Carol C Choo · Roger C Ho *Editors*

Clinical Psychology Casebook Across the Lifespan

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Preface

The idea for this casebook came to me while I was living and working in Perth, Western Australia. It took a few years of effort, planning, and perseverance to see this book finally come into fruition. The profession of psychology has taken me to different parts of the world, across Australia and Singapore. The journey has not always been the easiest one, but it has been a most rewarding journey.

I am grateful to the clients who have entrusted me with the privilege of being a part of their healing journey. I am impressed by their strengths and their resilience in the face of adversities, and their lives tell a story of their triumph over the troubles that life sometimes bring. I am also grateful to the students with whom I have supervised in their work with clients. For at the heart of what I do in education and training, there is a passion to empower my students in not only clinical and therapeutic skills, but I hope that they also revisit the importance of the therapeutic relationship, and also the humanistic element of their work, while embracing the relevant standards and prevailing ethical code for our profession. I am glad to be a part of their learning journey, and I am proud to hear of their stories of success, and I am very pleased to be a co-author with the students I had supervised both in Australia and Singapore.

Within this casebook, cases were presented across the lifespan. The seven therapy cases illustrated evidence-based approaches, and delivery of the interventions was adapted to the respective life stage, with due consideration of the influences from their cultural, environmental, and social contexts. The last two chapters illustrated evidence-based assessment practices tailored to suit the local context.

On behalf of all the contributing authors, we hope that this casebook is both an informative and heartfelt contribution to our local knowledge base in Clinical Psychology training. Firstly, I hope this casebook is a useful resource to encourage our local clinical psychologists in training in their learning journey. Secondly, I would also like to take this opportunity to applaud all of us who have faced life adversities but triumphed and maintained hope, confidence, and resilience in the face of life troubles. When life gets too murky, the hope that I draw on comes from my spiritual strength; and my personal motto is “Faith is being sure of what we hope for. It is being certain of what we do not see”.

I will end this section with quotes from three of my co-authors.

In my journey of professional training, I have been invited to draw upon my own imaginal, creative and intuitive wellspring in order to enhance reflexivity and processing skills required in the interpersonal work. It is a genuine privilege to be invited into the inner-world of the child client, and to be able to hold space and engage in work that is based on safety, integrity and trust. It never ceases to amaze me when witnessing the plethora of resources that the clients have within themselves for self-understanding and self-mastery. The time that you spend training as a therapist provides a humbling opportunity, indeed a responsibility, to explore the qualities, experiences and beliefs that you bring to this work that may help or hinder your client's progress. In this particular case I was mindful of preconceived ideas of domestic violence and consciously processed this with the help of supervision so it did not influence the therapeutic alliance. Selecting child-centered play therapy was perfectly suited for this case due to the sensitivities of the client's age, home environment and the emphasis on strength-based humanistic principles. It was deeply rewarding to see the client's self-empowerment and resilience by the end of our time together. (*André Burton*)

Here at JCU, a holistic view is taken in equipping graduates in terms of both advanced theoretical and practical knowledge in preparation for professional practice. The supportive and nurturing environment has also been a key factor in facilitating learning as well as imbuing me with the knowledge, skills and confidence to succeed. The opportunities and the extensive support provided by the various clinical supervisors has been key in helping me grow as a clinician, and it has been a most rewarding journey. (*Acacia Lee*)

Being part of the JCU Clinical Psychology programme has been an extremely fulfilling and enriching learning experience for me. It has definitely provided me with a safe and nurturing environment for my personal and professional growth as a clinical psychologist. I am more than blessed to be able to learn from my supervisors and lecturers who have much valuable expertise to share, not to mention the many stories of healing and breakthroughs in their work with various clientele. At the same time, with their guidance, I am also privileged and humbled to be able to witness and journey with my clients towards restoration in their lives. (*Lim Jun Pei*)

Singapore, Singapore Carol C Choo

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This casebook would not have come to fruition without the clients who have formed the essence and the core of this book. We would like to dedicate this book to their bravery in having undertaken these journeys in self-exploration and healing. We are also grateful to our authors who have so willingly recounted their work with the clients. We are especially humbled by their unwavering passion and efforts in facilitating change for their clients, as well as commitment and contribution towards the building of knowledge and expertise in this profession.

We are thankful to James Cook University Singapore for the internal grant provided that made this casebook possible. Our gratitude goes to our colleagues at James Cook University Singapore and Townsville campuses, as well as our industry partners and clinical supervisors who have supported us in our endeavours.

We would also like to express our heartfelt gratitude to James Cook University, Singapore (JCUS) Psychology Clinic, Singapore General Hospital, National University Hospital, and Montfort Care for having provided their support in the development of this casebook.

Confidentiality

The cases included here are based on actual case histories or a composite of cases. Ensuring client confidentiality is of utmost concern and essential for publishing any client-related information. This casebook was undertaken within the guidelines outlined by the National Health and Medical Research Council (NHMRC) "National Statement on Ethical Conduct in Human Research" (2007). Ethics approval for this casebook was obtained from James Cook University Human Resource Ethics Committee (Approval Number: H7172). All of the cases were based on actual clinical experiences. Various demographic characteristics (names, occupations, etc.) and clinical details have been changed to protect the anonymity of clients and their families. Any resemblance to actual people is purely coincidental.

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Chapter 1
A Case of Child Survivor of Family Trauma: Creating a Safe Place, Building Strengths Through Play

André Burton and Carol C Choo

Birds fly, fish swim, and children play.

Garry Landreth

1 Introduction

Learning how to trust other people commences from the moment of birth. Young children are dependent on their caregivers for fulfilling their basic needs of comfort, shelter, food and love (Mullender et al., 2002). However not all home environments can guarantee basic comfort. Children who suffer from trauma have been exposed to environments that are marked by chronic stressors, frequently occurring within a family system that is intended to be the child's main source of safety. When these environments involve domestic violence, children can experience a disruption to their secure attachment to caretakers (Mullender et al., 2002). Evidence indicates that witnessing interparental conflict can negatively impact a child's social competence and problem-solving abilities (Feldman & Masalha, 2010) and can lead to conflict with peers at school (Finger, Eiden, Edwards, Leonard, & Kachadourian, 2010). Young children living in dysfunctional households marked with high levels of interparental domestic violence are at higher risk for developing future psychiatric disorders and overall health problems (Holmes, 2013; Yount, DiGirolamo, & Ramakrishnan, 2011).

The term domestic violence broadly refers to coercive and assaultive behaviours used against intimate partners, involving both men and women as victims (Holden, 2003). Trauma is defined as an unusually severe stressor or event that is capable of causing threats to bodily integrity that is accompanied by intense feelings of

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helplessness, fear and terror (Herman, 1992). Child exposure to domestic violence involves victimization from observing or overhearing or being directly involved in the assault caused by the perpetrator of violence (Holden, 2003).

Trauma is particularly damaging when it occurs in childhood (Kinniburgh, Blaustein, Spinazzola, & van der Kolk 2005). The empirical evidence suggests that growing up in an abusive home environment can critically jeopardize the developmental progress and have a negative influence on youth psychopathology (Harold & Sellers, 2018). Children exposed to domestic violence early in their life can acquire feelings of powerlessness and are seen to possess biologically dysregulated responses to stress (Repetti, Taylor, & Seeman, 2002). Dysregulation of these functions can predict deficits in social competence, behavioural self-regulation and emotional processing (Mead, Beauchaine, & Shannon, 2010).

Negative relational encounters are indelibly imprinted into maturing brain structures which can affect their overall mood regulation, self-perception, memory and impulse control (Bernet, Wamboldt, & Narrow, 2016; Schore, 2003; Van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Besides behavioural problems, child witnesses of domestic violence have also been found to encounter academic problems. Inconsistent school attendance related to family instability and transience and issues with concentration has been traced to anxiety, over-tiredness and other factors related to family crises (Moore, Pepler, Mae, & Kates, 1989).

The emerging picture from the literature suggests that children are not passive, 'silent witnesses' of domestic violence (McIntosh, 2003), but rather active in constructing their own meaning-making and social world in the aftermath of abuse (Holt, Buckley, & Whelan, 2008; McIntosh, 2002; Mullender et al., 2002). Moreover, the effect of interparental conflict on the child's well-being depends upon the manner in which the conflict is expressed, managed and resolved and the extent to which children feel threatened or responsible for their parents' fighting (Harold, Aitken, & Shelton, 2007).

Treatments that are tailored for children who have been exposed to violent settings should be drawn from the established knowledge base. Despite disagreements in the literature, there appears to be expert consensus that treatment for traumatized children should address six main goals: *self-regulation, safety, traumatic experience integration, self-reflective information processing, relational attachment and positive affect enhancement* (Cook et al., 2005). Successful treatment interventions with this demographic group are varied, although existing research highlights the need for treatments that adopt a strength-based approach, which promote safety and nurtures interpersonal relationships (Bratton et al., 2013; Landreth, Ray, Sweeney, Homeyer, & Glover, 2010; Myrick & Eric, 2014).

Trauma-informed treatment infuses trauma awareness, expert knowledge and skills within a comprehensive treatment approach (O'Connor, 2015). It has long been understood that play is a powerful tool of learning and that children are able to form new ways of thinking when playing with others (Vygotsky, 1967). Proponents of play therapy modalities acknowledge that children who have witnessed domestic violence cannot be expected to possess the verbal acuity to sufficiently express the complicated feelings and thoughts that accompany their trauma (Landreth, Ray,

Sweeney, Homeyer, & Glover, 2010). Many traumatized children may feel unable to share their stories without the use of non-verbal play activities. To allow for healing, it is important to recognize the strengths of the client and support their resilience (Booth & Jernberg, 2009). Essentially, child-centred play therapy provides the client with a sense of empowerment and has been designed to address client strengths, cognitive coping, emotion regulation and the enhancement of interpersonal relationships (Myrick, Green, & Fazio-Griffith, 2017; Ray, Armstrong, Balkin, & Jayne 2015; Siu & Pon, 2018).

There are a range of protective factors that can mitigate against the impact of trauma. Some of these include resilience, humour, good communication skills, possessing goals and intelligence (Lieberman & Van Horn, 2005). Family protective factors include at least one parent who is nurturing and warm who consistently interacts with the child, as well as open communication and family routine structure (Graham-Bermann, DeVoe, Mattis, Lynch, & Thomas, 2006). Support garnered from figures outside of the family can also be helpful for mental health treatment for the traumatized child. This would include teachers, friendships and school counsellors/psychologists.

2 Background

Eliot is a 6-year-old White Australian male from a low socio-economic background who was brought to therapy by his mother, following a string of domestic events. The client presented with sleep disturbances and minor struggles in his capacity to regulate emotions.

2.1 Family History

Eliot's parents were separated, and legal proceedings over Eliot's custody had been long underway prior to his first therapy session. In the recent past, the client's mother had applied for a Violence Restraining Order and Apprehended Violence Order and contacted Child Protection Services. Eliot's biological father had a long history of verbal and physical abuse towards his mother. During treatment, it was later revealed that Eliot's mother had dropped all court orders with the condition that the father would abide by the custody requirements and drop off/pick up times.

On a fortnightly rotation, Eliot was switching homes, where he alternated between his father's home that was a 4-h drive away from his mother's house. The mother was recently engaged to her new fiancé. Eliot attended the local primary school and commented that he had a best friend at school and felt close to his maternal grandfather who sometimes picked him up from school.

2.2 Academic History

At the time of therapy, Eliot had commenced primary school. The teacher informed his mother that he was usually a well-behaved boy but had increasingly shown signs of over-tiredness, distraction, anxiety and off-task behaviour.

2.3 Psychosocial History

At 6 years of age, Eliot was at the psychosocial stage of 'Initiative versus Guilt' (Erickson & Erickson, 1998). At this stage of development, there is a desire to mimic the behaviour of adults and to initiate creative play scenarios. Moreover, this phase involves children creating stories and playing out roles in a 'trial universe' where they can experiment with the blueprint for what it means to be a 'bigger person'. Children have their sense of initiative reinforced by being given the freedom to play and use their imagination. Success at this stage embeds a sense of 'person' into the child, whereas struggling to overcome this stage can result in negative self-perception and guilt (Erickson & Erickson, 1998). At this stage of development, family is the most significant relationship and has an influence on the well-being and psychosocial functioning of the child. In years to come, the next biggest influence will include the school.

3 Assessment

Assessment involved a clinical interview with the mother who was the primary caretaker. In order to develop a comprehensive case formulation, the therapist gathered data regarding (1) the client's developmental functioning; (2) the mother's perception of the systems in which her and her child were embedded; (3) the specific reasons for referral and presenting symptoms; and (4) the organization of the system in which the child lived. Initial data was taken from the primary caretaker and later the child client throughout session work. The initial assessment gathered relevant information on the family system, educational system and legal system that the child was embedded within.

4 Formulation

Eliot presented with sleep disturbance and minor struggles in the capacity to regulate emotions. The precipitating factors were related to the separation of his parents, the violence he had witnessed, as well as the overall transience of residency. Eliot

presented as intelligent, articulate and observant in the therapy room. Eliot enjoyed going to school due to supportive relationships with school peers and held stable attachments with adults outside of his immediate family such as teachers and his maternal grandfather.

At Eliot's stage of development, family is seen as the most significant relationship in the child's life. However, the nature of family had changed considerably in the past few years, and he had no consistency or stability in his home life. Recent events had required him to live with a new male authority figure, his mother's fiancé, which had added to further instability. The history of witnessing domestic violence and constant changing of home settings highlighted his insecure attachment with others. The breakup of Eliot's parents may have also challenged his core beliefs and destabilized his self-narrative as to whether he had a role to play in it.

The case of Eliot required the therapist to consider the dysfunctional family history of the parents. It was clear that all family members had been engaged in conflict and had exposed Eliot to violence. From the data presented, it appeared that despite the mother's genuine efforts to support her son, the constant change in living arrangements and legal proceedings was inducing significant stress into the child's life. Eliot's over-tiredness, distraction and anxiety were related to the sensitivity he experienced in the aftermath of witnessing violence, the transience of living accommodation and the impact of pervasive family crises.

Eliot's behaviours suggested that the aggressive encounters were affecting his mood and contributed to negative self-evaluation. Regular exposure to a hostile emotional atmosphere led to Eliot's behavioural and mood problems that developed as a defensive coping strategy. Protective factors helped to buffer the extent and pervasiveness of the client's trauma. For example, Eliot showed resilience, problem-solving skills and intelligence and had a grandfather who provided a warm relationship.

Without intervention, Eliot might have remained developmentally immature, emotionally constricted and could have difficulties with peer relations and developing self-confidence. It was important that within Eliot's therapy, he was able to develop alternative means of expression dealing with internal tensions.

5 Treatment

5.1 Intervention

The chosen modality for Eliot's treatment was eclectic child-centred play therapy (Landreth, 1993). Empirical evidence validates the success of child-centred play therapy in helping children develop self-esteem and prosocial behaviours and overcome trauma when conducted by a therapist trained in play therapy procedures (Kot, Landreth, & Giordano, 1998; Landreth, Ray, Sweeney, Homeyer, & Glover, 2010). Within the treatment plan, it was important that the therapist addressed

Eliot's issues with attachment, self-regulation, self-control, mood regulation and feelings towards the family crises and transience. Theoretical underpinnings for the treatment modality are detailed in Table 1.1 below.

The choice for this particular treatment was due to the key treatment principles (see Table 1.2) that encouraged the facilitation of safety through self-expression, providing consistency and focusing on Eliot's strengths. The therapeutic alliance was critical for establishing an exchange of empathy and non-judgement and was the primary area of focus (Feller & Cottone, 2003). The strength-based approach was utilized which was critical for enhancing the client's self-esteem and attachments with caring adults (Smith, 2006). However, due to external circumstances and

Table 1.1 Theoretical underpinnings that framed trauma-informed child-centred play therapy

1. *Self-regulation and self-control*
Children who have endured family trauma often struggle to express, recognize or manage their affective experiences appropriately, especially compared to peers who have not grown up in violent home backgrounds (Cook et al., 2005). Key components of trauma-informed treatments are to assist individuals to enhance their self-regulation, sense of control and mastery over their environment and modulate their emotional responses. Safety and stabilization-based interventions are introduced at the beginning of trauma-informed treatment (Shelby, Aranda, Asbill, & Gallagher, 2015). It is the aim of play therapies to minimize any triggers of trauma and to promote environments that facilitate positive affect regulation.
2. *The development of a secure base and attachment*
Attachment theory (Bowlby, 1988) is a core model of developmental psychology that explains the importance of secure and positive relationships between primary caregivers and their infants and how this interaction can set the template for later secure adulthood relationships. Rupture to the relationship and the onset of insecure attachment is seen as a mechanism by which childhood trauma affects later emergence of adult self-concept and adult interpersonal relationships (Bowlby, 1988). Trauma-informed child therapy emphasizes the importance of providing a safe environment to expose disruption to attachments and to develop new internal 'scripts' and models to the self and relationships.
3. *Fundamental attribution error*
It has been identified by social psychologists that humans often make a 'fundamental attribution error' in which they overemphasize a person's personality in explaining their behaviour whilst underestimating the critical effect of situational and environmental factors as external influences on behaviours (e.g. the influence of family members) (Jones & Harris, 1967). Therapists understand that creating new environments of support is important. By creating new safe environments, the client is able to have long-standing life-scripts 'reprogrammed' (e.g. changing the belief that all environments are untrustworthy and dangerous).
4. *Person-centred and child-centred approach*
The child-centred approach is the method of play therapy developed by Virginia Axline (1981) who was inspired by Carl Rogers' person-centred approach and later revised by Garry Landreth (1993). The objective is to create a non-judgemental and emotionally supportive atmosphere where the child leads the direction of the therapeutic experience. The child-centred play approach is based on the concept that children's natural language is play, and this medium is most suitable for comfortable self-expression. Child-centred work aims to perceive and understand the client through the eyes of the child, not the eyes of the adult. The approach is grounded on the core tenets that children are unique and worthy of respect, resilient and capable of positive self-direction. Clear boundaries are needed to be established that provide the client with psychological safety as they learn behavioural and emotional self-regulation.

Table 1.2 Landreth's (2002) 6 objectives of child-centred play therapy

1. 'Establishing an *atmosphere of safety for the child. The* play therapist cannot *make* the child feel safe; the child naturally discovers that in the relationship'
2. 'To understand and accept the child's inner world. Conveyed by being genuinely interested in whatever the child chooses to do. Remaining patient with the pace of the child's exploration. Understanding is accomplished by relinquishing adult reality and seeing things from the child's point of view'
3. 'Encouraging expression of the child's emotional world. *Play materials are secondary to the expression of feelings conveyed by the child. In play therapy, there is an* absence of evaluation of feelings. *Whatever the child feels is accepted without judgement*'
4. 'To *establish a feeling of permissiveness. The* child must feel or sense the freedom available in this setting. Allowing *(non-directively encouraging)* the child to make choices creates a feeling of permissiveness'
5. 'To *facilitate decision-making by the child.* Accomplished largely by *refraining from being an answer source for the child.* Opportunity to choose: What toy to play with, how to play with it, what colour to use or how something will turn out create *decision-making opportunities* which *promote self-responsibility*'
6. 'To *provide the child with an opportunity to assume responsibility and to develop a feeling of control. Being in control of one's environment may not always be possible. Significant variable is that children feel in control.* Children are responsible for what they do for themselves in the playroom. When the play therapist does for children what they can do for themselves, children are deprived of opportunity to experience what self-responsibility feels like. Feeling in *control* is a *powerful* variable and helps children develop positive self-esteem'

transient living arrangements, the client and his mother relocated, and the intervention took place over five sessions. These five sessions focused on building therapeutic alliance, based on a person-centred approach.

The primary treatment objective was to create a consistent and trustworthy setting that Eliot could visit each week. Building trust is important for psychosocial functioning (Rotenberg, 2010), and children who come from dysfunctional families are often used to experiencing inconsistent home environments. Most childhood-based trauma is interpersonal in nature, which provides the first clue as to the nature of the treatment that was needed for, which was a nurturing relationship.

In line with Shelby, Aranda, Asbill, & Gallagher (2015) suggestions, the intention of the first session was for Eliot to feel comfort and orientated within the room. The therapist began to structure the session the moment Eliot and his mother entered the clinic reception, utilizing subtle behaviours and words to provide a sense of calm. Child-centred play therapy is based on a theoretical orientation that encourages as little predetermined structure as possible since too much structure is known to deny opportunities for the client to experience self-regulation and self-determination (Landreth, 2012).

An introductory message was delivered to Eliot that conveyed that he was beginning a safe process of play and was able to be self-directed. Due to witnessing so much conflict at home, it was clear that the instrument of growth for Eliot was the therapeutic relationship itself (Barrett-Lennard, 2013). The intervention was aimed at cultivating a relationship in which Eliot could safely express his feelings, thoughts and behaviours through his natural communicative medium of play. The therapist

provided the safe space by connecting with the child's point of view and relinquishing adult reality or judgements (Landreth, Ray, Sweeney, Homeyer, & Glover, 2010).

The first session was characterized by the therapist having a slightly more active role in the play. It was decided that scaffolding the first session was helpful in establishing boundaries early on and determining the theme of the play (Landreth, 2002). The structure of play was centred around Eliot's feelings about living between two households. Eliot's initial artwork expressed a deep-seated desire for stability as well as the anger he felt towards his parents. Eliot used puppets to describe the two parents fighting with each other and a third puppet to describe how he felt as the child.

The child-centred play relationship provided Eliot with a consistent environment, to ensure Eliot would feel safe, which could then help to build the trust that is inherent in the therapeutic process. The consistency was achieved through the therapist maintaining punctuality and upholding a calm, gentle and stable therapeutic presence. The therapist understood that his role in the relationship was to contribute to Eliot's unfolding of self-directed change and development of self-regulation. The play materials assisted Eliot in gaining a sense of self-mastery and control over his immediate environment, regulating his mood and externalizing the problems he was facing.

Eliot was drawn to use the sand tray and most of the play materials. Since traumatic events often leave victims with a sense of having lost control over their inner and outer world, it is essential to offer them ways to re-establish a sense of control. Our conceptualization drawn from both person-centred and narrative therapies is that the sand tray became a microcosm of the real world and afforded Eliot the opportunity to reclaim mastery (Mitchell & Friedman, 1994). The therapist offered a supportive presence to facilitate the client's play. In the miniaturized version of his worldview, the client was able to see what things looked like when he played out various storylines with the relevant characters. Play therapy emphasizes connectedness and aims to establish a rapport that is interpreted as caring and accepting. According to Landreth (2002), the empathic responsiveness of the therapist was essential to Eliot's changing view of himself as a valued human being.

Sessions two, three, four and five involved non-directive play that allowed for development of adaptive coping mechanisms at his own emotional pace (Landreth et al., 2010). Eliot was given direct control of the content, theme and process of the play and was encouraged to select the materials. He was also given control of the pace, and he was spontaneous in doing so. The play-based activities addressed age-appropriate issues he was facing such as friendship and school problems. Familial figures were regularly alluded to in Eliot's play narratives. There appeared to be a dichotomy of good versus bad, e.g. there was a consistent reference to rescuing 'the goodies' from harm's way. Eliot had expressed his own self-perception as benevolent when he said, 'I feel like I am the Prince, he is the goody'. Eliot self-identified as a hero figure and displayed to the therapist that the other figures were threatening to him.

By the fourth session, an emergent theme in Eliot's play was the power of using his voice to express his opinion. Through reverting out of play mode into narrator

mode, Eliot was able to be the author of his own story, which was something that was lacking in his life prior. The modulation of role-playing indicated his quick decision-making and flexibility to variance in his environment.

5.2 Outcome

Eliot presented with anxiety and sleep disturbance, yet through the use of puppets and sand tray activities, his anxiety was reduced. Eliot was able to externalize his problems and increase distance from 'the self' through the content of his playtime. By providing predictable safety and a nurturing relationship, it allowed for Eliot to explore and resolve some of his confusion about the conflict he witnessed. At first tentative, he eventually disclosed in detail due to the comfort he felt. The treatment outcomes included changes in (1) sleep disturbance; (2) perceptions of self; (3) mood swings; (4) appropriate social engagement; (5) methods of coping when feeling confused and angry; and (6) awareness that adults' problems were not his own problems. Eliot seemed capable of establishing and/or maintaining healthy relationships as noted by his engagement with the therapist and Eliot's mother.

The therapist was sensitive to the child's feelings and gently reflected those feelings back to him in such a manner that he was learning to develop self-understanding by the last session. Play therapy helped Eliot to establish a 'feelings first aid kit'. The first aid kit is a therapeutic mechanism that allows the client to fill a bag with transitional objects that represent their 'safe place'. Eliot was able to leave therapy with his feelings kit that he used as a regular form of self-care. The bag became one of the coping skills that Eliot would rely on within his dysfunctional home settings. For example, when hearing people yelling at home, Eliot could take out his 'scratch and sniff' stickers and place them on his notebook when stressed. Other objects in the bag included favourite glitter pens that he would draw with when unable to sleep.

6 Discussion and Conclusion

The instrument of growth for Eliot was the therapeutic alliance itself. The strength-based practice encouraged a collaborative process in which Eliot was affirmed in his competencies (Smith, 2006). Children need to be listened to and affirmed. They need to be met on their level, and not denied opportunities of self-determination. After all, the child-centred approach is not problem-oriented, and the focus of therapy is the child, not the child's problem framed within a 'fix it' mentality (Landreth, Baggerly, & Tundall-Lind, 1999).

In order for child-centred play therapy to succeed, the therapist had to hold a dedicated faith in the power of the process and a strong belief in the child's inner strength (Guerney, 2001). The therapist upheld this belief, attuned to Eliot's reality

and drew upon his strengths of intelligence and creativity to support growth. Eliot had been responsive to engaging in play therapy and worked through the conflict he had faced in recent years. Eliot's conflict was expressed and managed, thus mitigating the extent to which he felt threatened or responsible for his parents' fighting. Throughout session work he was able to freely explore in his 'trial universe' that he had control over.

Eliot was an example of a client who was able to benefit from the brief intervention of child-centred play therapy due to his trust in the process. Although it should be noted that not all children possess such willingness to engage in new activities, child-centred play therapy gave the opportunity for Eliot to gain a sense of mastery and offered a creative and child-appropriate way to express the conflict and make sense of the stress he was experiencing at home.

The manner in which Eliot manipulated the play materials and puppets to enact the aggression he witnessed at home provided a safe way of expressing his emotions, and he was able to convey the turmoil of his own story with a safe emotional distance. Consistent with the heart of narrative therapy (White & Morgan, 2006), he was able to develop a sense of control over the narrative and became the author of his story, where he constructed a preferred story line with the support of his therapist. Consistent with an integrative person-centred and narrative approach, delivered in the child appropriate medium of play therapy, the intervention helped to reduce feelings of confusion and anger and enhanced his emotional regulation.

6.1 Challenges

There is a growing awareness of the need for implementing strength-based trauma-informed therapy for clients who have grown up in households of domestic violence. Despite initial success, the short treatment period of five sessions was very brief. Implementing trauma-informed care that accommodates enough time for children such as Eliot requires a paradigm shift in service delivery (Hopper, Bassuk, & Olivet, 2010).

The literature around trauma-informed care reveals that there are still some challenges to implementing this approach for systems and services across Australia, as well as the need for research to evaluate service delivery outcomes and the effects of trauma-informed care on client well-being (Ashmore, 2013; Australian Centre for Posttraumatic Mental Health & Parenting Research Centre, 2013; Hopper, Bassuk, & Olivet, 2010). Due to the various stages of childhood maturation, specific competencies of children must be targeted at age-appropriate levels. In order to tailor treatment plans, it is critical that individualized assessment is able to identify the child's developmental status and any pre-existing familial and systemic stresses.

Although often challenging to arrange, it would be beneficial for future therapists to speak face-to-face with figures that the child holds secure attachment to (other than the primary caretakers). Teachers and grandparents are an example, although this form of interviewing was not conducted in the current treatment due

to limited time. Gathering qualitative information regarding the child's progress from these figures may help to inform treatment with more accuracy since it is tailored to the child's needs across all environments they find themselves embedded within and can indicate outcomes. Measures of parental observations of the child's behaviour may be biased, especially in a dysfunctional family system, which is why the extended family can sometimes provide a more balanced view.

There is often stigma and shame surrounding domestic violence, and many parents do not wish to disclose such information to the schools. Mental health counselling needs to start early in primary schools so that the consequences of domestic violence crises do not escalate. The school needs to be able to meet the challenges of effectively addressing the sensitive needs of children living in family crisis and to refer them to counselling as soon as concerns are flagged.

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Chapter 2
Developing a Child's Social-Emotional Skills in Therapy and Beyond

Karen Ang and Carol C Choo

1 Introduction

School is a place where children spend much of their time learning and playing together with their peers. Many children enjoy the interaction with peers. However, there are some children who have challenges with peer interactions and may dislike time with peers. Often, this may be due to a child's poor social skills. Social-emotional skills, otherwise known as social skills, encompass a range of different skills and can be defined as specific behaviours that are learned, including initiations and responses. These skills are interactive and situation-specific and can maximize social reinforcement (Merrell & Gimpel, 2014). These specific behaviours can include expressing feelings, accepting consequences, following directions, coping with conflict and helping others.

Social-emotional skills are essential and can be the foundation of personal social adjustment in life, impacting outcomes in adulthood, such as educational and career success (Carnerio, Crawford, & Goodman, 2007; Jones, Greenberg, & Crowley, 2015). Deficits in social-emotional skills are linked to poor social adjustment, mental health problems and low self-concept. Poor social skills in school may be related to the following factors: (a) limited opportunities to learn, (b) negative academic and social self-concept and (c) social isolation. Hence, it is important that children who have poorly developed social skills be identified as early as possible for intervention to enable them to develop adequate social skills for peer interaction, gaining positive peer experiences.

Assessment of children's social-emotional skills often involves identifying which area/s a child is having particular difficulty with. Caldarella and Merrell (1997) identified five major dimensions of children and adolescents' social-emotional skills:

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(a) Peer relationship skills
(b) Self-management skills
(c) Academic skills
(d) Compliance skills
(e) Assertion skills

These are broad categories of skills and include other more specific skills. Assessment involves gathering information from teachers and parents (Choo, 2014), as the child may not always be aware of his/her situation or may not be comfortable to talk about it. Most social-emotional skills consist of several component tasks or steps that must be enacted to perform each skill (Merrell & Gimpel, 2014); hence, the psychologist will need to further assess and understand whether there are certain component tasks/steps that the child may be having difficulty with.

2 Background

Aaron is a 7-year-old Chinese Singaporean male who comes from an intact family of four and is the older of two children. He is currently a primary one student at a local mainstream primary school.

Aaron's parents had initially referred Aaron for an assessment, due to concerns regarding Aaron's anger management and attention span. A definitive conclusion could not be reached about Aaron's cognitive abilities in the assessment done previously by another psychologist, due to his difficulty in staying alert, as he fell asleep halfway through the assessment. It was recommended that Aaron be taught emotional regulation and anger management skills. Aaron's parents decided to follow-up with therapy sessions to address concerns about his emotional regulation and anger management.

Aaron's parents reported that Aaron tended to become angry when he was not able to have things done in the way that he wanted. Aaron's mother described that he may shout when he is angry. A situation where Aaron got upset was in a group work situation at school when there was disagreement within the group members. As a result of repeated negative experiences in group work, Aaron's mother reported that Aaron currently tends to keep quiet during group work activities. Another specific situation involved Aaron hitting a peer at school.

2.1 Family History

Aaron is observed to have a close relationship with his parents and sister. Aaron's parents reported that Aaron is generally caring towards his younger sister. However, they can be competitive when playing games, and conflicts may arise regarding winning and losing.

2.2 Psychosocial History

Aaron's mother reported that Aaron's disruptive behaviour in the classroom started when he was 5 years old, when he engaged in rough play at times to gain attention from his teachers.

According to Aaron's form teacher, Aaron has poor behavioural and social skills. His classmates do not want to partner with him during group work as he tends to speak too loudly and is impatient and insistent on doing things his way. Consistent with the teacher's report, Aaron's parents also reported that Aaron tended to 'want his own way' when doing group work, and it was challenging to have him accept other people's ideas. Additionally, Aaron's parents observed that students who knew Aaron were fine with him initially, but Aaron had difficulty maintaining the friendships later due to him wanting his own ways.

In the previous assessment, Aaron had reported being bullied on the school bus by older children; hence, he is very reluctant to take the school bus. After speaking to the bus coordinators, Aaron's mother later clarified that it was children teasing each other on the bus and should not be a matter a concern. On a separate occasion, Aaron perceived his classmates to be laughing at him for being the only one that did badly in a test. However, according to his teacher, that was definitely not the case. These may suggest that Aaron is sensitive to peer rejection and may perceive others' laughing and friendly teasing negatively.

2.3 Learning, Educational Issues and Occupational History

Aaron's parents and teachers have observed that Aaron tends to do his work hastily, making several careless mistakes. Aaron was reported to often make spelling errors. In clinical sessions and consistent with parents' observations, Aaron tends to be reluctant to engage in activities involving much writing and prefers to provide the answers verbally.

In terms of verbal language expression, Aaron is able to communicate his needs, though it takes him a while to construct sentences in his mind before speaking. According to Aaron's form teacher, Aaron's Mother Tongue teacher also noted that Aaron tends to talk very loudly or shouts in class without being provoked.

Aaron's form teacher also reported that Aaron has difficulties focusing in class, often daydreaming and sleeping in class, across different subjects and during different times of the day. At the intake interview, Aaron's mother reported that Aaron was reported to 'sleep in class' at least once to thrice per week.

From the assessment done previously, Aaron's cognitive profile revealed that his personal strengths include logical reasoning (general reasoning). However, he is underdeveloped in his abstract reasoning ability, which is his personal weakness.

2.4 Medical and Psychiatric History

Aaron's mother reported that Aaron suffered from middle ear infection when he was about 3 years old, despite being vaccinated. As a result, he was not able to hear for about 7–8 months but subsequently recovered with medical intervention.

There is no family history of substance use, psychiatric history and developmental disorders reported.

3 Assessment

Assessment was done through gathering information through clinical interviews with Aaron's parents and Aaron himself. In-session observations of Aaron's behaviour were also another important source of information.

Initial engagement of Aaron in the clinical interviews was challenging. He was quiet and did not speak much, remaining quiet or giving short phrases when answering. He seemed more open to sharing about things he liked (i.e. animals, nature, astronomy, movies, cartoons, cars and planes) but tended to keep quiet when the psychologist approached topics regarding things he disliked or particular difficulties he faced in school.

From clinical interviews with parents, it was identified that Aaron had challenges with his voice control [volume], tending to speak at a loud volume both when angry and during normal talking. Furthermore, he had difficulty accepting differing views from others. As a result, he often had problems working with other peers for group work, as he was unable to accept when others chose different options from him. Also, it was noted that Aaron had difficulties with emotional regulation and had recently hit a peer in school, out of anger.

A checklist of specific task components of targeted social skills was developed to gather observation of specific social skills of concern and the simpler subset of skills required, to track his progress over sessions. His mother reported the behaviour she had observed, and the psychologist also gave feedback about what was observed in session. The form was completed at the third session and final session by both mother and psychologist.

4 Formulation

Aaron presented with difficulty managing his anger in situations where he was not able to get his way or where he thought that others had caused him trouble. When Aaron was angry, he tended to raise his voice and, on one occasion, hit another student in school. Aaron's behaviour contributed to his difficulty maintaining relationships with other students.

Aaron seems to have limited ability to take perspectives of others. He may only be beginning to realize that other people might have views that differ from him, but he may not be able to consider those perspectives which are very different from his views. Aaron's personal weakness in abstract reasoning may compound his difficulties in understanding and considering different perspectives in a situation. Aaron is able to communicate his needs adequately; however, he was noted to take a while to construct sentences in his mind before speaking.

As Aaron started schooling, he had increased opportunities to interact with peers in different situations. However, with his difficulty in taking other perspectives, Aaron tended to insist on his own way and had difficulty accepting other ideas and suggestions. When Aaron was not able to get his way, he tended to get angry and would shout. Subsequently, this led to several classmates not wanting to work with him in group work. When Aaron is angry, it is even harder for him to generate the sentences to express himself, and he required more time to do so; hence, he may choose not to speak at times and keep quiet but continue to feel upset about the situation.

Aaron's difficulty in understanding and accepting other perspectives perpetuates his responses of insisting his own way and anger with others when he does not get his way. Furthermore, Aaron's lack of knowledge on how to manage his emotions also impedes his ability to respond to situations in a calm manner; thus, he tends to respond impulsively. Repeated negative experiences with Aaron lead to peers distancing from Aaron, and in turn, Aaron feels rejected by his peers, leading to Aaron's feelings of loneliness which exacerbated his anger towards his peers.

Nonetheless, Aaron has supportive parents who are motivated to help Aaron manage his difficulties with emotions. Aaron's mother and teachers have also noted improvement in Aaron's behaviour with the use of positive reinforcement, indicating a potential to improve and progress with suitable supports in place.

5 Treatment

Throughout the course of treatment over 14 sessions, there was close communication with Aaron's mother, who brought him to attend sessions. After each session, Aaron, together with the psychologist, shared with his mother about what was done in session. Psychoeducation was provided to his mother too, regarding the following:

- The use of positive reinforcement with Aaron when he shows appropriate behaviours
- Parent psychoeducation on the growth mindset and praising child's academic efforts
- Parent psychoeducation on ways to help child talk about feelings

As Aaron's challenges with interacting positively with peers seemed to contribute to Aaron's negative emotions, supporting Aaron to build social skills to enable

good interactions with peers was identified to be an important focus in interventions. The following intervention goals were identified, namely, for Aaron:

(a) To be able to identify use of suitable volume in different contexts
(b) To be aware that different people may have different thoughts and feelings
(c) To be able to identify what to do when people have different thoughts and feelings from him
(d) To be able to stop and think, before responding, when he meets with people with different thoughts and feelings from him
(e) To be aware of things he could do to calm down when he is upset
(f) To be able to engage in activities to calm down appropriately when he is upset

In the initial sessions, the main focus was on building rapport with Aaron and understanding more about Aaron's perspective of his current situation. This was done through engaging Aaron through his interests and allowing him some opportunity to make choices, enabling him a sense of control.

5.1 Incorporating Activities of Interests

One of the activities conducted was reading books, including those about his interest topics of nature and animals. In particular, a book called 'Rawr!', by Todd Doodler, was read with him, which was about a dinosaur in school, which seemed to be different from others and had difficulties fitting in. Using the story, the psychologist asked questions to elicit Aaron's experience at school, through which he shared briefly about being told on by others and having no friends to play at school.

A 'cut and paste' activity, using characters that Aaron liked from 'Star Wars', was done too. He was provided with an A3 paper and printed pictures of the movie characters, which he could choose and cut out to paste freely on the paper. With colour pencils and crayons, Aaron was allowed time to draw out the scene which he was creating on the paper. As he did this, the psychologist helped to elicit from Aaron his view about what was happening and how different characters were feelings.

Aaron liked board games, and this was a useful tool that the psychologist used to evaluate Aaron's ability of managing different perspectives. For example, Aaron chose to play a game, and when rules were clarified with him, it was highlighted to him that his understanding of the rule was different from the psychologist's. Once Aaron knew that, he chose to play another game instead, seemingly to avoid the difference in perspectives. Later on, when playing the other game, when a difference in perspective of the rules was presented again, Aaron was observed to whine. The game only managed to move on when the psychologist shared verbally with Aaron that she will accept Aaron's view as the printing on the board had been ambiguous. Through this experience, the psychologist used the opportunity to model to Aaron how differences could be managed calmly in an appropriate manner.

5.2 Assessing Awareness of Volume Control

As parents had highlighted Aaron's difficulty with volume control, a 'volume control' game was used to evaluate if Aaron was aware about different volumes used in various contexts.

A volume chart was used for Aaron to reference the different volume levels. Then, slips of paper with different contexts Aaron might face were placed in a bag, from which the psychologist and Aaron took turns to pick, each taking turns to identify the suitable volume levels to use in each context. Aaron was able to identify accurately picking suitable volumes to use in various contexts.

5.3 Creating a Safe Environment to Talk about Feelings

At first, Aaron did not seem comfortable talking about negative feelings and experiences. Psychoeducation on feelings was incorporated through intervention sessions to help Aaron identify, label and articulate his feelings in different situations.

To enable Aaron to be more familiar with expression of feelings, feelings check-in was done with him at the start of every session. The psychologist would ask him 'how are you feeling now?', and Aaron was to identify and name his feelings either by drawing/writing the emotion or verbal expression.

As the sessions progressed, Aaron was able to talk and share more with the psychologist. Once, when the psychologist self-disclosed that she was feeling anxious about her university assignment, Aaron also shared that he was feeling anxious about his school work, e.g. mathematics subject. There was a brief discussion about how he could think different positive thoughts to help himself feel better.

5.4 Scaffolding Steps to Understanding about Different Perspectives

With the therapeutic relationship established, the therapy focus moved on to helping Aaron understand about different perspectives between people. This was done in a step-by-step manner, approaching from a more concrete and less threatening manner, by starting with physical differences that may be observed. At the start, the general concepts of 'same' and 'different' were explored with the use of pictures of things of interest, such as cars and planes. In the same session, he was then asked to identify similarities and differences in physical appearance among people in a picture. After that, he was asked to identify similarities and differences between the psychologist and him.

Subsequent sessions moved on to focus on similarities and differences in more abstract areas of thoughts and feelings. A video was shown to Aaron, in which a

child was waving a toy lightsaber. Aaron then shared about what he thought about it, before going on to view the remaining of the video where different children expressed their thoughts.

After that, a take-home activity was shared with Aaron and his mother to complete at home, to further highlight to Aaron about taking different perspectives and understanding how others may have different thoughts.

Lastly, the Stop-Think-Do framework was introduced to Aaron for him to know what he could do to respond in situations. 'Calming-down' strategies were explored as part of what he could do to manage an anger triggering event. This framework was later practised as part of a game, where Aaron 'drove' a toy car to different parts of the 'road'. Whenever he stopped at the 'traffic light', Aaron was required to pick a 'scenario card' and show what he would do in the scenario, using the 'Stop, Think, Do' framework.

The skills to work with different opinions were then generalized and used when the psychologist worked with Aaron on small projects in session, such as building a 'rocket' using scrap cardboard and making a greeting card. The psychologist expressed a different opinion from Aaron, and he was to respond to the situation. Similarly, it was shared with his mother to create such opportunities to generalize and continue practising the knowledge and skills learnt.

5.5 Outcomes

Aaron's mother reported that Aaron was expressing his emotions more and was better able to regulate his emotions, with verbal prompting from his mother, such as being reminded to 'calm down' when he is upset. Aaron's mother reported that the strategies taught had been helpful. She was reinforcing the same strategies at home and is seeing 'improvements in behaviour', indicating so in the observation checklist too. Furthermore, Aaron's mother shared that Aaron was coping better at school, being able to express to teacher when he is upset and have a break to calm down, before joining in lessons again.

It was discussed with Aaron's mother and agreed that it was a suitable time for therapy sessions to be terminated, as the required strategies had been taught. Materials that were covered with Aaron in session were shared with Aaron's mother, and Aaron's mother would be continuing to reinforce the strategies and help Aaron generalize them to different situations. Aaron's mother would continue to monitor Aaron's progress and would arrange therapy sessions again in the clinic, if needed, in the future.

At the time of termination, Aaron's mother also reported that all her concerns about Aaron had been addressed, with reported improvements, and he was sleeping less in class.

6 Discussion and Conclusion

Often, when working with child clients, parents may have a clear idea of the goal for therapy, but the child himself may not have any particular goals and may not be able to articulate any. In Aaron's case, it was also challenging for him to talk about difficult, upsetting situations, and the child himself may not see the need for the therapy sessions. Hence, it is particularly crucial to spend more time building the relationship with the child (Choo, 2014). Aaron was quiet and reserved at the start, shying away from talking about negative experiences, and it was especially important not to ask too many questions. With Aaron, the use of story books, games and drawing provided a non-intrusive way of inviting him to share bits of his world with the psychologist.

Another aspect that stood out in therapy work with Aaron was enabling him to feel safe in sharing his thoughts and feelings. Self-disclosure from the psychologist was a way to model to Aaron how he could share about feelings, and it let him know that he is not the only person who experiences these feelings. Checking in with Aaron about his preferences, in the content shared with his mother, or if he would like to sit in with the psychologist to share with his mother about what was done in sessions, also seemed to provide him a sense of control and safety in sessions.

For effective social-emotional skills interventions, different opportunities for the child to practise the skills are required, not only in-session but also in the child's environment. Fox and Lentini (2006) suggested referring to Bailey and Wolery (1992) three stages of learning to understand how social skills may be acquired. The three stages are (a) skills acquisition, the skills is introduced to child; (b) fluency, child has learnt the skill and can use it easily; and (c) skill maintenance and generalization, the child can use the skill over time and in new situations. Hence, it highlights the importance of having to work with Aaron's parents to generalize and practise the skills learnt beyond therapy sessions. If time and resources had permitted, it would have been beneficial to have Aaron's sister attend one of the sessions to involve in an activity together, for Aaron to practise the skills learnt, such that Aaron may generalize his skills learnt to other people beyond the psychologist. Where possible, small social skills group with other children may have been beneficial too.

Nonetheless, Aaron's mother working closely with the psychologist and school was an important aspect that contributed to the positive outcomes in intervention with Aaron, as it enabled consistency towards management of Aaron's behaviours. Also, his mother constantly reinforced positive behaviours, and followed through on strategies shared with her were beneficial in creating a conducive environment for development of Aaron's social and emotional skills.

In conclusion, this chapter highlighted the use of child-centred therapy, with strategies that were helpful to enhance the child's social-emotional skills.

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Chapter 3
Early Abandonment and the Impact in Adolescence: Using Narrative Therapy Approach in Therapy

Acacia Lee and Carol C Choo

1 Introduction

The physical, emotional and cognitive changes that occur during adolescence coupled with heightened anxiety levels and social issues can be challenging for adolescents. Researchers have found narrative therapy to be a beneficial method of treatment for adolescents for various social issues and mental health conditions (Romagnolo & Ohrt, 2017), and time-limited 10-session narrative therapy intervention with adolescents were effective for reducing mental health symptoms (Ikonomopoulos, Smith, & Schmidt, 2015).

Clients may face challenges in therapy sessions when they experience difficulty expressing their thoughts, feelings and experiences, due to various reasons. Therapists using narrative therapy assist clients in finding an alternate solution by faciliating a therapeutic dialogue to aid in externalizing their oppressive experiences. This facilitates a revised narration of their maladaptive perspective, which they have internalized. By externalizing their oppressive experiences, clients rewrite their life story, removed from their problem-saturated perspective. Clients' exploration of their life story in therapy can be enhanced using narrative therapy techniques in conjunction with creative art techniques. The narrative approach involves a paradigm shift from traditional theories (Freedman & Combs, 1996). Therapists establish a collaborative approach in listening respectfully to client's stories. Therapists actively search for times in client's lives when clients were resourceful and use skillful questioning to facilitate clients in mapping the influence a problem has had, while assisting clients in separating themselves from the dominant problem-saturated stories they have internalized so that space can be opened for the creation of alternative life stores.

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2 Background

Noy is a 14-year-old adolescent of mixed Filipino/Indian ethnicities. Currently, Noy lives with his adoptive family which consists of his adoptive parents and elder brother. His birth mother occasionally visits Noy and provides some financial support. It is noteworthy that no formal adoption procedures have been undertaken. Noy was referred for psychotherapy following concerns of emotional difficulties with respect to his birth father who left the family when he was a year old. Noy's birth father left the family when Noy was 1 year old, and his birth mother then gave him to a family friend for caretaking. He has been living with his current foster family since then. His adoptive parents, Mr. Rudy and Mrs. Gina described his birth parents as negligent in taking care of Noy when young and recounted Noy being unkempt with dirty diapers when his birth parents occasionally brought him over. Mrs. Gina also recalled Noy appearing undernourished when she adopted him into the family.

Since his birth father left the family, Noy had not been in touch with him and does not remember his presence. His birth mother occasionally visits him and spends time with him. Noy described his current foster family and foster parents as kind and supportive and reported being close to all of them, especially Mrs. Gina. However, he reported feeling angry at his birth father for not visiting him and anxious that he would return to separate him from his current family. Mrs. Gina has tried to broach the topic with Noy, and each time Noy has avoided the topic.

3 Assessment

Initial assessment interview was focused on eliciting history and circumstances that triggered his symptoms and nature of symptoms. Noy presented as a clean and well-groomed adolescent. During the sessions, he was open and engaged with appropriate eye contact. His speech content was fluent, and rate and volume were appropriate. He reported low mood was congruent with dysthymic affect. Noy was reluctant to address worries and concerns related to his birth parents and was observed to initiate topic changes often when the topic of his birth parents was brought up. However, with the use of tools such as drawing and play-doh, Noy expressed anger towards his birth parents and questioned with regards to whether he was an unlovable baby to have been abandoned. He also expressed anxiety over the possibility of his birth parents returning and separating Noy from his current adoptive family, whom he would prefer to live with. He denied having worries that his current adoptive family would return him to his birth family and asserted that he is aware of how much they love him. He also shared that his adoptive family has explicitly expressed to him that they would 'fight' for him to live with them. He reported having these worries daily, and these worries are affecting his concentration and mood, although this has not significantly affected his functioning and he shared that he remains happy most

of the time. Regardless, Noy expressed a desire to better use the time and energy spent on worrying on other domains of his life such as schoolwork. Apart from possible emotional difficulties from a history of abandonment, there were no other reported concerns in other domains of his life. Based on the information gathered, Noy fulfilled the criteria for VI5.42 (Z62.812) personal history (past history) of neglect in childhood based on the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) (American Psychiatric Association, 2013).

4 Formulation

Currently, Noy is doing well both at school and at home, and symptomatically, there are no acute or pressing concerns to be addressed. However, experiencing neglect when he was young may have resulted in attachment disruption, which could be a predisposing factor that contributed towards Noy's vulnerability for multiple emotional and behavioural challenges. Furthermore, Noy reported feelings of anger towards his birth parents, as well as anxiety regarding the future with his foster family, which impacted him to some extent. Currently, Noy suppresses these feelings and thoughts surrounding his birth father and actively avoids the topic, which may maintain or exacerbate his anger and anxiety. This is reinforced by his foster family's avoidance and skirting around the issue as well. Should these not be properly addressed, the issues may further negatively impact his emotional well-being in the future.

5 Treatment

A summary of the interventions completed with Noy across 12 sessions is outlined below. The intervention was delivered with the goal of aiding Noy to understand and accept past events to reduce anxiety and worry about the future. An integrative approach was undertaken, with an eclectic mix of narrative, gestalt, creative therapy and play techniques, to encourage discussion of thoughts, beliefs and feelings regarding his birth parents and facilitate understanding and acceptance of his situation. Re-storying and externalization of his problems were also undertaken to enable Noy to re-author a positive life story with a strength-based focus. These approaches will help to strengthen his resilience and reduce his vulnerability to emotional problems.

1. Co-formulation of difficulties to build insight and collaborative goal-setting
2. Creative play technique using play-doh to explore current and ideal family dynamics
3. Narrating of life narrative using creative mediums

4. 'Re-storying' to allow exploration of experiences to discover meaning, find alterations and re-establish an identity beyond perceived abandonment in early childhood
5. Externalization of worries
6. Joint authoring of a make-belief 'superheroes and villains' story to illustrate coping with problems at a symbolic level
7. Drawing parallels between 'superheroes and villains' story with reality for real-life application
8. Identification of inner strengths and each individual family member's strengths using placards
9. Exploration of how these family and individual strengths and resilience could be helpful in dealing with difficult situations and in achieving goals
10. Gestalt empty chair technique to facilitate integration of different parts of self
11. Discussion of positive attributes of various parts of self to facilitate acceptance of different parts of self
12. Joint session with caregiver/foster parents to facilitate sharing of thoughts and feelings and make salient current support network.

At the end of the interventions, Noy reported no longer having feelings of anger towards his birth father. His perception of the earlier parental loss has also shifted from 'they did not want me', and 'maybe there is something wrong with me' to 'they loved me but were not able to take care of me which is why he gave me to mummy Gina and Daddy Rudy', suggesting a helpful shift in meaning derived from the experience. He was also observed to be able to talk comfortably about his past abandonment, and no longer initiated topic changes. This was also reflected by his adoptive parents at home.

Noy also reported that he is no longer worrying daily about the future. He shares that although he still has some worries that his father might return to separate him from his adoptive family, he is also confident that he and his family members would be able to cope effectively even if his birth parents return. He also reported an acceptance of previously 'unwanted' parts of him (i.e. vulnerable, angry and sad) and saw them as all parts of himself that make him who he is.

6 Discussion and Conclusion

Upon reflection, the therapist was impressed by Noy's courage to face life adversities; he did not have control over his early life events, but he has control over how he prefers to re-author his preferred story line about his life. The therapist was constantly fascinated about how creative mediums and creative storytelling hold an element of fun for child and adolescent clients while helping them to process deep hurts they might have internalized from early oppressive experiences. In the creative activity where Noy and the therapist created a sculpture of his current and ideal family, Noy wanted to place his birth father as distant from the core family as possible,

however, in the ‘re-story’, he was able to accept this element as part of his life, from his position of a ‘strong Noy’.

In the therapist’s mind and heart, there was an image of a baby ‘birdie’ with broken wings, but with the creative journey of healing, the little ‘birdie’ heals and grows stronger as he flies to greater heights, with greater confidence, albeit life’s storms.

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Chapter 4
Working with Adult Survivor of Childhood Sexual Abuse: Creating a Safe Place, Building Strengths

Karen Ang and Carol C Choo

1 Introduction

Child sexual abuse is defined as any sexual conduct or contact of an adult or significantly older child with or upon a child for the purpose of the sexual gratification of the perpetrator (Hornor, 2010). Sexual abuse involves both touching and non-touching behaviours. Existing literature identifies history of sexual abuse as a key risk factor for depression among women, and that depression develops at a young age (Gladstone et al., 2004; Gladstone, Parker, Wilhelm, Mitchell, & Austin, 1999). Additionally, physiological effects of childhood sexual abuse have also been found, such as long-term dysregulation of physiological stress response systems (DeBellis, Burke, Trickett, & Puttnam, 1996). On the other hand, protective factors, such as familial support, especially parental belief in the sexual abuse allegation and support, can act as a strong buffer against the development of negative consequences for sexual abuse victims (Tremblay, Hebert, & Piche, 1999).

Experiencing sexual abuse often creates a feeling of powerlessness in the child, leaving the child with the perception of having little control over what happens (Dube et al., 2005). Consequently, this lack of control acts as a stressor, affecting the neurodevelopment of the victim. Both boys and girls who have been sexually abused are at increased risk for suicide and the development of depression, and this risk continues into adulthood (Dube et al., 2001, 2005). Posttraumatic stress disorder (PTSD) can also emerge as a result of sexual abuse (Hornor, 2010).

With the varied and unique experiences of each person (Davis & Petretic-Jackson, 2000; Higgins & McCabe, 2000), adult survivors of child sexual abuse are not a homogeneous group. Currently, there is little agreement in the literature on the 'best' therapeutic approach (Wise, Florio, Benz, & Geier, 2007) for adult survivors of child sexual abuse. Successful treatment interventions with child sexual abuse

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survivors are varied, and existing literature has found individual, group and family counselling and cognitive-behavioural interventions to be effective with some clients (Kessler, White & Nelson, 2003; Lubin, 2007). There have been research that report reduction of symptoms of depression, with patient-directed expressive writing about one's trauma, mindfulness and variations on cognitive-behavioural therapies (Earley et al. 2014; Foa, Keane, & Friedman, 2000; Lorenz, Pulverman, & Meston, 2013). Phase-based treatment has also been suggested, in which the initial phase focuses on establishing therapeutic alliance and stabilizing and preparing the client, before moving into more in-depth work in later phase (Sanderson, 2006).

2 Background

Tran is a 23-year-old Vietnamese female who self-referred for psychotherapy in regards to issues in her past, related to personal experiences in Vietnam. She presented with symptoms of depression, such as difficulty concentrating, loss of interest in activities, fatigue and feelings of hopelessness. She also reported a history of suicidal ideation and self-harming behaviour of cutting.

2.1 Family History

Tran described herself to come from a family with 'strict parenting', in which her father placed restrictions on her friends and had high expectations for her academic performance. She described herself as a 'naughty' child, but could not identify particular incidents where she had been called so.

Tran reported that her family relationship had been 'selectively close' and that she did not trust her family members enough to share her thoughts with them. She also perceived that her father did not value her opinions, giving examples of her father caring more about up-keeping of image, rather than caring for Tran's feelings. For example, Tran recounted a recent incident at home, in which she was upset and crying, but her parents wanted her to go into the kitchen so that guests would think that Tran was helping her mother in the kitchen.

As Tran is currently studying in Singapore, she stays with her uncle's family. She reported that her uncle often had arguments with her aunt, which made her feel anxious and uncomfortable at times to stay with them. She keeps in contact mainly with her parents through text messaging.

2.2 Academic History

Tran had attended school in Vietnam. She described it to be a competitive environment, and her parents had high hopes for her. She recalled having done well in her studies since primary school. However, her grades had dropped when she entered secondary school; thus her parents enrolled her in tuition lessons to help her improve her school results. Tran eventually completed her post-secondary school education with an average performance; she went on to apply for studies in a private university in Singapore, where she is currently in her first year of studies in business.

2.3 Psychiatric History

At the time when Tran referred herself for therapy, she was seeing a psychiatrist in Vietnam, and was on medication, to manage her depressive symptoms.

2.4 Psychosocial History

The table below compiles significant life events.

Table of significant life events detailing history of childhood sexual abuse, adverse sexual experiences and inappropriate touching
1. *Tran's account of childhood events*
Tran's family hosted family friends. Tran was playing alone with toys when her father's male friend came over to her and hugged her. Tran said she did not react but recalled thinking that she wished he would stop. Tran reported that she subsequently developed a fear towards older males, and she avoided physical contact with older males. She became fearful and anxious in the presence of older men, and she worried that something bad would happen to her.
Tran coped with her anxiety and negative thoughts by checking and ensuring that she was never alone with older males or by listening to music to distract herself, e.g. when taking public transport where male strangers would be present. The anxiety and vigilance persist presently.
Tran had weekly piano lesson at her teacher's house. She reported that the male teacher molested her, and this took place repeatedly for about a year. Tran had tried to discourage him by not responding to his smiles or talking to him harshly, but he had continued to touch her. She felt sad and ashamed of herself during that period and reported developing a fear of physical intimacy with all males.
Tran confided in her parents then, but her parents did not believe Tran. Tran said she received no help during this period of distress. Tran described that she felt angry with her parents, and this caused interpersonal tension and subsequently affected their relationships.

(continued)

2. *Tran's account of adverse sexual experiences*
Tran recalled that her first boyfriend constantly verbally and physically pressurized Tran to have a sexual relationship, which she repeatedly refused.
Tran reported feeling miserable for having to endure the pressure from her then boyfriend, and at that time, she reported that she engaged in self-cutting (2–3 superficial cuts on her thighs and wrists daily). Eventually, Tran gave in to the sexual advances from her ex-boyfriend.
Tran's sexual experiences with her ex-boyfriend lasted for half a year. She perceived it as an unpleasant experience, which made her feel humiliated and sad. She recalled that she attempted suicide by overdose, but the attempt failed. Subsequently, she was diagnosed with depression by a doctor at the hospital in Vietnam.
The relations with the piano teacher and ex-boyfriend subsequently ended. Her parents had decided to stop the piano lessons, and her ex-boyfriend terminated the relationship after Tran's suicide attempt.
3. *Tran's account of inappropriate touching*
When Tran was out alone with a trusted male friend at a party, Tran said he touched her sexually. After the incident, Tran felt 'horrible' and 'sad'. Around that period, she engaged in self-cutting superficially once or twice daily, with the highest frequency being 12 times in a day. She wrote about her experiences in her diary.
Tran felt disappointed and angry with her parents, after realizing that her parents had read her diary. Tran's anger towards her parents arose from, realizing that her parents did not believe her account of molestation by her ex-piano teacher. Tran was disappointed with the lack of parental concern and love for her. She perceived there was a betrayal of trust by her parents, as they had read her diary behind her back.
She attempted suicide by overdose. However, her parents found out about the attempt, and she was hospitalized for treatment.
Tran's brother entered her bedroom and started touching her inappropriately. Tran then told her parents about it. When her brother was confronted by her parents, he claimed that he could not remember what had happened.
Tran felt sad and started to engage in self-cutting, up to four superficial cuts on a part of her body per day. She was then warded for treatment. Tran viewed the incident as a betrayal of trust. Presently, she says she does not trust anyone in general and specifically does not trust her family members enough to confide in them.
Tran was in a crowded bus. A male stranger stood close behind her, but Tran said she was too fearful to react. The man only went away when someone else shouted at him.
Tran was surfing the Internet. She described chancing upon a picture with sexual connotations; she repeatedly thought about the picture and felt 'grossed out' and 'wanted to remove (the thoughts) from her mind'. This led Tran to cut herself to seek relief from the thoughts.
On several occasions, Tran's male cousin had gone into her bedroom and touched her inappropriately.
Tran informed her uncle after the incident happened. Tran's uncle apologized to Tran about the incident and said that it would not happen again. A rule was set that her male cousin was not allowed to go to Tran's room.
Tran noted that her cousin did not apologize to her and instead avoided her as it was awkward for him. She compared the incident with that involving her brother and felt that her cousin was not taking responsibility, as he had not apologized.

2.5 Current Relationship

Tran described her current boyfriend to be supportive. However, they have had a few conflicts with regard to their differences in ethnicity and religion, and Tran reported that she and her boyfriend have differing views about how they could overcome the differences. Tran expressed that she wanted to put in effort to work through the differences, but she reported that her boyfriend had wanted to give up on the relationship. Tran described that she felt 'angry' about how her boyfriend had wanted to give up so easily, though he had persisted in pursuing her initially, despite his knowledge about such differences between them.

3 Assessment

Assessment with Tran involved a clinical interview with her to gather information about her history and current presentation. She was also administered the Depression, Anxiety, Stress Scales (DASS) to understand her current mood.

Tran has been having depressed mood for most of the day, for more days than not, over the last 2 years. Symptoms that had been reported and/or observed were fatigue, poor concentration and feelings of hopelessness. Tran has not been without these symptoms for more than 2 months at a time. She was assessed to meet the diagnostic criteria for *300.4 (F34.1) persistent depressive disorder (dysthymia), early onset, with persistent major depressive episode*.

4 Formulation

Tran presented with depressive symptoms, such as difficulty concentrating, loss of interest in activities, fatigue and feelings of hopelessness. She also had a history of suicidal ideation and self-harming behaviour of superficial cutting. She has been experiencing these depressive symptoms for the past 5 years, since 2011.

Since childhood, Tran experienced strict parenting, where she had to adhere to rules and restrictions imposed on her. Hence, it is likely that she had often experienced corrections and blaming for doing things wrongly, and she might have internalised the message that she was 'naughty' through early childhood interactions with her parents. This predisposed Tran to have a negative appraisal of herself and to see herself as a 'naughty child'. Her negative self-appraisal and the response from her parents after her disclosure also contributed to her lack of trust in her immediate family members. Furthermore, traditional Asian family values and gender role

socialization might also have contributed to the family dynamics, e.g. Tran's family might have gone to great lengths to protect the reputation of the family. A history of experiences of adverse sexual experience with her boyfriend, as well as inappropriate touching by different males, could have reinforced her negative view of herself. A lack of trust in her immediate family members further exacerbated the issue. A combination of adverse life events and lack of family support precipitated Tran's depressive symptoms and self-harming behaviour.

These adverse life events continued to contribute to negative self-evaluation and adverse feelings, which exacerbated Tran's sense of defectiveness and hopelessness, compromising her sense of self control. Her maladaptive ways of coping, such as self-cutting, maintained her negative self-evaluation and further perpetuating her depressive symptoms.

Tran has developed protective behaviours which stemmed from early adverse experiences with males. It is noteworthy that despite non-supportive responses from her family, Tran remains resilient and assertive and persisted to disclose to her aunt about the inappropriate behaviour from her cousin, which subsequently stopped further inappropriate behaviours. Tran is also very motivated to engage in therapy and has shown herself to be resilient and insightful.

5 Treatment

5.1 Intervention

Interventions with Tran by a previous psychologist had focused on improving her mood through behavioural activation and distraction techniques to help her cope with negative thoughts. Tran also was guided in expressing her feelings by writing a letter to express her anger towards her parents. Tran was psycho-educated about the cognitive behavioural therapy (CBT) model and thought-recording, to enable Tran to gain more awareness of the thoughts that were contributing to her feelings and behaviour.

Tran attended 24 sessions of therapy with the current psychologist. In regard to the history of suicidality, suicide risk assessment was conducted (Choo, Diederich, Song, & Ho, 2014), and safety plan is agreed upon. In view of the history of childhood sexual abuse, adverse sexual experiences and inappropriate touching, psychoeducation was conducted, together with discussion of personal boundaries, and personal safety plan was devised with Tran.

The focus for the intervention sessions continued to be on improving Tran's mood and empowering Tran with emotional regulation strategies. The initial phase focused on psychoeducation on emotion regulation skills. Emotional regulation strategies include techniques drawn from Dialectical Behavioural Therapy (DBT), such as mindfulness, self-validation of feelings and self-soothing. In alignment with DBT, the concept of opposite action was introduced, where Tran could recognize

triggers, observe the urge to cut but engage in opposite action, such as self-care and self-soothing, instead of self-harming. Creative mediums were used, such as writing and drawing/painting, to facilitate the expression of feelings and self-validation of difficult and painful feelings, via creative mediums.

The Cognitive Behavioural Therapy (CBT) model was used to enable Tran to gain awareness of the thoughts that were contributing to her feelings and behaviours. There was also a focus on increasing her understanding of triggering situations which contributed to her low mood and self-harming behaviour, by use of the cognitive-behavioural approach, in which the sequence of events were explored and identifying thoughts, feelings and behaviour in the respective incidents were addressed. Thought distortions (e.g. 'should' statements) were also addressed, and alternative adaptive thoughts and balanced perspectives were identified.

Besides that, a crucial aspect of therapy was the therapeutic alliance between the psychologist and Tran. In view of Tran's history, it is important to build a trusting relationship and a safe environment in therapy, to enable Tran to be able to express herself in therapy. This was done by the psychologist consistently responding in a non-judgemental way and attending and listening to Tran. It was also beneficial to validate Tran's feelings and thoughts during the therapy session, to promote a healing experience of being validated by others and also to model for her how she can respect and value herself as a person by validating and acknowledging her thoughts and feelings.

5.2 Outcomes

Tran is able to identify strategies to regulate her emotions and reported that her emotions were more 'stable'. Tran also shared that being aware of her 'should' statements, and adopting a different perspective of validating her emotions, were beneficial in emotion regulation. Additionally, Tran reported engaging in emotional regulation activities, such as mindfulness, self-validation, writing and painting. During the period of therapy, Tran did not engage in self-cutting behaviours.

The housing situation with Tran's uncle has become more stable, and Tran reported being better able to manage the situation in the uncle's house, by a change of perspective of focusing more on caring for her own emotional space, instead of trying to control other aspects that are not in her control (e.g. aunt and uncle's quarrelling). Tran is also more aware and able to identify positive communication skills that can be used to enhance her assertive communication with her boyfriend. In the last therapy session with Tran, she indicated readiness to face her past and to process the past incidents, in future therapy sessions.

Tran's scores on the DASS-21 (Lovibond & Lovibond, 1995) and BDI-II (Beck et al., 1996) are as follows (Table 4.1):

A decrease in the scores on stress could be contributed by the more stable housing environment and Tran acquiring of emotional regulation strategies. However, it is likely that as the underlying trauma and issues related to Tran's past sexual abuse

Table 4.1 Scores on the DASS

Date	Depression	Anxiety	Stress
March	20 (Moderate)	14 (Moderate)	25 (Severe)
May	20 (Moderate)	14 (Moderate)	28 (Severe)
August	20 (Moderate)	14 (Moderate)	20 (Moderate)

Table 4.2 Scores on BDI-II (Beck et al., 1996)

Date	BDI-II score
March	24 (Moderate depression)
May	18 (Mild depression)
August	15 (Mild depression)

experiences had not been addressed yet, her rated levels of anxiety and depression on the DASS-21 remain consistent (Table 4.2).

The BDI-II has items that are more closely related to the diagnostic criteria in the DSM-IV, relating explicitly to appetite, sleep and suicidal ideation. Hence, the decrease in level of depression on the BDI-II possibly relates to reduction in some of the symptoms of depression.

6 Discussion and Conclusion

Tran had been responsive and open to learning emotional regulation strategies and was motivated to engage in therapy. The treatment delivered thus far has been effective with Tran. Her depressive symptoms, as reflected on the BDI-II, have lessened. Tran has also reported that her mood is more stable and has expressed confidence in going on to the next phase of therapy to face her past issues. Equipping Tran with strategies in emotional regulation and supporting her to apply them in her immediate circumstances have helped to increase her sense of control of situations, as she experiences the positive effects upon her mood.

Tran's increased awareness of the cognitive distortions that contribute to her low mood and self-harming behaviour have also enabled her to address them and adopt more adaptive ways of thinking. One of the important aspects for Tran's therapy was focusing on self-care, e.g. caring for her own emotional space and helping Tran to better manage her emotions in challenging situations. The building of skills to manage her emotions aligns with Sanders' (2006) suggestion that the initial phase of therapy with child sexual abuse victims focuses on building therapeutic relationship and sense of safety and equipping the client with skills in preparation for more in-depth work in later therapy sessions.

It would be important for Tran to continue to engage regularly in emotional regulation strategies to maintain her gains in therapy.

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Chapter 5
Cognitive Behavioural Therapy for Schizophrenia

Acacia Lee and Carol C Choo

1 Introduction

Schizophrenia is a disabling mental illness that impacts all major life areas, with recent research focusing on holistic interventions that enhance recovery and quality of life (Choo, Chew, Ho, & Ho 2017). Although the first line of treatment is psychotropic medication, after the acute symptoms resolve, many people continue to experience both hallucinations and delusions (Wykes, 2014). These are generally termed residual symptoms and are the phenomena that cognitive behavioural therapy (CBT) for psychosis was originally devised to target.

CBT holds promise as an adjunct to medication (Wykes, 2014) and is effective for the symptoms of schizophrenia (Jauhar et al., 2014). In the Asian context, CBT was found to be effective on symptoms and social functioning of people with schizophrenia in the long term (Li et al., 2015).

In addition, recovery-focused CBT interventions seem to be a promising treatment approach as they target disability from a broader perspective, including activity and participation domains, and reflect clients' views of recovery and trends towards improvement of mood, negative symptoms and functioning (Nowak, Sabariego, Switaj, & Anczewska, 2016).

2 Background

Mr. Raja is a male client in his late 30s, referred for psychotherapy to help him better cope with his symptoms of schizophrenia. Mr. Raja currently lives with his wife, who has also been diagnosed with schizophrenia, in a one-room rental flat.

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Mr. Raja's childhood and schooling years were unremarkable. He reported having cordial but not close relationships with his siblings and friends. The auditory and visual hallucinations began when Mr. Raja was in his early 20s. It was unclear as to what the precipitant was, but Mr. Raja suspected that it may have been due to stress from not being able to keep up in his first job then. He was subsequently diagnosed with schizophrenia and began pharmacological treatment. In the next 5 years, Mr. Raja reported feeling depressed and lying in bed for most of the time. It was unclear as to whether he also received a formal diagnosis of depression or if it was the negative symptoms of schizophrenia, anhedonia and avolition that resulted in his presentation then. He has been on follow-up from a psychiatrist since then.

After Mr. Raja got married in his mid-20s and moved out of his family home, he has not been in contact with her family members. According to him, they have shifted and changed numbers but did not inform him of the changes. The only person he still has contact with is his younger sister, who would occasionally send a small sum of money when Mr. Raja requests, to help him out financially.

3 Assessment

Initial assessment interview was focused on eliciting history and circumstances that triggered his symptoms and nature of symptoms. A suicide risk assessment was also conducted. Mr. Raja denied any active suicidal intent or plans. Auditory hallucinations (but not visual) were present, and content largely consisted of criticisms towards himself. No loose associations or tangential thinking was observed. However, Mr. Raja had delusions that the voices belonged to 'deities' and had 'powers'. No abnormal motor behaviours were observed. Mr. Raja displayed a high level of motivation to cope better with his voices and to improve his day-to-day functioning.

Health and Nation Outcome Scales (HoNOS) was administered. Mr. Raja's symptoms at initial assessment and over the course of therapy were tracked with the HoNOS, a clinician-rated tool used to measure the health and social functioning of individuals. The HoNOS is a quantitative measure assessing behaviour, impairment, symptoms and social functioning.

4 Formulation

Work and/or interpersonal stress may have precipitated the onset of his schizophrenic symptoms. Currently, his symptoms are perpetuated by his own negative self-beliefs. His lack of social support and perceived abandonment from his own family members not only contributes to his negative core beliefs but also remains a major source of sadness for Mr. Raja. Conflicts with his wife also caused Mr. Raja distress, perpetuating the intensity of his symptoms. Her overprotectiveness also

does not give Mr. Raja a chance to learn and practice independence and build on his self-esteem. Despite their disagreements, his wife remains the biggest pillar of support for Mr. Raja. Although his issues are long-standing, Mr. Raja remains motivated and open to address his issues.

5 Treatment

A summary of the interventions completed with Mr. Raja across 12 sessions is outlined below. The intervention was delivered with the goals of helping him to better cope with his symptoms of schizophrenia, to facilitate a higher quality of living.

1. Co-formulation of difficulties to build insight
2. Goal-setting
3. Identification of alternative solutions to distract himself from the voices when required, to reduce his immediate distress
4. Introduction of relaxation technique – progressive muscle relaxation (PMR)
5. Identification of early warning signs and corresponding coping strategies
6. Psychoeducation on the link between thoughts, feelings and behaviour to increase awareness of his thought processes and its impact
7. Identification of negative automatic thoughts and cognitive distortions
8. Cognitive restructuring to reduce maladaptive thinking patterns and cognitive distortions
9. Challenging of voice content, underlying self-evaluative beliefs associated with voices and beliefs about safety behaviours
10. Identification of more realistic and adaptive thoughts
11. Reiteration of coping plan aiding in relapse prevention and management of well-being

Overall, the HoNOS showed a reduction in severity of problems with hallucinations and delusions (*moderate* to *mild*), depressed mood (*minor* to *none*) as well as relationships (*minor* to *none*).

	Score	
Scale	Pre therapy	Post therapy
1. Overactive, aggressive, disruptive behaviour	1	1
2. Nonaccidental self-injury	0	0
3. Problem-drinking or drug-taking	0	0
4. Cognitive problems	0	0
5. Physical illness or disability problems	0	0
6. Problems with hallucinations and delusions	3	2
7. Problems with depressed mood	1	0
8. Other mental and behavioural problems	H: 1	B: 1

(continued)

Scale	Score	
	Pre therapy	Post therapy
9. Problems with relationships	1	0
10. Problems with activities of daily living	1	1
11. Problems with living conditions	1	1
12. Problems with occupation and activities	0	0

Mr. Raja's self-reported level of confidence in coping with his symptoms has increased from 3/10 to 8/10 across the course of therapy. Mr. Raja also reported a decrease in the frequency of 'episodes' when the voices get louder and more intense, on average from once every 4 days to once every 8 days.

Mr. Raja also reported having an improved relationship with his wife, with no episodes of verbal aggression towards her in the past 2 months. This is in accordance with his wife's report of his happy mood and increase in joint activities and communication, which has led to an improvement in their relationship.

6 Discussion and Conclusion

Mr. Raja's symptoms were characterized by predominantly auditory hallucinations, accompanied by delusions in relation to the voices. Even though his delusions still remained, he began questioning the validity and reliability of the voices, reducing the impact of the voices on his day-to-day functioning.

In summary, cognitive behavioural therapy was chosen as the approach to aid Mr. Raja in coping with his symptoms of schizophrenia. He responded well to initial treatment and showed improvements in various domains of functioning.

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Chapter 6
Cognitive Behavioural Therapy for a Case of Anxiety and Depression

Acacia Lee and Carol C Choo

1 Introduction

The advent of the cognitive theory of emotional disorders has brought about developments in contemporary psychotherapy; to date, cognitive behavioural approaches have become the most extensively researched psychological treatment for a wide variety of disorders (Lorenzo-Luaces, Keefe, & DeRubeis, 2016). Research indicated that the efficacy and effectiveness of cognitive behavioural therapy (CBT) for anxiety disorders including posttraumatic stress disorder, obsessive-compulsive disorder, panic disorder, generalized anxiety disorder, social anxiety disorder and specific phobia have been well established (Kaczkurkin & Foa, 2015). Two of the most commonly used CBT methods used to treat anxiety disorders included exposure and cognitive therapy. Literature indicated that CBT procedures were highly efficacious and tended to outperform other psychosocial treatment modalities in the treatment of anxiety disorders (Olatunji, Cisler, & Deacon, 2010). CBT treatments were based on disorder-specific protocols developed to target specific symptoms (Rector, Man, & Lerman, 2014). Due consideration needs to be given to co-morbid conditions, as anxiety disorders frequently co-occur and are comorbid with depression. Evidence indicated that the mood and anxiety disorders share a common set of psychological and biological vulnerabilities, treatment conceptualization should be carefully tailored with disorder-specific CBT.

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2 Background

Mr. Bala is a male client in his late 70s with a history of depression and anxiety. He was referred for psychotherapy to address his long-standing emotional difficulties.

Mr. Bala grew up in a large family and described having good relationships with all his family members. At school, he had several friends, got along well his classmates and teachers alike. He described himself as an "average" student. Following secondary school, Mr. Bala's first job was as a cleaner. However, he was released early from his contract after getting in a fight with a colleague over an issue that he no longer remembers. He reported feeling "regretful" and "disappointed" at having to leave the job. Subsequently, Mr. Bala worked as a gardener, technician and casual positions in facilities and maintenance.

Mr. Bala met his wife when he was in his 20s. According to him, his wife was unwell and committed suicide. He was first admitted at the age of 35 years old where he was diagnosed with major depression disorder with anxious distress features and commenced on pharmacological treatment. He was unable to articulate any possible trigger, but it was likely that his wife's suicide at the time precipitated his emotional difficulties.

Currently, Mr. Bala lives in a one-room rental flat with his roommate. He has stopped working full-time half 1.5 years ago due to physical health issues (chronic pain). He reported a conflictual relationship between him and his roommate, which is a major source of stress and anxiety for him since the joint living arrangement 1 year ago to reduce the financial burden.

3 Assessment

Initial assessment interview was focused on eliciting history and circumstances that triggered his symptoms and nature of symptoms. A suicide risk assessment was also conducted. During suicide risk assessment, he denied suicide intent and denied active suicide plans.

Mr. Bala described experiencing constant anxiety since the start of the joint living arrangement 1 year ago. He described anxiety as experiencing tension in his body, thoughts racing and feeling faint. According to Mr. Bala, his roommate would create a lot of noise in the wee hours when he comes home, negatively impacting Mr. Bala's sleep. He would also "accuse" Mr. Bala of "touching" or using his things. During conflict, Mr. Bala would generally remove himself from the situation by leaving the flat. Mr. Bala would also spend long hours in public places to minimise interactions with his roommate. Despite these avoidance behaviours, Mr. Bala still reported constantly feeling anxious and worried about the possibility of physical aggression from his roommate in future conflict situations. He reported two episodes where he felt exceptionally anxious and thought that he was "losing control". He described experiencing an accelerated heart rate, sweating, trembling, sensation of shortness of breath and feeling dizzy and faint. These episodes were triggered by

his roommate's verbal threats. Both times, he took a taxi to the Institute of Mental Health and saw the psychiatrist but was not admitted.

Health and Nation Outcome Scales (HoNOS) was administered. Mr. Bala's symptoms at initial assessment and over the course of therapy were tracked with the HoNOS, a clinician-rated tool used to measure the health and social functioning of individuals. The HoNOS is a quantitative measure assessing behaviour, impairment, symptoms and social functioning.

4 Formulation

Despite Mr. Bala not being able to articulate a precipitant for the onset of his depressive and anxiety symptoms, it is possible that experiencing the sudden passing of his wife may have increased his vulnerability to developing emotional difficulties or precipitated the onset of his symptoms.

Even though Mr. Bala has received a diagnosis of depression in the past, his main presenting problem now lies in his difficulty in coping with his anxiety. Currently, Mr. Bala experiences constant anxiety and worry about interpersonal conflict with his roommate. He has also had two panic attacks this year which were triggered by conflict with his roommate.

Mr. Bala's experience of losing a job he liked over conflict with his colleague in the past may have resulted in beliefs that conflicts lead to negative outcomes. As a result, he now adopts a passive conflict resolution style which contributes to ineffective conflict resolution and increase the likelihood of future conflict, perpetuating his anxiety. In addition, his tendency to catastrophise and overestimate the likelihood that bad things are going to happen not only directly contributes to his anxiety but also result in avoidance behaviours that indirectly perpetuates his anxiety through the process of negative reinforcement. In other words, Mr. Bala's coping strategy of avoidance maintains his anxiety as he does not get the opportunity to learn how to cope or have new experiences that would allow him to unlearn the maladaptive beliefs that he has come to associate with his roommate and conflict. The in-session experiential avoidance behaviours of distressing topics may also suggest poor emotional regulation skills, which may be maintaining his anxiety.

5 Treatment

A summary of the interventions completed with Mr. Bala across 12 sessions is outlined below. The intervention was delivered with the goals of helping him to cope better with his anxiety.

1. Co-formulation of difficulties to build insight.
2. Goal-setting.
3. Relaxation technique – progressive muscle relaxation (PMR).

4. Identification of strategies to improve day-to-day life (e.g. sleep).
5. Identification of early warning signs of anxiety and effective management strategies to engage in before escalation to panic state.
6. Psychoeducation on cognitive behaviour therapy (CBT).
7. Identification of situations, thoughts, feelings and actions associated with anxiety and worry using the hot-cross bun model.
8. Discussion of the unworkability of current attempts at resolution (i.e. avoidance).
9. Mindfulness.

    9.1 Five senses exercise

10. Thought challenging and identification of adaptive responses (i.e. coping thoughts).
11. Psychoeducation on cognitive distortions.

    - Impact of excessive irrational worry on anxiety symptoms.

12. Behavioural experiment targeted at cognitive distortions.
13. Mr. Bala was encouraged to re-engage in social interactions with his roommate, i.e. to decrease avoidance behaviour. Mr. Bala was encouraged to discuss different communication styles, and he was encouraged to practise assertive communication.
14. Clarification of early warning signs (internal cues and overt early warning signs) and plan for relapse prevention and management of wellbeing.
15. Encouragement of increased engagement in social interactions and leisure activities.
16. Linking Mr. Bala with volunteers and fellow residents in the community to enhance social interactions.

Overall, the HoNOS showed a reduction in severity of problems with anxiety (*moderate* to *mild*) and relationships (*mild* to *minor*).

	Score	
Scale	Pre-therapy	Post therapy
1. Overactive, aggressive, disruptive behaviour	1	1
2. Nonaccidental self-injury	0	0
3. Problem-drinking or drug-taking	1	1
4. Cognitive problems	0	0
5. Physical illness or disability problems	2	2
6. Problems with hallucinations and delusions	0	0
7. Problems with depressed mood	1	1
8. Other mental and behavioural problems (i.e. anxiety)	B: 3	B: 2
9. Problems with relationships	2	1
10. Problems with activities of daily living	0	0
11. Problems with living conditions	0	0
12. Problems with occupation and activities	0	0

Mr. Bala's self-reported rating of the quality of relationship with his roommate increased from 3/10 to 9/10 across the course of therapy. Mr. Bala was observed to be able to identify unhelpful cognitions ("negative automatic thoughts") and replace them with more helpful thoughts. For example, he has increasingly been able to show empathy towards his roommate, making situational versus dispositional attributions for his behaviour, which has helped Mr. Bala to view his roommate in a more favourable light and in turn positively impact Mr. Bala's feelings and behaviour towards his roommate.

Through the identification of early warning signs, Mr. Bala has been able to effectively cope with his anxiety using the identified strategies before reaching a panic state. As such, there have also been no further self-admissions to the hospital because of his perceived inability to cope with anxiety. Mr. Bala's self-reported rating of his level of confidence in his ability to cope with his anxiety has also increased from 4/10 to 5.5/10 over the course of therapy.

Mr. Bala has also recently joined an elderly group which is in line with his interests and builds on his level of social support. He reported enjoying the activity and improved mood following the physical activity. However, he has not been consistent with the sessions, stating the reason as occasionally having difficulty waking up in the morning.

6 Discussion and Conclusion

Mr. Bala presented with a myriad of cognitive distortions and avoidance behaviours that were maintaining his anxiety. Through the sessions, Mr. Bala was able to successfully address these unhelpful thinking patterns and identify more helpful coping strategies. Intervention also had to be tailored to Mr. Bala's cognitive and language ability, and conversations were facilitated by concrete objects.

In summary, an integrative approach, with cognitive behavioural therapy as the core, was chosen as the approach to aid Mr. Bala in coping more effectively with his anxiety symptoms. Mindfulness was also a helpful adjunct to increase Mr. Bala's awareness of his body's physiological sensations when anxious, building on his emotional awareness. Mr. Bala responded well to treatment and showed improvements in various domains of functioning.

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Chapter 7
Bereavement in an Elderly Client: Making Sense and Finding Meaning

Acacia Lee and Carol C Choo

1 Introduction

Losing a loved one can be a traumatic and devastating experience that places the bereaved at a heightened risk of psychological suffering and impairments in functioning (Stroebe & Schut, 1999). Bereavement increases the risk of developing other related mental health conditions such as depression and anxiety-related disorder (Zisook & Kendler, 2007) and is associated with poorer physical health as well as increased suicidality. Feelings of grief and its related symptoms (e.g. insomnia, poor appetite and weight lost) during the bereavement process can be reminiscent of a major depressive episode, MDE (Zisook & Kendler, 2007). The dysphoria in grief however, is likely to decrease in intensity over time, and occurs in waves, whereas depressed mood is more persistent (American Psychiatric Association, 2013). In addition, the pain of grief may be accompanied by positive emotions and humour that are uncharacteristic of the pervasive unhappiness and misery characteristics of MDE. Grief and MDE can also be distinguished on other subtleties, for example, the thought content during grieving features a preoccupation with thoughts and memories of the deceased, rather than self-critical pessimistic ruminations as seen in depression. Typically, symptoms of grief resolve and a progress to restoration of a satisfactory, if changed, life is made by the bereaved.

The relationship between the bereaved and the deceased can have an impact on the degree and severity of grief symptoms. Parents who have experienced the loss of a child tend to have more intense and severe grief symptoms, including heightened levels of suicidality, as compared to other types of bereavement (Zetumer et al., 2015). As compared to losing other loved ones, the death of a child violates the perceived order of natural living and often come unexpectedly. Furthermore, being

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a parent may also engender a sense of identity and purpose (Rubin & Malkinson, 2001). When a child dies, parents not only experience sadness over the loss but may also feel that a part of themselves have died as well (Malkinson & Bar-Tur, 2005), intensifying the grief experience. Parental bereavement and the accompanying grief experience will be explored further in depth in the following sections. The factors affecting the grief experience are described below:

1.1 Demographics of Bereaved

Old age and female gender (Kersting, Brahler, Glaesmer, & Wagner, 2011; Lobb et al., 2010) have been shown to be associated with adverse bereavement outcomes (Cohen-Mansfield, Shmotkin, Malkinson, Bartur, & Hazan, 2013).

1.2 Relationship to Deceased

Mothers face greater difficulties adapting to a death of a child than fathers (Sidmore, 1999). Parents who lose their only child also have a more difficult time (Dyregrov, Nordanger, & Dyregrov, 2003) as compared to parents who have other living offspring.

1.3 Circumstances of Death

Parents who lose their child by a violent or sudden death are at increased risk of poorer bereavement adaptation (Lehman, Wortman, & Williams, 1987; Murphy, Johnson, Chung, & Beaton, 2003a).

1.4 Culture

In the Chinese culture, the death of a child is considered against the law of nature and shameful as it may represent that the family is not blessed. Parents may condemn themselves, believing that the gods have not blessed them for their wrongdoings either in their current or past lives. Traditional Chinese parents also do not attend their deceased child's funeral, and the subject of the child's death is considered a taboo topic and commonly avoided.

Chinese parents cope with their child's death as claiming it as part of their own destiny, and although they still struggle with the loss, the cultural belief can in part relieve them cognitively from self-blame and guilt by assuming the cause of death

as due to supernatural forces of which they are incapable of controlling (Ho & Brotherson, 2007). In addition, there is the belief that even if the deceased is no longer on Earth, he or she is alive in the afterlife, and it is the responsibility of the living family members to continue providing care (Yick & Gupta, 2002).

The various cultural beliefs are complex and can both be helpful and unhelpful in the grieving process. On one hand, the cultural stigmatisation and the discouragement of related emotional expression may impede processing of the loss. On the other hand, these beliefs can also aid in making sense of the loss and facilitating an enduring connection with the deceased beyond the physical loss, alleviating grief symptoms to some extent. Hence, it is important to be aware of the impact of these beliefs on each individual and how it could facilitate the treatment process. In addition, culture also impacts on risk and protective factors and when faced with emotional pain and life stressors, whether individuals resort to maladaptive and destructive suicidal gestures or they tap on internal and external resources to cope (Choo, Harris, Chew, and Ho, 2017). People are influenced by their society and culture, so it is important that such cultural mechanisms and meanings are elicited and woven into conversations to help the bereaved make sense of their grief experience.

The main challenge for the bereaved during the grieving process is to integrate the loss into their lives, make sense of and find meaning in the loss (Neimeyer, 2006). Finding meaning can be conceptualized into sense-making and benefit-finding in adapting to bereavement (Currier, Holland, & Neimeyer, 2006; Davis, Nolen-Hoeksema, & Larson, 1998). Sense-making refers to the survivor's capacity to find a benign explanation for the loss, which can often be framed in philosophical or spiritual terms. On the other hand, benefit-finding refers to the survivor's ability to uncover positive outcomes or value in the personal and social consequences of the loss. Failure to construct a sense of understanding in the child's death and/or life after the loss could result in elevated distress (Davis, Wortman, Lehman, & Cohen Silver, 2000; Murphy, Johnson, & Lohan, 2003b), whereas successful attempts at finding meaning over the grieving process predicted less emotional distress and healthier adaptation (Davis et al., 1998; Murphy, Johnson, & Lohan, 2003b). Thus, the focus of the treatment would be to guide the bereaved in finding meaning in the loss, both sense-making and benefit-finding, through various techniques.

The dual process model, DPM (Stroebe & Schut, 1999, 2008), is a model of coping with loss as opposed to one aimed at explaining the broad range of manifestations associated with bereavement. The DPM describes two categories of stressors associated with bereavement: loss-orientated and restoration-orientated. Loss-orientated refers to the bereaved person's concentration on, appraisal and processing of the loss experience itself. Restoration-orientated refers to the bereaved person's struggle to reorient oneself in a changed world without the deceased, rethinking and replanning one's life in the face of bereavement. According to the DPM, the process of attending to or avoiding of these two types of stressors is dynamic and fluctuating. This regulatory process is termed as "oscillation". In other words, at times, the bereaved would confront aspects of loss and tasks of restoration, and at other times, avoid them. It is posited that this process of confrontation

avoidance is central in adjustment to bereavement, and maladaptation occurs when there is an extreme and extensive focus on one orientation and avoidance of the other.

As the DPM is a model of coping, it can directly link to and inform intervention. Following DPM principles, if the bereaved person is suffering from complications in their grieving process, intervening to change his or her pattern of confronting versus avoiding loss and restoration-stressors would lead to better adjustment (Shear, Frank, Houck, & Reynolds, 2005). In addition, both loss and restoration techniques would be focused on meaning finding, both sense-making and benefit-finding. An integrative/ eclectic approach would be undertaken (Corey, 2013). Principles of intervention would be derived from the DPM to aid in the understanding of grief, techniques would be drawn from existential therapy (promoting self-awareness, searching for meaning, facing living and dying), person-centred therapy (promoting therapeutic relationship and inner directedness) and postmodern approaches (meaning making). In view of MC's prominent grief symptoms and her cultural beliefs around death, this approach could help to promote therapeutic alliance and for MC to make sense of her grief through facilitated conversations and help MC to discover her strengths to cope with the losses.

2 Background

Mrs. Choi is a female client in her early 80s, referred for psychotherapy to address her emotional difficulties after her son's death, 4 months ago. Mrs. Choi currently lives alone in a two-room flat. Her husband passed away around a decade ago. Her deceased son's girlfriend, Jane, stays over a few times a week.

Mrs. Choi grew up in a large family; she reported little conflict within the family and got along well with all her family members. She described the family environment as boisterous and warm. As a child, Mrs. Choi did not attend formal schooling as girls in the family were not given the opportunity. Her father taught Mrs. Choi and her sisters daily after work. Her parents and majority of her siblings had since passed away, except her older sister.

Mrs. Choi married her husband when she was 21 years old. They had an only son, Sam. She described their marital relationship as "easygoing" with little conflict. Her husband, Mr. Choi, passed away 16 years ago due to a heart attack. She reported feeling "depressed" at the time but continually told herself to "be strong for her son". She reported her relationship with her son becoming closer after Mr. Choi's death.

Early last year, Sam stopped working due to medical conditions and was subsequently hospitalised multiple times over the duration of his illness. During Sam's last hospitalisation, Mrs. Choi was also hospitalised at a different hospital for surgery and was hence unable to take care of Sam. Sam's girlfriend, Jane, was a major pillar of support during Sam's illness. Shortly after both Mrs. Choi and Sam returned

home from their individual hospitalisations, Sam passed away unexpectedly in his sleep. The cause of death was stated to be organ failure.

3 Assessment

Initial assessment interview was focused on eliciting history and circumstances that triggered Mrs. Choi's symptoms and nature of symptoms. A suicide risk assessment was also conducted.

Following her son's death, Mrs. Choi started experiencing low mood and constantly ruminated over the details of Sam's death. She viewed the medical help that Sam received as inadequate and culminating in his death. She also reported having difficulties in falling asleep, as well as interrupted and poor sleep. She reported having low levels of energy and constantly feeling fatigued and withdrew from social interactions from both neighbours and friends. She also felt guilty and blamed herself for Sam's death. She reported having passive suicidal thoughts of wanting to "join her son", and when queried by the clinical psychologist in training during suicide risk assessment, she articulated a plan to overdose on her medication, but she did not report active suicide intent. At the time, she was prescribed sleeping pills and was taking more than recommended (i.e. prescribed two but taking three), which seems to be related to lack of medical understanding, that taking this will help her to sleep better, and not a suicidal gesture. She also asserted that she would not commit suicide as she perceived it as a sin and associated with negative repercussions according to her religious beliefs. During suicide risk assessment, she denied suicide intent and denied active suicide plan. She agreed on taking medication as prescribed, and medication review was arranged promptly with her treating doctor; the treating doctor was informed of the alleged overdose.

Health and Nation Outcome Scales (HoNOS) was administered. Mrs. Choi's symptoms at initial assessment and over the course of therapy were tracked with the HoNOS, a clinician-rated tool used to measure the health and social functioning of individuals. The HoNOS is a quantitative measure assessing behaviour, impairment, symptoms and social functioning.

4 Formulation

Mrs. Choi's depressive symptoms were precipitated by an identifiable stressor, namely, her son's sudden death, and could be understood as grief symptoms. Currently, there is insufficient evidence to support any DSM-V diagnosis, her grief symptoms were prominent and triggered by her son's death, but the intensity is currently abating, and the duration of her symptoms does not meet DSM-V criteria, e.g. for persistent complex bereavement disorder. Successive experiences of the deaths of significant family members and the resultant feelings of loneliness are in stark

contrast to her upbringing in a big and lively family and predisposed Mrs. Choi's emotional vulnerabilities after her son's death. Her current grief symptoms were precipitated by her son's sudden death. Chinese cultural and family expectations of a female's role to be a wife and mother have been imbued in Mrs. Choi since young, and the death of both her husband and her son may have resulted in a perceived loss of identity and role, which perpetuated her symptoms. Her self-blame and guilt for her son's death, ruminative tendencies as well as social withdrawal also perpetuated her symptoms. Her religious beliefs are a strong protective factor, helping her to make sense of and stay spiritually connected to the deceased. Her older sister and Jane are important pillars of support in her life. Mrs. Choi also spoke fondly of a job that she held when she was younger, drawing focus to her strengths, resilience, assertiveness and interpersonal skills, especially in an era where there are limited occupational opportunities for Chinese females.

5 Treatment

A summary of the interventions completed with Mrs. Choi across 11 sessions is outlined below. The intervention was delivered with the goals of helping her to process her grief, adjust to a world without her son and ultimately to find an enduring connection with her deceased son while embarking on a new life.

1. Goal-setting
2. Suicide risk assessment, suicide risk monitoring and commitment to safety plan
3. Psychoeducation on importance of medical compliance and monitoring of medical compliance
4. Holistic well-being assessment

   As part of an ongoing process, Mrs. Choi's sleep, appetite, energy level and somatic health were monitored.

5. Empathic support to help MC to process her grief experience
6. Supportive ventilation facilitating sense-making and benefit-finding:

   - Circumstances of the dying process
   - Frustrations and resentments regarding medical care
   - Guilt regarding not having done enough – "I am not a good mother"
   - Feelings of shame for being "too emotional"
   - Residual anger towards the deceased
   - Dimensions of loss in concrete terms
   - Social impact of loss

7. Facilitating process of reintegration to find an enduring connection with the deceased and rediscover one's personal meaning and direction:

   - Discussion of positive memories and shared experiences with deceased
   - Discussion of mutual beneficial contributions between bereaved and deceased

- Facilitation of process of symbolically taking into the self the best parts of the deceased

8. Encouragement of increased engagement in social interactions and leisure activities
9. Linking Mrs. Choi with volunteers to enhance social interactions

Overall, the HoNOS showed a reduction in severity of problems with nonaccidental self-injury (*Mild* to *Minor*), depressed mood (*Moderate* to *Minor*), sleep (*Mild* to *Minor*) as well as relationships (*Mild* to *Minor*).

Scale	Score	
	Pre therapy	Post therapy
1. Overactive, aggressive, disruptive behaviour	1	1
2. Nonaccidental self-injury	2	1
3. Problem-drinking or drug-taking	0	0
4. Cognitive problems	1	1
5. Physical illness or disability problems	2	2
6. Problems with hallucinations and delusions	0	0
7. Problems with depressed mood	3	1
8. Other mental and behavioural problems	H: 2	H:1
9. Problems with relationships	2	1
10. Problems with activities of daily living	0	0
11. Problems with living conditions	0	0
12. Problems with occupation and activities	0	0

Mrs. Choi no longer has active suicidal ideation although she still expressed a passive desire of wanting to join her family members in the afterlife, which reflect her religious and cultural beliefs rather than active suicide intent; such cultural beliefs are typical of elderly Chinese women in the local context. She also asserted that she would not harm herself and would take good care of herself while she still lives.

Mrs. Choi reported mostly being able to get sufficient sleep without the aid of sleeping pills, although she would still have difficulty falling asleep on average once a week.

Mrs. Choi reported increased interactions with her neighbours, attending events and activities on a weekly basis at the nearby church. She has also attended talks addressing physical health concerns organised by the community centre and has made friends during these events. She has also expressed interest in joining a dance course at the community centre but would like to wait till she heals completely from the operation she underwent last year.

6 Discussion and Conclusion

Mrs. Choi held many of the abovementioned cultural beliefs and initially avoided talking about her loss, perceiving the topic as taboo and others as unwilling to talk to her about it for fear of "bad luck". As such, she withdrew from social interactions and spent much of her time ruminating about her loss alone. Hence, the initial part of therapy was largely focused on normalising her experiences and rapport building to increase her willingness to open and share.

Intervention also had to be tailored to Mrs. Choi's cognitive, language and physical ability. For example, focus is on facilitated conversations rather than writing as Mrs. Choi is illiterate.

In summary, an integrative approach, with a focus on finding meaning (sense-making and benefit-finding), was chosen as the approach to aid Mrs. Choi in processing her grief, adjusting to a world without her son and ultimately finding an enduring connection with her deceased son while embarking on a new life. Mrs. Choi responded well to the treatment and showed improvements in various domains of functioning.

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Chapter 8
Finding Courage: A Case of an Older Adult with Cognitive Impairment Due to a Medical Condition

Jun Pei Lim, Carol C Choo, and Kinjal Doshi

1 Introduction

With the rapid growth of aging populations across Asia, the aging problem not only brings about the rising trend of cognitive impairment incidence but is also often characterized by increasing disabilities and declining physical functions in the elderly population (Miyawaki, Kumamoto, Shimoda, Tozato, & Iwaya, 2017). It has been estimated that about 8–22% of the Asian elderly have been diagnosed with cognitive impairment and dementia (Hilal et al., 2013), and this is estimated to reach 20,000 by 2030 (Sahadevan, Tan, Tan, & Tan, 1997). Elderly with motor-related disorders were also found to have moderate cognitive deterioration (Pillon et al., 1995).

Corticobasal syndrome (CBS) is a progressive complex neurological disorder which affects both motor and cognitive functions. Its clinical features include poor coordination and balance, akinetic rigidity, limb apraxia, myoclonus, cognitive impairment and speech and language impairment, which may also occur in other diseases like frontotemporal dementia, Alzheimer's disease and supranuclear palsy (Matthew, Bak, & Hodges, 2011). The onset of symptoms usually begins between the ages of 50–70 with the mean onset at 60. The disease duration has been found to be 6–7 years. Given a lack of validated and agreed diagnostic criteria and biological markers, it is difficult to make a CBS diagnosis. Research also found that corticobasal degeneration occurs in the cerebral cortex which is involved in higher executive brain functions such as voluntary movement, memory and learning and in the basal ganglia which controls the motor and learning functions due to an abnormal accumulation of a protein called Tau in the brain cells (Matthew, Bak, & Hodges, 2011; Pillon et al., 1995).

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2 Background

Mr. Eli was referred for a neuropsychological assessment to evaluate his current and functional status in view of his limited mobility and medical diagnosis of CBS. His symptomology included slurred speech, limited gait stability, left hand dystonia, apraxia and short-term memory loss. While his son reported no significant cognitive difficulties, Mr. Eli highlighted feelings of stress and low mood.

Mr. Eli is a male in his early 50s who lived with his son. He has another daughter who was married and living apart. His wife has passed away from ovarian cancer about 14 years ago. He graduated with primary school education and owned a Nasi Lemak stall for a living. Since his wife's death, he was the main caregiver and financial support to their children. Due to his limited mobility, Mr. Eli had to stop working 2 years ago. He spent his weekdays at a nearby day-care centre from 9 am to 5 pm; his son worked full-time and was unable to take care of him during daytime.

Mr. Eli was first brought to the previous outpatient clinic by his son for gait abnormality and was prescribed medication for this condition in 2014. According to clinical notes, he was irregular on medications and continued to experience parkinsonian freezing. Subsequently, he was referred to the current outpatient clinic in 2015 where he was diagnosed with lower limb parkinsonism. Although it was reported that he suffered from short-term memory loss (i.e. misplaced certain personal items), no executive functional degeneration was found. In 2016, Mr. Eli was diagnosed with CBS. He had stopped responding to medication, and he also became wheelchair-bound and had to retire from his job. Previous x-rays showed subcutaneous soft bone swelling in his calves, and CT brain scan showed cerebral atrophy with background small vessel disease. No neuropsychological cognitive assessment was conducted at this point to conclude or rule out the possibility of meeting the criteria for DSM-5 major and mild neurocognitive disorders.

Functionally, Mr. Eli's basic functional abilities were not intact due to his limited mobility. He required a walking frame when moving about at home and a wheelchair when travelling beyond his house. Mr. Eli also reported being slower in preparing and dressing himself in the morning due to his limited mobility, which resulted in feelings of stress. As he is currently attending a day-care centre on weekdays (7 am–5 pm daily), his instrumental functional abilities were unclear given the limited activities (i.e. watching TV programmes in a communal area, mostly stayed in his wheelchair.). However, he could manage his current traditional medications independently and keep track of appointments on his mobile phone with his son's supervision.

3 Assessment

In view of Mr. Eli's medical diagnosis, limited physical mobility and self-reported mood-related issues, his current cognitive functioning was assessed to determine if he met the criteria for DSM-5 major and mild neurocognitive disorders, major depressive disorder. Given his self-reported negative emotions, a mood and risk assessment were included as part of the neuropsychological assessment.

The assessment was a single 2-h session at the outpatient clinic. It comprised of separate clinical interviews with Mr. Eli, his son, neuropsychological testing and a mood assessment.

3.1 Mini-Mental State Examination (MMSE)

The MMSE is a 30-item screening tool for cognitive impairment (Folstein, Folstein, & McHugh, 1975). The local version has been modified to ensure that the items are more culturally and linguistically relevant to the local population; it is validated for use in Singapore with a cut-off score of 26 (Feng, Chong, Lim, & Ng, 2012; Yeo et al., 1997).

3.2 Elderly Cognitive Assessment Questionnaire (ECAQ)

The ECAQ is a 10-item cognitive screening test for dementia; it has been developed and validated locally with an optimal cut-off score of 6 (Kua & Ko, 1992). These items were also called from the above MMSE, which is more sensitive towards elderly with lower educational status.

3.3 Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

The short version of the IQCODE is a 16-item caregiver report measure which is used to screen for dementia. It measures the changes in cognitive functioning such as memory, ability to learn new skills and manage financial matters and reasoning when compared to 10 years ago, previous assessment or the onset of any medical conditions across a 5-point Likert scale. The IQCODE has been validated for use in Singapore among the Chinese elderly and is more sensitive in detecting cognitive changes when administration with the ECAQ and MMSE (Lim, Lim, Anthony, Yeo, & Suhadevan, 2003).

3.4 Alzheimer's Disease Cooperative Study: Activities of Daily Living Inventory (ADCS-ADLs)

The ADCS-ADLs is a caregiver report measure which measures the patient's ability to perform basic (i.e. personal grooming, bathing, eating, toileting) and instrumental functional tasks (i.e. travelling beyond own house and managing household chores, personal items, medications).

3.5 Vascular Dementia Battery (VDB)

The VDB is the standard protocol used for neuropsychological testing of Singaporean elderly aged 50 years and above at the outpatient clinic. It was developed to assess the cognitive function in elderly Singaporeans in a culturally and linguistically sensitive manner for the population (Yeo et al., 1997). The VDB consists of seven broad neurocognitive domains: executive function, attention and working memory, language, verbal memory, visual memory, visuospatial construction and processing speed. Each domain includes more than one test, as seen in Table 8.1 below. All the tests included in the VDB have been validated for use in Singapore with education-adjusted cut-off scores (Chong et al., 2010, Sahadevan, Lim, Tan, & Chan, 2000). The verbal tests are administered separately by visual tests to minimise interference effects, vice versa.

The visual reproduction, block design and symbol-digit modalities tests were not administered due to Mr. Eli's limited physical ability. Despite his inconvenience, Mr. Eli was able to perform the other visuomotor-related tasks such as visual memory span and the tests in the visuospatial construction and processing speed domains.

3.6 Modified Geriatric Depression Scale (MGDS)

The MGDS short version is a 20-item measure to assess mood- and anxiety-related symptoms (Sheikh & Yesavage, 1986). A score of 0–5 indicates no depression, 6–10 indicates mild depression and 11–20 indicates moderate depression. It is especially useful for older adults who may be physically ill or have shorter attention span.

Table 8.1 List of specific tests under each neurocognitive domain

Domain	Test(s)
Executive function	Frontal assessment battery (FAB)
Attention	WMS-R digit span (forward and backward)
	Visual memory span (forward and backward)
Language	Modified Boston naming
	Verbal fluency (animal, food)
Verbal memory	Word list recall (immediate, delayed, recognition)
	Story recall (immediate, delayed)
Visual memory	Picture recall (immediate, delayed, recognition)
	WMS-R visual reproduction (immediate, delayed, recognition)
Visuospatial construction	WMS-R visual reproduction (COPY)
	Clock drawing test
Processing speed	Digit cancellation task
	Maze task (completion time/seconds)

3.7 Neuropsychiatry Inventory (NPI)

The NPI is a 12-item measure to assess multiple dementia-related behavioural symptoms across ten subdomains: delusions, hallucinations, agitation/aggression, dysphoria, anxiety, euphoria, apathy, disinhibition, irritability/lability, aberrant motor activity, night-time behavioural disturbances and appetite changes (Galasko et al., 1997). The level of caregiver distress and frequency of these symptoms are also assessed.

3.8 Mental State Examination

Mr. Eli presented as an appropriately dressed and pleasant individual, exhibiting appropriate behaviour and eye contact. His speech was slurred at times; his verbal responses were coherent and relevant to the topics discussed. During formal testing, he was cooperative and participated in all tasks. He exhibited reasonable comprehension of test instructions and did not require any repetition of task instructions. He did not indicate any deficits in hearing or vision that could affect his ability to perform on the tasks, except that he had difficulty with gross and fine motor skills. After formal testing, Mr. Eli teared up, during the mood assessment when interviewed about his loss of mobility.

3.9 Neuropsychological Tests

All the neuropsychological test results were administered to Mr. Eli in his mother tongue, Malay. Mr. Eli's performance on the global dementia cognitive scales was within the impaired range compared to age-group peers with similar background. On the global dementia screening tests, Mr. Elli performed below the normal range score on the MMSE. Specifically, he could not perform a series of actions, mental arithmetic calculations and a delayed recall of words. He could demonstrate orientation to only the place, month and year. His son's ratings on the IQCODE suggested significant cognitive decline as compared to the last 10 years, specifically with respect to remembering things about family, conversations and location of personal items. He was also indicated to have poorer management of financial matters and was slower in learning new skills.

His neuropsychological cognitive assessment results showed impaired executive function and visuospatial construction with significantly reduced speed of information processing. He also exhibited difficulties with verbal memory retrieval, though visual memory abilities were preserved. Attention, working memory and language abilities were intact.

On the executive function domain, his poor performance in the frontal assessment battery (FAB) indicated poor mental flexibility and inhibition to interfering stimuli. Specifically, he was unable to inhibit conflicting instructions. He also exhibited difficulty with planning in a few other tasks. For instance, he could not plan the route in the maze drawing task correctly, resulting in the termination of the task. Similarly, on the clock drawing task, he demonstrated difficulty with arranging the numbers and clock hands correctly.

His poor performance in these visuomotor-related tasks was likely associated with impaired visuospatial perception and construction abilities. He performed below the fifth percentile in the visuospatial construction domain when compared to age-group peers of same background and education. When asked to copy visual diagrams in the visual reproduction copy task, he was unable to do so correctly. It is likely that his significantly reduced speed of processing was associated to poor executive functional and visuospatial construction abilities.

On the verbal memory domain, Mr. Eli also performed below the fifth percentile in the word list delayed recall task. He could not recall any verbally given words after a short period of time. However, when encouraged to attempt the story delayed recall task with the given contextual cues, he could demonstrate retrieval of verbal information. This suggested that he was better able to recall verbally presented contextual information as compared to distinct information; this finding was also consistent with the research finding by Pillon et al. (1995) that patients with corticobasal degeneration were able to overcome their learning deficits with semantic cues.

Taken the results together, it is likely that he presented with mild neurocognitive disorder due to another medical condition (CBS). Although he has never done a baseline cognitive assessment before, his cognitive deficits required greater effort and compensatory strategies in his daily functioning.

3.10 Mood Assessment

It is likely that Mr. Eli met the DSM-5 criteria of a major depressive disorder as his onset of depressive symptoms had been at least 1 year ago. However, given that the duration of his depression was less than 2 years, results from the mood assessment did not the DSM-5 criteria for persistent depressive disorder. Mr. Eli endorsed several depressive symptoms (i.e. feeling helpless, worse than most people and hopeless in his current situation, feelings of fatigue and loss of interest in the things he usually enjoys), especially when asked on his limited mobility. He reported having had suicidal thoughts and ideation (i.e. jumping off the building) during family quarrels; though he acknowledged having suicidal ideation, he reported having no intention or current plans to act on the ideation given his worries of the consequences of his action, including his children's feelings. He has not made any attempt to hurt self or others.

Given his reported suicidal ideation, a safety plan was established and discussed with Mr. Eli and his son. Mr. Eli agreed to a safety plan, which is to contact his son and older brother when he was feeling overwhelmed by suicidal ideation.

4 Discussion and Conclusion

Mr. Eli's neuropsychological assessment results revealed impairment in the global dementia screening scales, executive function, visuospatial construction and processing speed domains, with difficulties noted in verbal memory retrieval. These assessment results were partially consistent with the hypothesis whereby only his executive function and verbal memory retrieval domains were impacted. Interestingly, his ability to identify and name objects on the language-related tests were preserved, whereas speech and articulation were clearly impacted.

His low scores on the questionnaires reflected difficulties in accomplishing basic functional tasks, moderate depressive and neuropsychiatric symptoms. These corroborated with his son's verbal accounts of limited functional mobility, depressive mood and suicidal ideation, which supported the assessment hypothesis.

While Mr. Eli's personal history included completing primary school education, experiencing his wife's death 14 years ago, being the sole parent and breadwinner for his children and past medical diagnosis of spondylosis, these life events coupled with the limited social support and possible development of maladaptive cognitive beliefs (i.e. 'I cannot be a burden to my family'.) could have predisposed him to emotional vulnerabilities that contributed to his current depressive symptoms and suicidality.

On the other hand, Mr. Eli's early retirement and loss of his job due to his limited functional mobility and his own awareness of his CBS diagnosis were clear precipitants of current presenting issues. These precipitants are characteristic of significant transitions in role investments and health status which are also activating stressors of internal negative age-related stereotypes in older adults (Laidlaw & Kishita, 2015, Laidlaw, Thompson, & Gallagher-Thompson, 2004). His declining control of his functional mobility, unemployed status and his daily struggle in preparing himself for day-care independently continue to perpetuate low mood and suicidal ideation.

However, a few protective factors were also identified. Mr. Eli's caregiver son remains proactive in caregiving. He is currently liaising with a social worker at the day-care centre to work with Mr. Eli. In addition, Mr. Eli is also open and willing to receive help for his depressive mood.

A few key areas could be considered should Mr. Eli continue to receive treatment for his depressive symptoms and declining functional mobility. Firstly, as Laidlaw and McApine (2008) posited, it may be more meaningful to focus on maintenance of the quality of life rather than investigating the cause. Selection, optimisation with compensation (SOC) in cognitive behavioural therapy (CBT) is a useful and simple problem-solving technique that helps clients to achieve goals in light of their losses

(Fruend, 2008). It includes the selection of the daily tasks-of-focus, practising and optimising the efficiency in completing it with compensating strategies. At the same time, as part of the CBT processes, psychoeducation, cognitive reappraisal to address his stress and negative thoughts and learning stress-relieving behaviour such as relaxation are also important.

Secondly, as Mr. Eli continues to manage his increasing disability, incorporating an element of mindfulness and acceptance into CBT would also be realistic. For instance, focusing on embracing unwanted thoughts or feelings (i.e. 'I feel like a burden to my family'.), approaching them in a non-judgemental manner and remaining present focused are helpful (Petkus & Wetherell, 2013). In this case, adaptive CBT (Marino, DePasquale, & Sirev, 2015) allows individuals to accept their existing disability and reconnect with their own values. Hence, as part of the treatment objectives to help Mr. Eli find acceptance in his given condition, collaborative goal setting would then also be intended to explore his goals for the future and various meaningful occupational alternatives or activities that he can work with.

Upon reflection, it is impressive and humbling to ponder the courage shown by Mr. Eli to face life adversities with a persevering spirit despite the many life events that have been adverse and debilitating. Despite his losses on multiple fronts, he continues to persist, in quiet courage, which to a young clinician – this is meaningful and a testimony of strength and courage.

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Chapter 9
A Case of Subjective Cognitive Complaints in Older Adults: Anxiety, Stress, and Aging in an Elderly Client

Yammie Chin, Carol C Choo, and Kinjal Doshi

1 Introduction

About 80% of the elderly have memory complaints (Balash et al., 2013). Individuals with mild memory deficits are likely to require extra time or compensatory strategies to complete tasks, whereas those with severe deficits will need assistance to complete tasks or may abandon them altogether (American Psychiatric Association, 2013). Amongst healthy cognitively normal elderly, subjective memory complaint is positively associated with sub-syndromal anxiety and depression (Balash et al., 2013).

Anxiety disorders are the most common late-life psychiatric diagnosis, with an estimated lifetime prevalence of 15.3%, surpassing the estimates for mood and neurocognitive disorders (Beaudreau & O'Hara, 2008). Late-life anxiety and cognition are related, such that anxiety is more prevalent in cognitively impaired elderly, elevated anxiety is related to poorer cognitive performance, and more severe anxiety symptoms predict future cognitive decline. While depressive symptoms alone are not related to cognitive deficits in the elderly, coexisting anxiety and depressive symptoms are associated with a poorer memory and slower processing speed (Beaudreau & O'Hara, 2009).

The estimated prevalence of cognitive impairment and dementia amongst the local elderly (aged 60 years and above) is 15.2%, with the rate increasing with age (Hilal et al., 2013). An earlier local study has found the prevalence of cognitive impairment to be higher amongst those with lower educational status of less than 6 years (Lim, Lim, Anthony, Yeo, & Sahadevan, 2003).

An objective assessment with a detailed history taking (including the individual's baseline status) is essential to distinguish between neurocognitive disorder and

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normal cognition, delirium, major depressive disorder, specific learning disorder, and other neurodevelopmental disorders (American Psychiatric Association, 2013).

2 Background

Mr. Ee was referred for a follow-up neuropsychological assessment to evaluate his current cognitive and functional status in view of self-reported complaints of further difficulties in cognition, including memory problems, slower processing speed, and a poor sense of direction, since the previous assessment 5 years ago. He reported experiencing negative moods (i.e. boredom, stress, and anger) due to conflictual relationships with his family.

Mr. Ee is a male in his late 60s who lived with his wife, Mrs. Ee, and a domestic helper. He had two adult children, an elder son and a younger daughter, who were both married. He graduated with postgraduate qualifications and worked in a high-performing job till retirement at 60 years old. Since retirement, he regularly volunteered in the community and met up with his friends for meals and exercises. There was no report of substance use. Mrs. Ee indicated that Mr. Ee recently showed a decreased ability to understand what was going on, reason things through, and make appropriate judgments. Mrs. Ee further added that Mr. Ee displayed increased agitation and hoarding behaviour subsequent to retirement, and these had put a significant strain on his relationship with the family.

Mr. Ee first consulted at the outpatient clinic in 2010 with memory complaints that persisted for the past 10 years. He was referred for a baseline neuropsychological assessment, and his results indicated no impairment across all the cognitive domains assessed. His account suggested that he was able to perform his basic and instrumental activities of daily living independently. Overall, it was concluded that he did not meet the criteria for DSM-5 Major and Mild Neurocognitive Disorders in 2010.

Mr. Ee's educational attainment and previous neuropsychological profile are suggestive of an average or higher intellectual premorbid functioning, thereby ruling out specific learning disorder and other neurodevelopmental disorders. Delirium was ruled out too, given that that his self- and family-reported cognitive difficulties appeared to be stable and persistent (as opposed to time-limited and fluctuating pattern in delirium).

3 Assessment

In view of Mr. Ee' self- and family-reported cognitive difficulties, his current cognitive functioning was reassessed to determine if he met the criteria for DSM-5 Major and Mild Neurocognitive Disorders. It is noted that both Mr. and Mrs. Ee were

concerned about Mr. Ee's mood disturbance, so a mood assessment was included as part of the neuropsychological assessment. Mood symptoms (e.g. depressive, anxious, agitated) are common, particularly in the earliest stages of neurocognitive disorders (American Psychiatric Association, 2013), and can have the potential to induce an adverse effect on the results of neuropsychological testing (Balash et al., 2013; Kosaka, 2006).

The assessment was a single 2-h session at the outpatient clinic. It comprised of separate clinical interviews with Mr. Ee and his wife, Mrs. Ee, neuropsychological testing, and a mood assessment.

Normative comparison is essential in neuropsychological assessment (Harvey, 2012). The key strength of the following measures lies in the availability of local norms, thereby allowing the evaluation on whether Mr. Ee is performing as would be expected or poorer than expectations, given his age and educational attainment, as compared with local norms.

3.1 Mini-Mental State Examination (MMSE)

The MMSE is a 30-item screening tool for dementia (Folstein, Folstein, & McHugh, 1975). The local version has been modified to ensure that the items are more culturally and linguistically relevant to the local population; it is validated for use in Singapore with a cut-off score of 26 (Feng, Chong, Lim, & Ng, 2012; Yeo et al., 1997).

3.2 Elderly Cognitive Assessment Questionnaire (ECAQ)

The ECAQ is a 10-item cognitive screening test on memory, information, and orientation that is developed and validated for use in Singapore with a cut-off score of 6 (Kua & Ko, 1992).

3.3 Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)

The short version of the IQCODE has 16 items on a 5-point Likert scale to be completed by the caregiver to screen for dementia (Jorm, 1994). The IQCODE is validated for use in Singapore and is used to supplement the ECAQ (Lim et al., 2003) and MMSE because it appears to be more sensitive in detecting earlier stages of dementia amongst the local elderly (Narasimhalu, Lee, Auchus, & Chen, 2008).

3.4 Vascular Dementia Battery (VDB)

The VDB is the standard protocol for neuropsychological testing in elderly aged 50 years and above, used at the outpatient clinic. It is developed for the assessment of cognitive function in elderly Singaporeans to ensure that the tests are culturally and linguistically appropriate for the population (Yeo et al., 1997). The VDB incorporates tests of six broad neurocognitive domains, with more than one test per domain, specifically, attention (digit span and visual memory span), language (verbal fluency), verbal memory (word list recall and story recall), visual memory (picture recall and visual reproduction), visuospatial construction (visual reproduction copy, clock drawing, and block design), and processing speed (digit cancellation, maze task, and symbol digit modalities test). All the tests included in the VDB have been validated for use in Singapore with education-adjusted cut-off scores. The verbal tests are administered separately by visual tests to minimise interference effects and vice versa. Altogether, the testing of specific cognitive domains aids to detect cognitive impairments and for differential diagnosis of the causal subtypes too (Hugo & Ganguli, 2014).

The visual reproduction copy test was not administered because his full scores on the immediate and delayed recall tests provide clear evidence that his visuospatial construction ability was intact. Moreover, Yeo et al. (1997) stated that it was acceptable to administer one or two of the tests in the visuospatial construction domain to attain a psychometric indication of the examinee's ability given the moderate correlation amongst the tests. Likewise, the picture recall tests were not administered to Mr. Ee because it was evident that his visual memory was intact based on his performance on the visual reproduction tests. The auditory detection test was not administered to Mr. Ee because it served as a supplementary test in the attention domain and his performance on the digit span and visual memory span tests were sufficient to support the conclusion that his attention ability was intact.

3.5 Depression, Anxiety, and Stress Scale 21 (DASS-21)

The DASS-21 is a 21-item self-report questionnaire to measure the severity of depression, anxiety, and stress (Lovibond & Lovibond, 1995). It is a psychometrically sound instrument, with good reliability and validity, for local use (Oei, Sawang, Goh, & Mukhtar, 2013).

3.6 Mental State Examination

Mr. Ee presented as an appropriately dressed and pleasant individual. He exhibited appropriate behaviour and eye contact. His speech was clear and fluent. His verbal responses were coherent and relevant to the topics discussed. During formal testing,

he demonstrated good comprehension of the instructions and was motivated and participated in the tasks readily. His attention and concentration were reasonable throughout the course of the testing. He did not indicate any deficits in motor skills, hearing, or vision that could affect his ability to perform on the tests.

3.7 Neuropsychological Tests

All the neuropsychological test results were administered to Mr. Ee in English. On the global dementia screening tests, Mr. Ee's performance on the MMSE and ECAQ indicated his functioning appeared to be stable and intact; he obtained the maximum score on both the MMSE and ECAQ. However, his wife's responses on the IQCODE indicated that Mr. Ee exhibited cognitive decline (e.g. handling financial matters, making decisions on everyday matters, etc.) as compared to 10 years ago.

Comparison between Mr. Ee' current and previous test results indicated that his performance on executive functioning, attention, language, verbal and visual memory, visuospatial construction, and processing speed appeared to be stable. His current scores for all the tests were above the cut-offs for each cognitive domain assessed and most laid at or above the 50th percentile. Overall, his current neuropsychological test results indicated general well-preserved cognitive functioning with no significant impairments in any of the cognitive domains assessed.

3.8 Mood Assessment

On the DASS-21, Mr. Ee' responses indicated a moderate level of anxiety (e.g. awareness of dryness of his mouth, worrying about situations in which he might panic and make a fool of himself, feeling close to panic, scared without any good reason, etc.) and a severe level of stress (e.g. finding it hard to wind down and relax, a tendency to overreact to situations, finding himself getting agitated, feeling that he was rather touchy, etc.). He did not present with clinically significant depression on the DASS-21.

4 Discussion and Conclusion

Overall, Mr. Ee' neuropsychological test profile, taken together with his current functional independence, suggests that he did not meet the criteria for DSM-5 Major and Mild Neurocognitive Disorders. Additionally, he presented with sub-syndromal anxiety and stress.

The neuropsychological test findings suggest that Mr. Ee is of normal cognition with subclinical features of anxiety and stress. It is probable that his subjective cognitive difficulties may be related to his symptoms of anxiety and stress (Balash et al., 2013).

The current method of neuropsychological assessment involves a normative comparison to determine the presence and extent of cognitive impairment but excludes an objective assessment on his premorbid cognitive abilities. Notably, it is possible for individuals with high intellectual premorbid functioning to score within normal limits on global dementia screening measures and formal neuropsychological batteries despite actual cognitive decline (Molano & Petersen, 1994). Hence, the Advanced Clinical Solutions for WAIS-IV and WMS-IV (The Psychological Corporation, 2009) is recommended for an objective evaluation of his premorbid cognitive functioning to increase the sensitivity of the neuropsychological assessment in detecting cognitive decline.

The VDB consists of a single form, with no variation available for follow-up testing. Repetitive neuropsychological testing is strongly related to content practice effects (Bartels, Wegrzyn, Wiedl, Ackwermann, & Ehrenreich, 2010). Hence, the Repeatable Battery for the Assessment of Neuropsychological Status, RBANS (Randolph, 1998), is recommended for repeat evaluations because alternate forms are available to control for content practice effects. Moreover, the RBANS has been established to be an appropriate neuropsychological assessment for the local geriatric population with age- and education-adjusted norms (Collinson, Fang, Lim, Feng, & Ng, 2014; Lim, Collinson, Feng, & Ng, 2010).

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Chapter 10
Epilogue

Carol C Choo

The nine cases included in the book illustrated pragmatic ways of working with clients across the lifespan. Within this casebook, cases were presented, spanning from childhood, adolescence and adulthood until late adulthood. The seven therapy cases illustrated evidence-based approaches, and delivery of the interventions was adapted to the respective life stage, with due consideration of the relevant influences from the clients' cultural, environmental and psychosocial contexts. Interventions were adequately tailored to suit the individual case formulation. The framework of the analysis of precipitating, perpetuating, protective and predisposing factors formed a rich tapestry to enhance a holistic understanding of the client's presenting problem. Therapeutic outcomes were also presented. The last two chapters illustrated evidence-based assessment practices tailored to suit the local context.

The book was not intended to provide comprehensive and in-depth coverage of the entire spectrum of all aspects of diagnosis, formulations, assessments and treatment modalities in clinical psychology. The focus is on a pragmatic approach to working with common presenting problems encountered by trainees, with due consideration of cultural contexts and developmental influences.

Upon reflection, it is heartening to appreciate the diverse settings where clinical psychology continues to be practised. I am thankful for all who have made valuable contributions to the multiple dimensions of professional clinical psychology training. It is a great pleasure to know that all the authors who co-wrote this book during their internships have completed their training, as of the expected time when the book will be published. I hope that this book will encourage educators and students in clinical psychology to persist, persevere and uphold the prevailing standards of the practice of the profession of clinical psychology both locally and beyond. My notion of the profession both in psychological practice and in education is not one

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of a self-serving agenda but an embodiment of the capacity to convey a deep, authentic and genuine sense of empathy and connection, where clients' needs and clients' stories are heard and listened to. Within the safe and therapeutic environment, growth could happen. Upon perusal of where the profession has taken me over two decades, it is with this positive vision that I will also continue to hope and to persist.

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Appendix

Chapter 1: A Case of Child Survivor of Family Trauma – Creating a Safe Place and Building Strengths Through Play

Information Sheets

- What is domestic violence:

  Website: https://www.whiteribbon.org.au/understand-domestic-violence/what-is-domestic-violence/domestic-violence-definition/

- What is childhood trauma:

  Website: https://www.blueknot.org.au/Resources/General-Information/What-is-childhood-trauma
  Website: http://www.istss.org/public-resources/remembering-childhood-trauma/what-is-childhood-trauma.aspx

- Child resilience:

  Website: https://www.blueknot.org.au/Resources/General-Information/Resilience

- Impact of child trauma on brain development:

  Website: https://www.blueknot.org.au/Resources/General-Information/Impact-on-brain

Interventions

- Blue Knot Foundation – National Centre of Excellence for Complex Trauma guidelines for workers on trauma-informed care and practice:

  Website: https://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care

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- Child-centred play therapy:

  Website: https://www.psychology.org.au/inpsych/2015/june/short
  Website: https://www.childplayworks.co.nz/play-therapy/

- Child-centred play therapy- clinical session demonstration:

  (Written and presented by Garry Landreth (Denton, Texas: Center for Play Therapy, 2012), 49 min)
  Website: https://search.alexanderstreet.com/preview/work/bibliographic_entity%7Cvideo_work%7C1865851?ssotoken=anonymous
  Website: https://www.youtube.com/watch?v=JIMWOOlR_9g

- Narrative therapy with children:

  Website: http://www.narrativeapproaches.com/about-narrative-therapy-with-children/

Chapter 2: Developing a Child's Social-Emotional Skills in Therapy and Beyond

Social Skills Games Resources

- Play works – Twelve games to teach children social-emotional learning:

  Website: https://www.playworks.org/resource/twelve-games-to-teach-students-social-emotional-learning/

- Teacher vision – Free resources for teaching about social emotional issues:

  Website: https://www.teachervision.com/social-emotional-issues

- PBS parents – Activities for children:

  Website: http://www.pbs.org/parents/arthur/activities/index.html

Understanding Development of Social and Emotional Skills

- Center on the Social and Emotional Foundations for Early Learning – Practical strategies for teachers/caregivers

  Website: http://csefel.vanderbilt.edu/resources/strategies.html

- Kamloops Child therapy centre – resources about social and emotional skills milestones

  Website: http://www.kamloopschildrenstherapy.org/infant-milestones

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Chapter 3: Early Abandonment and the Impact in Adolescence – Using Integrative Narrative Therapy Approach in Therapy

Information Sheets

- Long-Term Consequences of Child Abuse and Neglect:

  Website: https://www.childwelfare.gov/pubpdfs/long_term_consequences.pdf

Measures

- Mental Health Outcome Measures for Children and Young People

  Website: https://www.ucl.ac.uk/drupal/evidence-based-practice-unit/sites/evidence-based-practice-unit/files/pub_and_resources_resources_for_profs_mh_oms.pdf

Interventions

- Favourite Therapeutic Activities for Children, Adolescents, and Families: Practitioners Share Their Most Effective Interventions:

  Website: http://www.lianalowenstein.com/e-booklet.pdf

- Narrative Therapy Techniques, Interventions and Worksheets:

  Website: https://positivepsychologyprogram.com/narrative-therapy/

Chapter 4: Working with Childhood History of Sexual Abuse – Creating A Safe Place and Building Strengths

- Sexual Assault Care Centre (SACC)

  Website: http://sacc.aware.org.sg/

- SACC – Resources for counsellors

  Website: http://sacc.aware.org.sg/get-help/counselling/resources-for-counsellors/

- Ministry of Social and Family Development (MSF) website on resources for Child Abuse

  Website: https://www.msf.gov.sg/policies/Strong-and-Stable-Families/Supporting-Families/Family-Violence/Pages/Child-Abuse.aspx

- Information for parents – How to protect child from sexual abuse

  Website: https://www.healthhub.sg/live-healthy/376/protect_your_child_sexual_abuse

- International support website for adult survivors of child abuse

  Website: https://www.havoca.org/

- American website with resources for therapists and clients of childhood sexual abuse

  Website: http://www.csacliniciansguide.net/resources.html

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Chapter 5: Cognitive-Behavioural Therapy for Schizophrenia

Information Sheets

- What is psychosis:

  Website: https://web.archive.org/web/20140910061458/http://www.psychosis-sucks.ca/pdf/03-What_is_Psychosis.pdf

- What causes psychosis:

  Website: https://www.earlypsychosis.ca/files/documents/04-Causes_of_Psychosis.pdf

- Pharmacological treatment:

  Website: https://web.archive.org/web/20140910070547/http://www.psychosis-sucks.ca/pdf/09-Medication.pdf

- Psychosocial treatment:

  Website: https://www.earlypsychosis.ca/files/documents/12-Psychosocial_Treatments.pdf

- Relapse prevention:

  Website: https://www.earlypsychosis.ca/files/documents/13-Relapse_Prevention.pdf

- Relapse prevention plan:

  Website: https://www.earlypsychosis.ca/files/documents/13-Relapse_Prevention_Plan.pdf

Measures

- Beliefs about voices questionnaire:

  Website: http://bjp.rcpsych.org/content/bjprcpsych/177/3/229.full.pdf

Intervention

- Understanding psychosis and schizophrenia:

  Website: https://www1.bps.org.uk/system/files/user-files/Division%20of%20Clinical%20Psychology/public/CAT-1657.pdf

- Cognitive-behaviour therapy for psychotic symptoms – A treatment manual:

  Website: http://www.cci.health.wa.gov.au/docs/Psychosis%20Manual.pdf

- Social anxiety in schizophrenia: A cognitive behavioural group therapy programme:

  Website: http://www.cci.health.wa.gov.au/docs/SA_Schizophrenia.pdf

- Social skills training for severe mental disorders:

  Website: http://www.cci.health.wa.gov.au/docs/SocialSkillsTraining.pdf

Chapter 6: Cognitive-Behavioural Therapy for a Case of Anxiety and Depression

Information Sheets

- What is generalised anxiety:

  Website: http://www.cci.health.wa.gov.au/docs/ACF3C57.pdf

- What is panic:

  Website: http://www.cci.health.wa.gov.au/docs/ACF3C85.pdf

- Biology + psychology of panic:

  Website: http://www.cci.health.wa.gov.au/docs/ACF3C87.pdf

- Fight or flight response:

  Website: https://psychologytools.com/worksheets/free/english_gb/fight_or_flight_response_free_en-gb.pdf

Measures

- Hamilton Anxiety Rating Scale (HAM-A):

  Websites:

  – http://dcf.psychiatry.ufl.edu/files/2011/05/HAMILTON-ANXIETY.pdf
  – https://outcometracker.org/library/HAM-A.pdf

- Spence Children's Anxiety Scale:

  Website: http://www.scaswebsite.com/docs/scas.pdf

- The Penn State Worry Questionnaire (PSWQ):

  Website: https://outcometracker.org/library/PSWQ.pdf

Interventions

- Generalised anxiety disorder: Patient treatment manual:

  Website: https://crufad.org/wp-content/uploads/2017/01/crufad_GADmanual.compressed.pdf

- A therapist's guide to brief cognitive-behavioural therapy:

  Website: https://depts.washington.edu/dbpeds/therapists_guide_to_brief_cbt-manual.pdf

- Anxiety disorders treatment protocol:

  Website: https://echo.unm.edu/wp-content/uploads/2014/10/Anxiety-Disorders-Treatment-Protocol.pdf

- Cognitive behavioural model of fear of bodily sensations:

  Website: https://psychologytools.com/worksheets/free/english_gb/fear_of_bodily_sensations_free_en-gb.pdf

- Progressive muscle relaxation:

  Website: https://psychologytools.com/worksheets/free/english_gb/progressive_muscle_relaxation_free_en-gb.pdf

- Relaxed breathing:

Website: https://psychologytools.com/worksheets/free/english_gb/relaxed_breathing_free_en-gb.pdf

Chapter 7: Bereavement in an Elderly Client – Making Sense and Finding Meaning

Information Sheets

- Grief and bereavement information sheet:

  Website: https://www.researchgate.net/publication/14432009_Inventory_of_Complicated_Grief_A_scale_to_measure_maladaptive_symptoms_of_loss

- Coping with grief and loss:

  Website: https://www.ucdmc.ucdavis.edu/hr/hrdepts/asap/Documents/Coping_with_Grief.pdf

- Your grief: You're not going crazy:

  Website: https://web.archive.org/web/20110102062753/http://www.madd.org/victim-services/finding-support/victim-resources/your-grief-youre-not-going.pdf

Measures

- Measuring grief: A short version of the Perinatal Grief Scale

  Website: https://www.researchgate.net/publication/227027205_Measuring_grief_A_short_version_of_the_Perinatal_Grief_Scale

- Inventory of Complicated Grief: A scale to measure maladaptive symptoms of loss:

  Website: https://www.researchgate.net/publication/14432009_Inventory_of_Complicated_Grief_A_scale_to_measure_maladaptive_symptoms_of_loss

Interventions

- Principles of grief work:

  Website:

  – http://www.blatner.com/adam/psyntbk/grief.htm
  – https://psychologytools.com/assets/files/Grief_work_Blatner.pdf

- Interventions for prolonged grief:

  Website: http://www.solutionsdoc.co.uk/documents/INTERVENTIONS%20FOR%20PROLONGED%20GRIEF.pdf

- A guide for professionals offering bereavement support:

  Website: https://hee.nhs.uk/sites/default/files/documents/24%20-%20when%20someone%20you%20know%20has%20died%20-%20professionals.pdf

Chapter 8: Finding Courage – A Case of an Older Adult with Cognitive Impairment Due to a Medical Condition

Referrals for Neuropsychological Assessment

- Cognitive Neuropsychology, National University Hospital

  Website: https://www.nuh.com.sg/umc/about-us/about-us/department-of-psychological-medicine/clinical-services/outpatient-services/cognitive-neuropsychology.html

- Neurology, Singapore General Hospital

  Website: https://www.sgh.com.sg/Clinical-Departments-Centers/Neurology/Pages/overview.aspx

- Psychological Medicine & Geriatric Medicine, Khoo Teck Puat Hospital

  Website: https://www.ktph.com.sg/psychmed

Programmes for Patients and Family Members

- A New You (for patients with early dementia), Khoo Teck Puat Hospital
- GOLD Programme (for patients with subjective memory complains), Khoo Teck Puat Hospital
- The Dementia Support Group (for family members), Khoo Teck Puat Hospital

  For more information, please visit https://www.ktph.com.sg/geriatrics

Online Handbook for Caregivers on Anxiety

- A Handbook for Caregivers on Anxiety, Khoo Teck Puat Hospital

  Website: https://www.ktph.com.sg/uploads/1493877964A%20Handbook%20for%20Caregivers%20on%20Anxiety.pdf

Dementia Day Care Centres

AWWA Dementia Day Care Centre
Address: 123 Ang Mo Kio Avenue 6 #01-4035, Singapore 560123
Telephone: 6511 9479
New Horizon Centre (Bukit Batok)
Address: 511 Bukit Batok Street 52 #01-211, Singapore 650511
Telephone: 6565 9958
For more locations, please visit http://alz.org.sg/nhc/

St Luke's Eldercare (Nee Soon Central Centre)
Address: 766 Yishun Street 72, Singapore 760766
Telephone: 6567 0708
For more locations, please visit https://www.slec.org.sg/our-services/?service=dementia-day-care

Sunlove Home
Address: 70 Buangkok View, Buangkok Green Medical Park, Singapore 534190
Telephone: 6483 0841

Chapter 9: A Case of Subjective Cognitive Complaints in Older Adults – Anxiety, Stress and Ageing in an Elderly Client

Referrals for Neuropsychological Assessment

- Cognitive Neuropsychology, National University Hospital

  Website: https://www.nuh.com.sg/umc/about-us/about-us/department-of-psychological-medicine/clinical-services/outpatient-services/cognitive-neuropsychology.html

- Neurology, Singapore General Hospital

  Website: https://www.sgh.com.sg/Clinical-Departments-Centers/Neurology/Pages/overview.aspx

- Psychological Medicine & Geriatric Medicine, Khoo Teck Puat Hospital

  Website: https://www.ktph.com.sg/psychmed

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