, it seems probable in the sense that one's faults or incapacities are disguised as jokes, thereby alleviating its chronic repugnance. In other words, self-disparaging jokes could help individuals to "laugh off" their misfortunes, convincing them that it is probably not very severe. However, when the degree of personal violation is excessive, it may contravene its own positive function of relief (McGraw & Warren, 2010). The underlying mechanism of such negative contra-effects has not been explored, encouraging the use of self-defeating defeating humor for intrapersonal relief.

In addition to offering intrapersonal relief, self-defeating humor helps improve relationship with others (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003). The social function of self-disparaging jokes could be explained by adapting from Superiority Theories(Ferguson & Ford, 2008). This theory suggests that humor arises from a form of downward social comparison, which offers a sense of ascendance over a group of people. Self-defeating humor, however, could involve voluntary subservience through joking about one's own mishaps in an effort to improve relationship with others. In other words, individuals may joke about their blunders to allow others experience a sense of triumph, resulting in affiliation. Unfortunately, the effectiveness of this technique is limited by the intensity of disparagement (Ferguson & Ford, 2008; Kuiper, Kirsh, & Leite, 2010). Although the confluence of these theories suggests a plausible explanation for an individual's choice of self-defeating humor, the latent processes remain unexamined.

Humor Intervention Program

Humor as a positive coping strategy is limited to its nature. The intrapersonal relief and interpersonal benefits associated with self-defeating humor is not clearly established. Therefore, it is important to consider intervention programs that emphasize on building such self-denigrating humor as a central coping mechanism. McGhee developed a manualized humor intervention program to bolster positive humor habits, which will strengthen an individual's coping system and improve his/her emotional resilience. The 7 Humor Habits Program (7HHP) is the first humor intervention to use a systematic route in terms of the eight steps it follows (Ruch& McGhee, 2014). However, the effectiveness of this intervention is narrow (Ruch & McGhee, 2014). A plausible reasoning points at the infusion of self-defeating humor in the training program. The sixth step as per the manual – "Take yourself lightly: laugh at yourself" focuses on the areas in life that are sensitive to criticism; it proceeds from the least to the most sensitive (Ruch & McGhee, 2014). A deep understanding of the origin and working of this form of deleterious humor is warranted, before applying it as part of therapy.

The current paper aims at re-conceptualizing self-defeating humor in humor interventions, through elaborating on novel propositions pertaining to its development, operating process, and its expansive detrimental impact on psychological wellbeing.

The Schematic Explanation of Humor

The conceptualization of the cognitive aspect of depression stems from the perceptual sets of core beliefs about self and enduring internal structures of prototypical features of the stimuli, ideas or experiences that are used to organize information in a meaningful way. These were called self-schemas. These schemas are largely activated early in life by negative life experiences that provides substantial effects in the development of psychopathology (Brown & Beck, 2002). The expansion of cognitive-behavioral therapy by Young integrates the childhood/adolescent experiences, emotive techniques, therapist-patient relationship, and maladaptive coping styles. Young hypothesized a sub-set of schemas known as Early Maladaptive Schemas (EMS), which he describes as a self-defeating emotional and cognitive pattern that begins early in our development and repeat throughout our life. It was perceived that people who use negative schemas are drawn towards events that trigger it. These schemas are used despite the detrimental effects it produces on oneself (Young, Klosko, & Weishaar, 2003). The relationship between humor styles and early maladaptive schemas found the correlates of self-defeating humor with specific domains of maladaptive schemas. The domains include 'Disconnection and Rejection' where the perceived instability, expectation of rejection/hurt, emotional deprivation, shame, and isolation had been observed to have effects on the self-defeating humor. The 'Impaired Autonomy' and 'Impaired Limits' also finds equal correlation with self-defeating humor which suggest that certain experiences mold an individual towards experiencing the detrimental effects of maladaptive humor (Dozois, Martin, & Bieling, 2009).

The model proposes that if the Early Maladaptive Schemas (EMS) are addressed among the individuals using self-defeating humor, it might directly challenge their motivation behind the use of this style of humor. The individual is drawn to the events that strengthen the maladaptive schemas. If these schemas act as a source for the detrimental usage of humor, the perpetuating factor might have to be modified by reducing the vulnerabilities for these individuals.

The Virtue of Humor

The central characteristics which employ a particular virtue give rise to character strengths. The Values in Action (VIA) Inventory systematically classifies human strengths and virtues which contains six central virtues of 24 strengths such as wisdom, courage, humanity, justice, temperance,

and transcendence. Out of these, only one or two of these strengths are particularly dominant (McGrath, 2015). Humor is defined as "the playful recognition, enjoyment, and/or creation of incongruity", "a composed and cheerful view on adversity that allows one to see the light side and thereby to sustain a good mood" and "the ability to make others smile or laugh". McGhee perceived playfulness as the motor underlying the sense of humor. He conceptualized humor as a personality based model where appreciation of incongruency-resolution and nonsense humor develops across the lifespan. An individual who is able to face adversities, suppress, mitigate or interrupt or change negative impact permanently would imply the traditional sense of humor as a psychological strength (Cloninger, 2005).

The character strength Humor will be solely effective when it is used as a coping mechanism against an unfavorable condition or situation. The model establishes the relationship between the trait humor and the intensity of use to mask the insecurities within oneself or in relation with others. If the intensity is high, this tends to activate the maladaptive schemas and the resultant use of detrimental humor becomes a threat to well-being.

Conceptualizing Self-Defeating Humor

The Self-defeating humor is a detrimental pattern of humor style that engages an individual towards the potential effects of psychopathology. The humor is said to be a character strength stemming from the virtue of transcendence which conceptualizes humor to generate throughout lifespan. This character strength integrates with the early experiences that activate Early Maladaptive Schemas (EMS). This explains the emotional output of the schemas manifesting as negative emotions while the behavioral output is in terms of verbal humor and laughter. When the behavioral output is reinforced or strengthened for the individual, the resulting effect perpetuates the current maladaptive usage of humor by strengthening the EMS. The model proposes that if early maladaptive schemas are addressed in individuals who are using self-defeating humor, the resultant detrimental effects can be prevented. Therefore, it tends to prevent individuals from progressing to pathological symptoms.

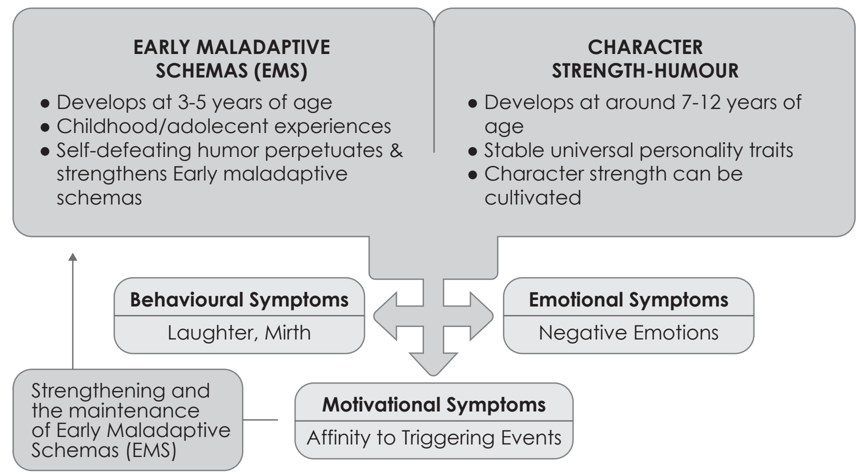

Figure 1 represents the Self-Defeating Humor Model that explains the manifestation of maladaptive humor

Behavioral Tendencies

According to Young, the behavioral responses are a reaction to and not a part of an individual's schemas. The maladaptive schemas result from an unmet need from childhood that drives an individual later in life. These schemas are responsible for the moment-to-moment emotional states and coping responses.

A dysfunctional schema mode is activated when the early maladaptive schema is taken over as a self-defeating or disruptive behavior. One of the dysfunctional coping mode explains the self-defeating behavior known as the 'Compliant Surrender' who gives in to the schema becoming a helpless individual (Young et al., 2003). Therefore, the cognitive manifestation of maladaptive schema endures as a relatively permanent pattern of maladaptive coping styles that perpetuates the effects of detrimental humor, which in turn strengthens the maladaptive schemas.

Emotional Tendencies

The use of maladaptive style of humor may lead individuals to create an emotional distance from the negative event than to accept the bright side of the event itself (Samson & Gross, 2012). The individuals high in self-criticism and neediness might use detrimental humor style which allows the perpetuating effects of dysfunctional transaction cycle. The dysfunctional transaction cycle is when individuals with high levels of self-criticism and neediness make them vulnerable to create their own stressful situation. Therefore, self-defeating humor is used as a defense against the insecurities or fears which further increases their distress. It was found that needy individuals tend to use self-defeating humor which have significantly led to the increase in depressive symptoms (Besser, Luyten, & Blatt, 2011).

We therefore infer from the model that events that increase negative emotions in individuals might as well create their own vulnerability by being dominated by their misfortunes. It acts as a cumulative effect on the individual as the negative emotions rise; it activates the schema related to the event in turn drawing individuals towards the same negative events. This phenomenon can be understood from the concept of 'circular causality' where effect of an event indirectly increases the original event (Fish, 1990)

Motivational Tendencies

The perceived control over events has positive outcomes in functioning to maintain the states of equilibrium. The illusion of control where individuals perceive unrealistic control over negative influences on their wellbeing can serve a positive coping mechanism. The use of unrealistic optimism and exaggerated control over events enable individuals to cope at the light of negative stimuli. It enables them to adapt to the damaged self by exaggerating the obvious (Taylor & Brown, 1988).

The level of motivational aspect in the model focuses on the triggering circular causality of events as explained by the model. The exaggeration of perceived control over negative events might sometimes have detrimental effects as opposed to the above research where the coping is at the expense of the self. This triggers the ripple effect that initiates the negative perpetuating loop by affecting psychological well-being.

Perpetuating Effects of Self-Defeating Humor

The maladaptive ways of coping often lead to the underlying chronic axis 1 symptoms of the DSM while the activating event of the early maladaptive schema depends on the severity and pervasiveness. If the activating event occurs early in life and is caused by a significant other, the severity of the self-defeating behavior is stronger than those activated later in life by less extreme agents that do not produce a significant detrimental effect (Young, Klosko, & Weishaar, 2003). This explains the summation effect of the behavior that perpetuates the use of humor in which a series of events contributes to the activation of schema, and at the same time focusing on the extent of severity in each of these situations. The model is provided to explain the severity of usage of maladaptive humor in the event of a triggering stimulus.

IMPLICATIONS OF THE MODEL

Explaining the Results of Humor Interventions Outcome

The 7HHP encourages the use of self-defeating humor which may facilitate the therapy for some while harboring negative emotions in others (Based on the proposed model). Crawford and Caltabiano (2011) could not properly show the effectiveness of the study even though they were able to show that it might enable positive emotional wellness (Crawford & Caltabiano, 2011). Another study which used brief humor interventions found that self-reported depressive symptoms in a non-clinical population reduced in the short-term follow up tests (1-, 3-months) but not the 6-month follow up (Gander, Proyer, Ruch, & Wyss, 2013). The implications of the self-defeating humor model suggest the dissection of the intervention program questioning the use of this style of humor in therapy due to its perpetuating nature.

The Cognitive-Behavior Therapy Model and Self-Defeating Humor

This conceptualization of self-defeating humor can be incorporated in Beck's CBT model (Beck, 1979) to emphasize the unfavorable effects caused by this detrimental style of humor. The previously accepted healthy coping mechanism is a psychological phenomenon that may also play a main role in maintaining the maladaptive schemas that lead to dysfunctional assumptions. The core schemas that arise from the early experiences lead to core beliefs that create a pathological cycle that is difficult to escape for the individuals.

Re-Conceptualization of Humor Intervention Programs: Need for a Screening Tool

The new understanding of self-defeating humor critically looks at one of the techniques used in the 7HHP which iterates the idea of making fun of one's insecurities and sensitivities. A screening tool that assesses the clients' maladaptive schemas such as the Young Schema Questionnaire (Young, Klosko, & Weishaar, 2003b) can be used to select participants who score low on the domains that are related to self-defeating humor. Screening clients to check for early maladaptive schemas can prevent not only the activation of the perpetuating loop but reduce its strength. This perspective about humor emphasizes the harm humor can cause in therapy when used without caution.

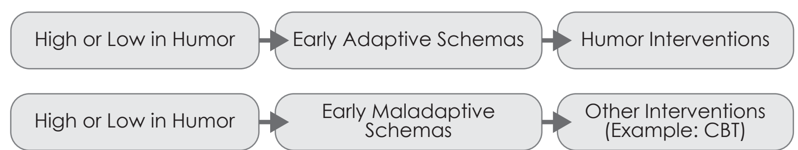

Figure 3 represents the screening process needed for selecting therapy before opting to use Humor Interventions

FUTURE DIRECTION

The manualized humor interventions suggest the use of a screening tool for humor but the implications of this is yet to be explored; the purpose of the screening has not been tested to see if varying levels of humor scores may influence the effectiveness of the intervention (Ruch & McGhee, 2014). The humor styles questionnaire (Martin et al., 2003) that measures four different humor styles can incorporate the present findings to redefine self-defeating humor using the suggested cognitive theories such that it can be used as a screening tool as well. The new understanding of humor also insinuates the need to explore other detrimental humor styles such aggressive humor (Martin, Puhlik-Doris, Larsen, Gray, & Weir, 2003) which may give explain other possible underlying mechanisms.

CONCLUSION

The integration of cognitive theories with positive psychology opens new portals to explore in the field of psychology. Humor in the broadest sense as a research interest had a comeback with the emphasis positive psychology placed on virtues and character strengths. Exploring the maladaptive aspects of humor widens the scope for understanding the nature and the implications of it. This becomes especially applicable in a therapeutic setting where structured humor interventions are used.

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ABOUT THE AUTHORS

PEARLENE HELEN MARY. D

Student, Master of Clinical Psychology (Christ University, Bengaluru)

SHEFALEY PHEBE K

M.Sc. Clinical Psychology (Final Year), Christ University, Bengaluru

MARY ANN S

M.Sc. Clinical Psychology (Final Year), Christ University, Bengaluru

Corresponding author: E-mail: pearlenedaniel@gmail.com, Phone: +91 9176136239

Mailing Address: 32, Thirumangalam Road, Anna Nagar, Chennai – 600040, Tamil Nadu, South India.

Part VI
REVIEWERS

PATRON

Dr. P. Krishnakumar

is the director of the Institute of Mental Health and Neurosciences (IMHANS), an autonomous institute under Government of Kerala and one among the institutes selected by the National Mental Health program of Govt. of India to develop into a centre of excellence in mental health. He is an additional professor of Paediatrics in the medical education service of Govt. of Kerala with postgraduate degrees in Paediatrics and Psychiatry with more than 20years' experience in teaching and research. His areas of interest include child and adolescent psychiatry and neuro-developmental disorders and has 30 publications in indexed journals to his credit. As director he was instrumental in starting MPhil courses in clinical psychology and psychiatric social work at IMHANS. He was also instrumental in developing an extensive community psychiatry network as part of primary health care services in North Kerala and starting the innovative mobile intervention units for children with developmental disorders.

REVIEWERS

Rytis Pakrosnis, PhD (Psychology)

currently works as associate professor at the Department of Psychology, Vytautas Magnus University, Lithuania; psychologist at the VMU Psychology Clinic; psychologist in private practice. Fields of interest are: SFBT outcome research; application and research of Solution-Focused approach in different areas and contexts; training of SFBT; psychotherapy outcome and process research; positive psychology; free will research.

A. Biba Rebolj. PhDc

FRSA is a solution focused therapist, coach and trainer from Slovenia, Europe. She has been working with young people for more than 9 years, starting in the pioneering group who launched tutor system at the University of Ljubljana in 2006. While pursuing research in the United Kingdom, she encountered Solution Focused Brief Therapy. It was love at first sight, which prolonged her staying in the UK by completing training with BRIEF in London, thus becoming the first Slovenian practicing and teaching solution focused practice, coaching and therapy. In 2014, she won an international award for distinguished debutante, which enabled her extensive training in the USA. Returning back home, she opened the first Slovenian research and training institute for the solution focused approach (www.ribalon.org). Today she continues doing therapy and coaching, working within youth and business settings on the European level for the EU Commission. She recently received a nomination from UK and became a Fellow of the Royal Society of Arts (RSA).

Dr. Shibukumar TM

is Assistant Professor of Psychiatry at Institute of Mental Health and Neurosciences, Kozhikode, Kerala. He has completed his MBBS from Government Medical College, Kozhikode and MD in Psychiatry from National Institute of Mental Health and Neurosciences, Bangalore. His clinical career included providing mental health care and palliative care in hospital and community settings. He has an active interest in psychiatric epidemiology, community psychiatry and psychosocial rehabilitation. He was the Principal Investigator for the state in National Mental Health Survey, India. Currently Dr. Shibukumar iis Regional Principal Investigator of National Drug Use Survey, India.

Santhosh Kareepadath Rajan, PhD

is the Assistant Professor of the Department of Psychology at Christ University (Bangalore, Karnataka) in India, since 2016. His research interests spans positive-solution-focused-correctional-psychology, which includes resilience, strengths, and pratixas (newly emerging concept). He has authored 19 publications (one book, two chapters and 16 journal articles). He is the member of International Positive Psychology Association, and is professionally associated with Association of Solution Focused Practices-India.

Dr. Abdul Salam K P

He completed his MA in Psychology from Barkatullah University,and got trained in Clinical Psychology (MPhil) from NIMHANS, Bangalore. Subsequently, he received his doctorate from NIMHANS, Bangalore for his work on Mindfulness in Social Phobia. He's been trained in Psychoanalysis and actively uses analytic framework in his clinical practice. His areas of interest include mindfulness as a transtheoretical construct and application of analytic thinking in individual and couple therapy.

Dr. Suresh Kumar M

is a professional Clinical Psychologist and therapist. His basic education in Psychology like UG, PG and M.Phil degrees were obtained from University of Kerala, Trivandrum. He pursued his M.Phil training in Medical and Social Psychology, from Central Institute of Psychiatry, Ranchi and he also procured his doctoral degree from Mahatma Gandhi University, Kottayam. He started his career as a therapist after his M.Phil and later entered in to the eld of teaching and research. He worked as Assistant Professor in Clinical Psychology in Sri Ramachandra University, Chennai for 6 years prior to the recent assignment. Currently he is working as Assistant Professor and Head in the Department of Clinical Psychology, Composite Regional Center, Ministry of Social Justice & Empowerment, Government of India. During these period of his service as an academician he had been published more than 20 original research articles in various national and international journal. He was also recognized as resource person in the areas of interests such as disability, addiction, psycho-diagnostics and therapeutics. He also received reputation as Fellow member in internationally recognized Psychology associations.

Jaseem Koorankot, PhD

is a Licensed Clinical Psychologist by profession and a trained Solution Focused Practitioner. He is currently working as Lecturer in Clinical Psychology at Institute of Mental Health and Neurosciences (IMHANS), Calicut, Kerala. Jaseem has published many scientific articles in the area of Solution Focused Practice(SFA) and presented papers in national and international scientific sessions. Apart from Training and Practice, he is actively involved in research and won grants. He is also a trained Clinical Supervisor of Solution Focused Brief Therapy. He has facilitated several introductory and advance level workshops on solution focused approaches in India and abroad. Jaseem is also the founder and Present General Secretary of Association of Solution Focused Practices – India (ASFP - I) - www.asfpindia.org, the one and only professional body for Solution Focused Practices in India. He Co - founded Academy for Solution Focused Approaches and Research (ASFAR)- www.asfar.in- with Dr. Arnoud Huibers in 2016, which is the only one institute in India, that solely train professionals in Solution Focused Approaches.

Dr. Seema P Uthaman

currently working as assistant professor and head, department of psychiatric social worker at institute of mental health and neurosciences (IMHANS) Calicut She completed her M Phil and PhD in Psychiatric Social Work from National institute of mental health and neurosciences, Bengaluru She has more than 8 years of post PhD experience in clinical, teaching and research. Her areas of expertise include child and adolescent mental health, autism spectrum disorders, and parent management training. She is a life skills trainer too.

Mr. G. Ragesh

is a Psychiatric Social Worker by profession. Completed Ph.D in Psychiatric Social Work from NIMHANS, Bangalore. He has work experience as Psychiatric Social Worker in various institutions and has experience is teaching in Psychiatric Social Work. He has publications in various national and international journals and has reviewed papers in various national and international journals. He is interested in perinatal mental health, human rights of persons with mental illness, suicide prevention, public health, non-adherence to treatment, forensic social work, psychotherapy, palliative care, clinical supervision & training in mental health.

Mr. Ijas Abdul Majeed

received his Master of Philosophy in Psychiatric Social Work from National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore in 2013. He holds a Master Degree in Social Work with specialization of Medical and Psychiatric social work from Pondichery Central University and a Bachelor of Arts in Sociology. Currently he is working as Junior Consultanat in Psychiatric Social Work in NIMHANS, Bangalore. Prior to his current position, he served as a Rehabilitation Social Worker in RFS, Bangalore and as Employee Assistance Program (EAP) Counselor in PPC Worldwide, Bangalore. He is also a certified Psychosocial Counselor and also life member of Indian Society of Professional Social Work (ISPSW) since 2011. He has been showing immense interest in Solution Focused Practice since 2013 and closely associated to Association for Solution Focused Practices – India (ASFP-I) thereafter. His interests include solution focused practices with individauls affected by psychosocial issues and mental illness and in providing training on solution focused practices. He is also an enthusiastic of solution focused supervision. His long term wishes for the future to become a social entrepreneur. Ijas is an accredited solution focused practioner by Association for Solution Focused Practices – India (ASFP-I).

Mr. Baijesh A. R

is a Clinical Psychologist based at Hyderabad. As a consultant clinical psychologist he has a regular clinical practice where clients with various psychological- interpersonal problems seek psychological assessments and psychotherapy. He is an SFBT practioner, a member of EBTA and an accredited member of ASFP-I. He is a visiting faculty for different universities and consultant to different organizations. A mindfulness practitioner and guide, he extensively use mindfulness based interventions and ACT in his clinical practice and research. He is trained in ACT with Russ Harris, a pioneer in the field. Apart from clinical practice and teaching, he also provides training, conducts workshops, carry out independent research and provide supervision. He has published scientific articles and has written chapters in books.

MANAGING EDITORS

Mr. Jithin K

is a Licensed Clinical Psychologist and Solution Focused Practitioner, presently working as a Clinical Psychologist at Institute of Mental Health and Neurosciences (IMHANS,) Kozhikode. He pursued his MPhil in Clinical Psychology from Post-Graduate Institute of Behavioural and Medical sciences, Raipur, Chhattisgarh. He is a Master Trainer in Autism Tool recognized by National Trust, Ministry of Social Justice and Empowerment, Govt.of India. He is a well-known therapist in child and disability rehabilitation. He organised various national and international events in the field of behavioural science. Mr. Jithin K is a professional member of Association for Solution Focused Practices-India (ASFP-I) and Indian Association of Clinical Psychologist (IACP).

Mr. Anas A

is a Solution Focused Practitioner & Psychologist specialised in organisational psychology, currently working as Psychologist cum Academic Coordinator at Academy for Solution Focused Approaches and Research (ASFAR)- www.asfar.in. He completed his master degree in Psychology from Periyar University, Tamilnadu. He has coordinated numerous workshops, seminars and conferences, nationally and internationally in the area of Solution Focused Practices, Psychotherapy, Disability Management etc., and currently acting as the coordinator of International Training Conference in Brief Psychotherapy (ITCBP2017). He worked as the coordinator for International Conference in Solution Focused Practices 2016 (ICSFP2016) held at University of Calicut in 2016.

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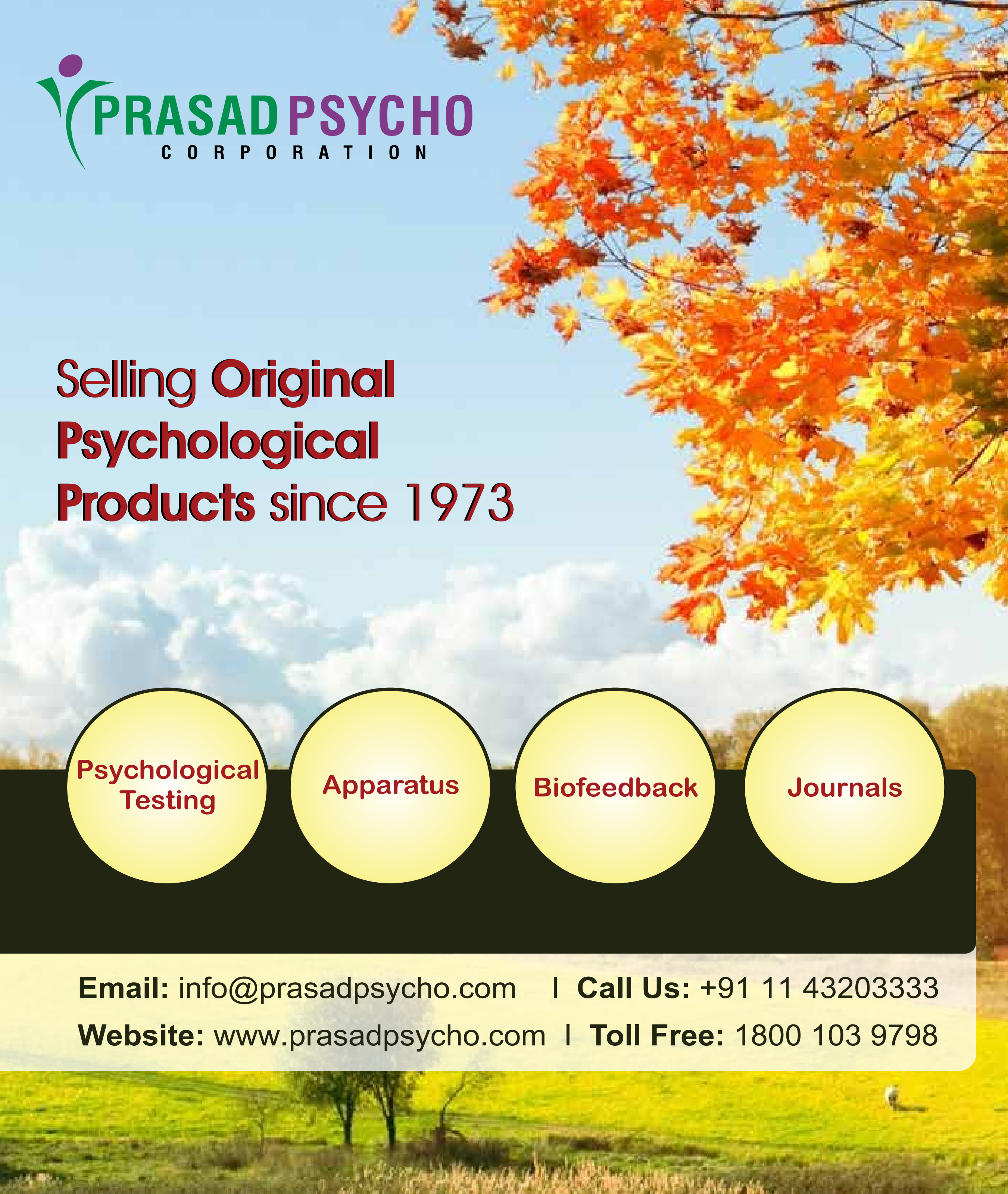

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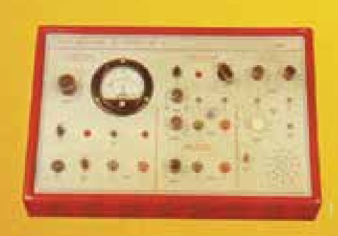

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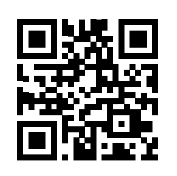

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