

**A TRAINING MANUAL FOR
PREVENTION OF MENTAL ILLNESS:
MANAGING EMOTIONAL SYMPTOMS AND
PROBLEMS IN PRIMARY CARE**

**Materials for training of primary health care professionals
to help patients with emotional symptoms**

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TABLE OF CONTENTS

Contents of the manual and introductory pages	7
Programme of the training	15
Session 1 Introduction	17
Session 2 Seven Stages of Problem Solving Treatment, communication skills	29
Session 3 Problem Solving Stages one, two and three	59
Session 4 Problem Solving Stage four, five and six	71
Session 5 Goals of BPS, Stage 7, managing BPS in every-day practice	85
Session 6 Bringing it all together practicing BPS visits	103
Session 7 Generalised anxiety and avoidant behaviour	109
Session 8 Unexplained physical symptoms and insomnia	123
Evaluation form	135
References	137
Appendix	139
• Effective feedback	141
Alternative way of conducting sessions 6 and 7	
• Bringing it all together, session 6	147
• Generalised anxiety and avoidant behaviour, session 7	149
Acknowledgements	151

Visual aids

1.	Objectives of session 1	23
2.	PowerPoint presentation 'Prevention and promotion in mental health' (including symptoms and risk factors)	24
3.	The Framework	27
4.	Objectives of session 2: 7 stages of Problem Solving Treatment	36
5.	PowerPoint presentation 'Goals of BPS and '7 stages of Problem Solving Treatment'	37
6.	PowerPoint presentation 'Brief rehearsal of communication skills'	41
7.	Objectives of session 3: stages 1, 2 and 3 of Problem Solving	68
8.	PowerPoint presentation 'Problem Solving stage 1, 2 and 3'	69
9.	Case vignette Gertie	70
10.	Objectives of session 4: stages 4, 5 and 6 of Problem Solving	83
11.	PowerPoint presentation 'Problem Solving stage 4, 5 and 6'	84
12.	Objectives of session 5	92
13.	PowerPoint presentation 'Goals of BPS, stage 7, managing BPS in everyday practice'	93
14.	Case Vignette Philippa	94
15.	PowerPoint presentation: 'Summary of the 4 visits' (how to manage BPS in everyday practice)	95
16.	Objectives of session 6	107
17.	Objectives of session 7	116
18.	PowerPoint presentation 'Explaining about anxiety'	117
19.	PowerPoint presentation 'Managing anxiety: coping with anxiety, distraction and exercise'	118
20.	PowerPoint presentation 'Avoidance and simple exposure'	119
21.	Case vignette Helga	120
22.	Objectives of session 8	129
23.	Case vignette Odette	130
24.	PowerPoint presentation 'Reattribution: intervention for unexplained physical symptoms'	131
25.	PowerPoint presentation 'Insomnia: simple sleep hygiene and stimulus control'	132

Handouts

1.	Feedback form and summary of the rules of effective feedback	42
2-7.	Case vignettes	44
8.	Problem Solving worksheet	56
9.	Summary of the goals of Brief Problem Solving	96
10.	How to manage BPS over 3 or 4 visits	97
11.	Patient leaflet	99
12.	Personal case vignette	101
13.	Checklist for explanation of anxiety	121
14.	Checklist for explanation of how stress and tension lead to physical symptoms ..	133

CONTENTS OF THE TRAINING MANUAL

This manual consists of two components:

1. A two day training programme in Problem Solving and symptom management skills for primary health care professionals - eight sessions. Each session is planned to run for 90 minutes.
2. An appendix with list of references to other EU products and other useful information.

The training module aims to equip participants with interventions to use both for patients with problems (Brief Problem Solving - BPS) and for patients with symptoms (management of anxiety and insomnia). The appendix has a list of references and other useful information. Information on the impact of prevention and mental health promotion, materials to help identify groups of people with emotional symptoms at risk for development of mental illness, and a communication skills component are included within the training modules. During the training in BPS there will be emphasis on communication-skills. This will be achieved by a review of the theory, followed by practising the skills.

During the first session all participants will receive a participant's manual. This contains relevant information from the background notes in the trainer's manual and copies of all relevant visual aids and handouts.

For each session the following materials are provided:

- Session plan
- Statement of aims and objectives and list of materials required
- Background notes
- Visual aides
- Handouts of case vignettes

The statement of aims and objectives and list of materials required, the session plan and the background notes are for the trainer's use and reference.

The visual aids are in PowerPoint and can be copied onto overhead projector transparencies. They are shown to the health care professionals participating in the training as indicated in the session plan.

Case vignettes on handouts will be used during the role plays of the various stages of Problem Solving as indicated in the session plans.

All presentations will be copied in the participant's manual. They are intended to reduce the need to take notes and to help them participate actively in discussions and activities.

Trainer and participant numbers

The training is skills based. It has been developed to be delivered to groups of 12 participants by two trainers. During role play each trainer will supervise two groups of three participants and will divide their time between these groups. Trainers are free to organise the role-play's in a different way and adapt the role-play to the number of participants.

Using the manual

The training has been written up as a two-day programme with eight sessions of one and a half hour each, but can be delivered in many ways.

The content is 'fixed' but the length of the sessions may be varied according to the pre-existing knowledge and skills of the participants, or the wishes of the trainers. If for example more role-play is necessary to consolidate the skills of the various stages of Problem Solving, more time is needed for these sessions. For certain groups of participants the trainers might decide that in some sessions an interactive plenary will work better than practising in pairs. This will shorten those sessions.

The programme can also be spread out over a longer period of time, so the skills can be used in every-day practice between training sessions. In this case a good option is to train BPS first in a two-day programme, followed by a one day training programme some weeks or months later. In that case the follow-up session should contain feedback by the trainers on BPS of real patients, as well as training in Anxiety management.

The training methods that will be used are as follows:

Input

This is an information giving process, which may either be a short lecture or a focused discussion. Participant's backgrounds and existing levels of knowledge will influence the decision on how participatory each input session can be.

Brainstorm

This is a session eliciting ideas from a group and subsequently listing and discussing them. It is intended to raise energy levels and refocus attention on a particular issue by involving all group members. It also enables a group to briefly consider many aspects of an issue before focussing on key areas. In conducting a brainstorm:

- Explain the method to the group
- Use the headings described in the background notes of that particular session; ideally write them up before the session
- Record everyone's contribution first, without alteration or discussion
- Encourage a broad variety of options, aim to fill the board
- Then discuss and make final lists

Interactive plenary

This is a combination of input (focussed discussion) and brainstorm with a whole group of participants. It can be used as an alternative for an input session followed by role-play when

active involvement of participants is necessary, but role-play might be too much, for instance when there has been a lot of role-play previously that day.

Role-play

This describes practice sessions where participants are playing a role – pretending to be an imaginary patient or health care professional. Role-play is the best way to practise skills other than real life supervised practice with patients. It works best when students understand clearly why they are doing it and what is required of them. They are free to elaborate on the context information provided in the scenario handout if this helps the role play, as long as the description of symptoms is not changed. Role play will usually be done in groups of three. During role-plays participants, will alternate between the roles of patient, health care professional and observer.

Key Reading

As this manual is to be used in many European countries it is not possible to include references in all languages of participating countries. Only key references in the English language are mentioned.

Notes for Translators/Adapters

It is impossible to write a manual where every piece of information fits all countries and cultures. To ensure the high quality of the training, make sure to check and if necessary adapt all details to the specific needs required locally.

**Materials for training of primary health care professionals
to help patients with emotional symptoms**



Implementing Mental
Health Promotion Action

PROGRAMME OF THE TRAINING

DAY 1

1. First Session: 1h 30 min

- Introductions
- Prevention
- What is anxiety, what is depression – symptoms versus condition
- Framework

Break (30 minutes)

2. Second session: 1h 30 min

- Goals of BPS, Seven stages of Problem Solving treatment and brief rehearsal of communication skills

Lunch (1 hour)

3. Third Session: 1h 30 min

- Problem Solving stage 1, 2 and 3

Break (30 minutes)

4. Fourth session: 1h 30 min

- Problem Solving stage 4, 5 and 6

DAY 2

5. Fifth session: 1h 30 min

- Summary of where we have got so far
- Goals of BPS
- Stage 7
- How to manage BPS in a 10 – 15 minute appointment system
- Introduction to personal case-vignette

Break (30 minutes)

6. Sixth session: 1h 30 min

- Bringing it all together, consolidation in role play of BPS visit 2 and 3 and feedback

Lunch (1 hour)

7. Seventh session: 1h 30 min

- Introduction to symptom management
- Generalised anxiety symptoms: education and reassurance, distraction and exercise
- Avoidant behaviour

Break (30 minutes)

8. Eighth session: 1h 30 min

- Unexplained physical symptoms: reattribution
- Insomnia
- Questions

Evaluation and wrap up

SESSION 1: SESSION PLAN

TIME	METHODS
	<p>1. Introduction to Participants</p>
5 mins	As participants arrive, if possible, pair participants to people they do not already know and ask them to introduce themselves to each other (name, occupation, town) and what brings them to this course.
30 mins	Ask each person to introduce their partner - name, occupation, town – and if appropriate how he or she would like to be addressed (short version of name). Trainers introduce themselves.
	<p>Introduction to the course</p>
10 mins	Describe briefly programme and style in which it will be presented. Give all participants a copy of the training manual for their personal use, containing all background information on Problem Solving and symptom management. Show visual aid 1: objectives of session 1.
	<p>2. The context of prevention and Primary Health Care</p>
10 mins	Give information about the impact of prevention, based on visual aid 2, the PowerPoint presentation 'Prevention and promotion in mental health' and on the background notes. A copy of this presentation can be found in the participant's manual. Do not present the slides about the groups and risk factors yet.
20 mins	Invite participants to brainstorm and 'shout out' what groups of patients at risk for development of mental illness they can come up with until new ideas have dried up. Write these ideas on a white/blackboard under the headings listed in the background notes. Then point the participants to the slides in their manual on visual aid 2 and if there is time, show the corresponding slides of this visual aid of session 1.
	<p>3. Summary and framework – input</p>
10 mins	Bring everything together by explaining about depression and anxiety, making a distinction between symptoms and conditions. Use the background notes of session 1 for reference. Explain that in this 2-day course management of both problems and symptoms is covered.
2 mins	Explain the framework using visual aid 3.
3 mins	Invite participants to discuss any questions they might have.

SESSION 1 Aims and Objectives

INTRODUCTION

AIM:

To introduce participants to each other and to the course, to provide them with brief information on prevention and groups at risk for development of mental illness, to give an explanation about anxiety and depression, symptoms versus conditions and explain the framework to work from.

OBJECTIVES:

By the end of this session participants will be able to:

- Give the name and occupation of at least one of the other participants
- Describe the impact of prevention and mental health promotion
- Identify groups of people at risk for development of mental illness
- Make a distinction between symptoms of anxiety and depression, and diagnostic conditions
- Use the framework to decide whether to treat symptoms or problems

MATERIALS NEEDED:

A participant's manual for each participant
Flip-chart and pen or blackboard and chalk

PowerPoint presentation of session 1, this includes:

Visual aid 1: Objectives of session 1

Visual aid 2: PowerPoint presentation 'Prevention and promotion in mental health'
(including symptoms and risk factors)

Visual aid 3: The Framework

SESSION 1**Background notes for the trainer****INTRODUCTION****1. Introduction to Participants**

As participants arrive, if possible, pair participants with people they do not already know and ask them to introduce themselves to each other (name, occupation, town) and what brings them to this course. Ask each person to introduce their partner - name, occupation, town – and if appropriate how he or she would like to be addressed (short version of name). Trainers introduce themselves.

Trainers may need to adapt this process to the needs of the participants. If participants already know each other introductions can be limited to the participant's motivations to participate in this course. If participants are complete strangers and / or there are reasons to believe they are particularly shy or vulnerable, it may be worthwhile extending the time spent getting to know each other.

Where there is an odd number, form one group of three instead of a pair.

Encourage use of first names for both participants and trainers, as informality will help facilitate discussion and role-play, giving and receiving feedback, and avoid difficulties later on in the course.

Name badges are helpful with the use of first names in order to create the right atmosphere.

Introductions to the Course

It is important to explain that the course will be participatory, drawing on and adding to student's existing skills. The ground rules will be those that help people learn from each other and share their ideas and expertise.

A typical list of ground rules is:

'We agree to.....

- Keep confidentiality – do not talk about each others personal matters outside the course
- Respect every-ones viewpoint, even if you do not agree with it
- Be punctual in attending and returning from breaks
- In group discussions, speak one at a time and listen to each contribution.
- Respect difference and do not discriminate against people who are of different (cultural) backgrounds, beliefs, abilities etc.
- Ask for clarification if anything is unclear

It may be important to remind participants that the course is a whole, not a series of individual seminars. Each session relates to the previous and following ones. Participants should attend every session.

2. The context of prevention and Primary Health Care

First explain the impact of prevention and mental health promotion, using the following information and the power point presentation on visual aid 2 'Prevention and promotion in mental health' which is copied in the participant's manual but do not present the slides about the groups and risk factors in that presentation (yet).

Prevention and promotion in mental health

In addition to treatment for those already suffering from mental disorders, prevention and promotion in mental health have been shown to work across the life span (Hosman, Jané-Llopis & Saxena, in press).

Mental health promotion has been defined as "activities that imply the creation of individual, social and environmental conditions that enable optimal psychological and psycho-physiological development. Such initiatives help individuals achieve positive mental health, enhance quality of life and narrow the gap in health expectancy between groups".

Mental disorder prevention has been defined as "reducing incidence, prevalence, recurrence of mental disorders, the time spent with symptoms, the risk condition for a mental illness, and also decreasing the impact of illness in the affected person, their families and the society" (WHO, 2004).

Primary prevention, as defined in the public health classification, is composed of promotion and prevention strategies directed at populations that do not meet the diagnostic criteria for a disease. Primary prevention in mental health can include: (1) interventions that are targeted to the general public or a risk-free population group; (2) interventions for individuals or subgroups of population whose risk of developing a mental disorder is significantly higher than average as evidenced by biological, psychological or social risk factors; and, (3) interventions targeted at high-risk persons having signs or symptoms of a mental disorder but who do not meet diagnostic criteria for disorder at that time.

Risk and protective factors

Primary prevention interventions focus on the reduction of risk factors and the enhancement of protective factors that are related to one or more mental disorders. Risk and protective factors can be individual (e.g. being a woman), family-related (e.g. having suffered from child abuse, marital problems) social (e.g. lack of social support), economical (e.g. poverty) or environmental (e.g. job loss). Mostly it is the accumulation of risk factors and the lack of protective factors that predisposes individuals to increased vulnerability which can lead to a full-blown disorder. The identification of individuals eligible for preventive interventions is often undertaken through the assessment of presence of risk factors and absence of protective factors.

Evidence that prevention works

Strong evidence suggests the efficacy and effectiveness of prevention strategies in the reduction of risk factors (e.g., self esteem), associated symptoms such as depressive symptomatology, and the actual prevention of new cases both for depression (Clarke et al., 1995; 2001) and anxiety disorders (Dadds, 1997). Other outcomes related to prevention and promotion programmes have also included social outcomes (for example, decreases of violence, increased family well-being and the acquisition of better jobs). Evidence suggests that prevention programmes for depression are more effective when delivered by health care professionals than when delivered by other personnel (Jané-Llopis et al., 2003).

Prevention and promotion of mental health in primary care

In spite of the effectiveness of preventive strategies there have been little efforts to date to integrate primary prevention of mental disorders in primary health care. Evidence of the effectiveness of such interventions in primary care is available for related topics such as alcohol (Anderson, 2000) and tobacco (Anderson & Jané-Llopis, 2004).

This training manual aims to integrate prevention and promotion strategies for mental health into primary health care daily practice. There is a focus on Problem Solving skills. Problem Solving treatment has proven to be effective with depressed patients in primary care. In addition, Problem Solving skills are frequently used with success in interventions to prevent depression and anxiety across the life-span. This evidence suggests that Problem Solving skills may be helpful as a preventive strategy for primary care patients at risk of or already suffering from emotional problems but not yet fulfilling diagnostic criteria for full-blown disorders.

'Plenary brainstorm' session about risk groups

During this input, try to get the participants involved actively in drawing up of a list of risk groups, rather than giving this information as part of the input. This can be done in the following way: invite the participants to brainstorm for a moment and then invite them to shout out as many 'risks' for development of mental illness as they can think of. Tell them you want to hear signs and symptoms of individual patients as well as groups at risk. To facilitate this, tell them you have the following headings in mind, which you then write on a black or white-board (or ideally have done already) : specific symptoms and clusters of symptoms; signs; individual and family-related risk factors; social-environmental and economic risk factors.

List all ideas under the appropriate sub-heading, without any discussion. Stop when no new ideas are brought up. Discuss their suggestions briefly and add or subtract using the information of visual aid 2, the PowerPoint presentation about prevention and point participants to the print of this presentation in their manual. If there is enough time left, show these slides.

3. Brief explanation about the distinction between symptoms and conditions, the framework

Pull everything together with an explanation about the distinction between a diagnostic condition and symptoms. To make a formal diagnosis of depression or anxiety (a set of criteria have to be met, a fixed number of symptoms clustered in a specific way. In that case a specific treatment is needed. Use the symptoms that came out of the brainstorm exercise to indicate specific clusters but do not make it into a lesson about making a diagnosis. Instead and if relevant, point participants to the information in the appendix on how to make a specific diagnosis.

Explain that the interventions in this manual are for patients presenting in primary care, not with a diagnostic condition but with (one or more) symptoms or problems. These patients do not meet criteria for a specific diagnosis, but nevertheless do not function optimally. Managing their symptoms or problems could help to prevent development of a full-blown mental disorder. Interventions to manage symptoms and problems will be covered in the 2-day course presented in the manual.

To help the professionals make a decision about which interventions should be used and when to aim for symptoms and when for problems, explain the frame work using visual aid 3.

SESSION 1: Visual Aid 1







INTRODUCTION

Objectives:

By the end of this session participants will be able to:

- Give the name and occupation of at least one of the other participants
- Describe the impact of prevention and mental health promotion
- Identify groups of people at risk for development of mental illness
- Make a distinction between symptoms of anxiety and depression, and diagnostic conditions
- Use the framework to decide whether to treat symptoms or problems

SESSION 1: Visual aid 2

<p style="text-align: center;">Session 1: Introduction</p> 	<h3>Scope of this training</h3> <ul style="list-style-type: none"> This training provides short interventions for primary care that apply principles of: <ul style="list-style-type: none"> – Problem Solving Treatment and – Anxiety Management With the aim to: <ul style="list-style-type: none"> – Help manage emotional symptoms and mental health problems, and ultimately, – Prevent new cases of depression and anxiety This training has been developed under a primary prevention framework 
<h3>Primary prevention of mental disorders</h3> <p>Targets people who:</p> <ul style="list-style-type: none"> Do not fulfil a diagnosis for mental disorder but who are at risk or suffer from mental health problems <p>Aims to:</p> <ul style="list-style-type: none"> Reduce the risk for a mental disorder Reduce symptoms and/or the time with symptoms Reduce incidence of mental disorders Decrease the impact of illness in the affected person, their families, the society 	<h3>Who is addressed?</h3> <ul style="list-style-type: none"> Individuals are identified by the presence of mental health problems or risk factors <p>Risk (and protective) factors can be:</p> <ul style="list-style-type: none"> Individual: suffer chronic physical illness Family-related: child abuse, marital problems Social-environmental: (lack of) social support, job loss, bad neighborhood Economical: low socio-economic status, poverty 
<h3>Does it work?</h3> <p>Have proven to be efficacious in different settings and across the life span</p> <p>Have lead to (up to 40% - 50%):</p> <ul style="list-style-type: none"> Decreases in risk factors (e.g., low self-esteem) Increases in protective factors (e.g., resilience) Decreases in symptoms of anxiety - depression Decreases in onset of anxiety - depression 	<h3>Prevention in Primary Care</h3> <ul style="list-style-type: none"> No randomized studies for mental disorders Strong evidence of GP advice in primary care for: <ul style="list-style-type: none"> – Tobacco (10% of smokers quit smoking) – Alcohol (15% less heavy drinkers) Problem solving treatment is effective in primary care Problem solving skills are effective in prevention across the life span This training uses problem solving skills for prevention in primary care 

Specific Symptoms and Clusters of Symptoms

1. Common physical symptoms of anxiety
2. Common cognitive symptoms of anxiety
3. Common behavioural symptoms of anxiety
4. Depressive symptoms
5. Signs suspect of a (developing) mental illness



1. Common Physical Symptoms of Anxiety

Gastrointestinal:

- dry mouth or difficulty swallowing
- diarrhoea
- abdominal discomfort
- nausea
- "butterflies"

Genitourinary:

- frequency/urgency micturition
- menstrual pain/disturbance
- erectile dysfunction

Neuromuscular:

- aching muscles, incl. chest pain, headaches
- tremor / shaking
- tingling sensations

Cardiovascular:

- palpitations, pounding/racing heart
- dizziness/light headedness

Respiratory:

- hyperventilation
- difficulty inhaling, feeling short of breath

Other features:

- sleep disturbance
- derealisation
- depersonalisation
- sweating



2. Common Cognitive Anxiety Symptoms:

- Anticipatory fear
- Excessive worry
- Tension, feeling on edge, keyed up
- Difficulty concentrating
- Irritability
- Tiredness, easily fatigued
- Fear of losing control/going mad



3. Common Behavioural Symptoms:

- Avoidance
- Smoking more
- Nail biting
- Restlessness



4. Depressive Symptoms:

- Depressed mood
- Loss of interest and enjoyment
- Reduction of energy or increased fatigability
- Reduced self-esteem
- Ideas of guilt and unworthiness
- Ideas of acts of self-harm or suicide
- Impaired concentration and attention
- Objective evidence of definite psychomotor retardation or agitation
- Disturbed sleep
- Diminished or increased appetite



5. Signs Suspect of a (Developing) Mental Illness:

- Frequent attendance
- Presenting with varying and or vague/unexplained symptoms
- Persisting symptoms without a physical cause, in particular with symptoms of
- Nervousness, stress, irritability or instability
- Request for sleeping medications or tranquillisers



Risk Factors

1. Individual
2. Family related
3. Social-Environmental
4. Economic



1. Individual Risk Factors

- Chronic physical illnesses (pain, insomnia)
- Disabilities (reading, sensory, organic handicaps)
- Job burden (responsibilities, low salaries...)
- Life transitions (job retirement) / Stressful life events
- Loneliness, helplessness, hopelessness
- Personal loss – bereavement / Widowhood
- Poor problem solving, coping skills, security, prosocial behaviour, etc
- Previous failed suicide attempts
- School related problems: academic failure, attention deficits, bullying
- Social incompetence and failure, poor social skills



2. Family Related Risk Factors

- Abuse (child abuse and neglect, elder abuse)
- Care-giving of chronically ill or dementia patients
- Family stressors: divorce, conflict,
- Parental or spouse's mental illness or parental substance abuse
- Substance abuse



3. Social-Environmental Risk Factors

- Displacement, social disadvantage, racial injustice, discrimination
- Exposure to aggression, delinquency, violence and trauma, substance abuse
- Isolation and alienation
- Lack of education, transport, housing
- Lack of social support networks
- Low social class, poor social circumstances, social disadvantage
- Neighbourhood disorganisation
- Peer rejection
- Work stress



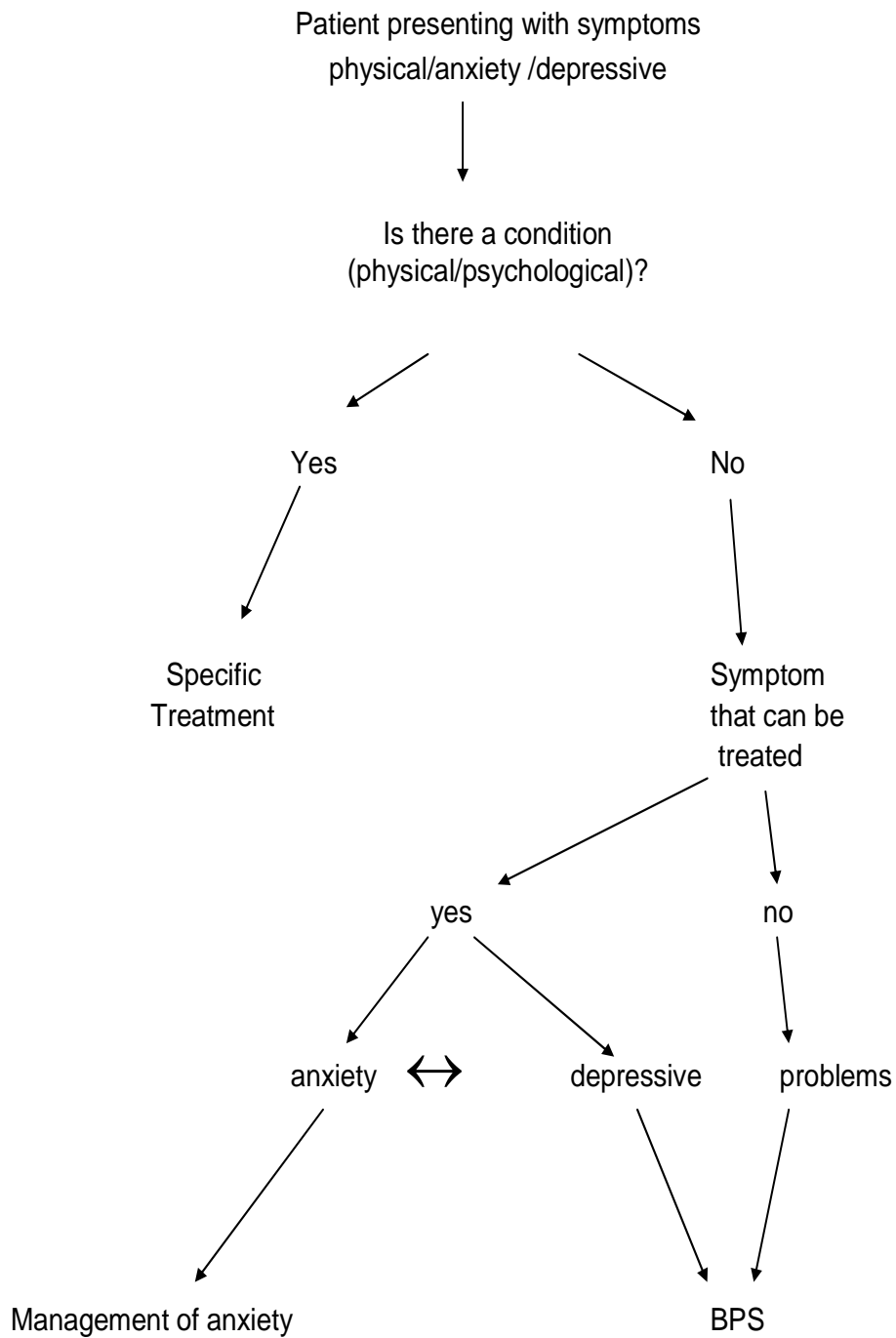
4. Economic Risk Factors

- Poor nutrition
- Poverty
- Unemployment



SESSION 1: Visual aid 3

Framework



SESSION 2: SESSION PLAN

TIME	METHODS
40 mins	<p>1. Goals of BPS and seven stages of Problem Solving Treatment – Input</p> <p>Show visual aid 4, objectives of session 2. Describe the goals of BPS, the structure and the 7 stages of Problem Solving Treatment, basing input on the PowerPoint presentation of visual aid 5. Use an example from your own patients to explain the structure. Explain about activity scheduling.</p> <p>Point to the slides of the PowerPoint presentation in the participant’s manual.</p>
20 mins	<p>2. An example of Problem Solving</p> <p>Show the Video/DVD with an example of Problem Solving used in a consultation with a patient.</p>
5 mins	<p>3. Discussion and questions about the video</p> <p>Invite and discuss any questions participants may have after having seen the video.</p>
20 mins	<p>4. Refreshing communication skills - input.</p> <p>Discuss the following communication skills briefly: questioning, listening, responding, explaining, summarising and negotiating, basing input on the background notes of session 2 and visual aid 6, the PowerPoint presentation ‘Brief rehearsal of communication skills’. The trainer uses examples from BPS from his or her personal experience where possible.</p>
5 mins	<p>5. Participant paperwork</p> <p>Briefly explain the use of the feedback forms and Problem Solving worksheets for the next sessions</p>

SESSION 2 Aims and Objectives

SEVEN STAGES OF PROBLEM SOLVING

AIM:

To introduce participants to the principles of Problem Solving and the goals of BPS. To rehearse communication skills.

OBJECTIVES:

By the end of this session participants will be able to:

- Describe the goals of Brief Problem Solving (BPS)
- Indicate the 7 stages and the structure of Problem Solving
- Describe which communications skills to use during Problem Solving

MATERIALS NEEDED:

PowerPoint presentation of session 2, this includes:

Visual aid 4: Objectives of session 2: 7 stages of Problem Solving Treatment

Visual aid 5: Power point presentation 'Goals of BPS and '7 stages of Problem Solving Treatment'

Visual aid 6: PowerPoint presentation 'Brief rehearsal of communication skills'

Video/DVD: Example of the seven stages of Problem Solving

Handout 1: Feedback form and summary of the rules of effective feedback

Handouts 2-7: Case vignettes

Handout 8: Problem Solving worksheet

SESSION 2**Background notes for the trainer****SEVEN STAGES OF PROBLEM SOLVING TREATMENT**

1. Briefly explain the goals of BPS and the 7 stages of Problem Solving treatment using visual aid 5, the PowerPoint presentation of the 7 stages of Problem Solving Treatment. Also use the information about the individual stages of Problem Solving in the background notes of sessions 2 – 5, and examples from your own personal experience. A summary of the goals of BPS is found on the first slides of the power point presentation of the seven stages. Explain briefly and point the participants to the print of this visual aid in their manual.

The Goals of Brief Problem Solving

- a) The first goal is to increase the patient's understanding of the link between their current symptoms and their current everyday problems. Included in this goal is an understanding that problems are an expected part of everyday living, and that effective resolution of such problems will help to improve how the patient is feeling.
- b) The second goal, is to enable the patient to clearly define their current problems and to determine which problem/problems they wish to work on.
- c) The third goal is to provide the patient with a specific Problem Solving procedure in an attempt to solve their problems in a structured way. Specific Problem Solving skills will be introduced and can be practised by the patient using the real-life problems the patient is currently attempting to solve.
- d) The final goal is to produce more positive experiences regarding patient's ability to solve problems, thereby increasing their confidence in their Problem Solving ability and their feelings of self-control and mastery.

Explain that BPS in itself should not be considered as a full psychological treatment but more as a skill, which can be used within a regular appointment system in primary care. It is a skill that is taught by the healthcare professional to the patient. A sufficient number of BPS sessions however, going through the full process of all 7 stages of PST a number of times with a patient on various problems, might add up to full PST.

Include activity scheduling in your explanation. It is helpful for patients with depressive symptoms and is also a good way for a patient to practise the stages of Problem Solving.

Use the following Activity Scheduling Patient Handout which is also included in the participant's manual.

Why is it Important to Do More Pleasurable Activities?

Activity Scheduling Patient Handout

When people get depressed they do not feel up to doing the kinds of things they typically enjoy. By doing fewer enjoyable things they begin to feel even worse. As they feel worse, they do even less, and get caught up in a vicious cycle of doing even less and feeling even worse.



A simple and effective introduction to some Problem Solving techniques is to take the problem of reduced pleasurable activity, and set a goal of doing one pleasurable activity each day. In other words, arranging to provide yourself with "a treat a day".

The positive benefits are:

- a) You can work through the steps of Problem Solving using a simple problem;
- b) The tasks can usually be easily arranged and managed;
- c) You will start to assert control over your life in a positive and beneficial way.

2. Show the Video/DVD where Problem Solving is used by Laurence Mynors-Wallis in a consultation with a patient with emotional symptoms, demonstrating an example of the principles of Problem Solving.

3. Discussion and Questions about the video

Invite participants to clarify any matters that are not clear to them and make sure there is some discussion about the video.

4. Refresh Communication skills

This can be done during a brief input session, by explaining and refreshing the skills required for stage one: questioning, listening, responding, explaining, summarising and negotiating and non-verbal communication. The discussion of communication skills should include examples from BPS where possible. A summary is available on visual aid 6, the PowerPoint presentation 'Brief rehearsal of communication skills'.

Questioning

Explain the various types of questions.

Open questions encourage patients to tell their own story and reveal information that might otherwise not have been volunteered. They are particularly helpful to start with and when more information is needed on something that has been said. An example: 'How can I help you?'

'*Greater response*' questions are necessary to get a better picture of what is going on, in this case 'could you tell me more about that nervousness' could be a helpful question. If she answered 'Well, I really feel awful' the next question could be: 'Could you tell me a bit more about it?'

'*Clarification questions* are necessary to make sure everything is understood correctly: if the patient had answered the previous question with 'I feel tired all the time, I cry a lot and I feel so nervous. I think it has to do with work because I feel my heart racing and I feel faint every time my work comes up and in particular when I think about that bully of boss I have. A clarification question could be: 'I want to make sure I get this straight: you believe your boss is an important reason for your nervousness at work?'

Probing or focussed questions may also be helpful now, these are follow-up questions that stimulate patients to think more deeply about their answers. For instance in this patient: 'have you noticed anything else that brings on this nervousness?'

Closed questions specify the type of information you want to collect and are likely to produce short answers. They are helpful when you are searching for particular items of information such as in this case (clusters of) emotional symptoms. This type of question is particularly helpful when you want to determine the presence or absence of a clear mental disorder. Some examples: 'do you feel sad', 'have you lost weight' etc.

Leading questions are a particular kind of closed questions that seek specific information. Try to avoid these questions as much as possible because they encourage patients to give answers they believe you want to hear: 'would you agree that her criticisms bring on your tears? Better is to phrase the question in a way the patient gets more opportunity to qualify the answer as necessary.

Also try to avoid asking *overlapping questions* as this will confuse a patient and they are very difficult to answer accurately. 'Do you have difficulty with your appetite and weight?' The answer to appetite and weight may be different. It is better to ask the questions separately and wait for the answers in between.

Listening and responding

To listen it is necessary to be relaxed but vigilant. *Active listening* is trying to understand the message, verbally and non-verbally. This means *clarifying* now and then, sometimes *repeating in your own words* what a patient has said and making sure you have really understood. 'There were lots of difficulties in taking care of your mother, you told me you nearly broke down. Could you tell me what you mean exactly? .. What happened?.. How did you manage?' It also means *reacting with empathy* when required. 'You had been very close and then your mother died. This must be very difficult for you.' This could also be called *reflective listening* and contains *reflection of meaning* (content) as well as *reflection of feeling*.

Summarising

A summary helps to ascertain that all relevant details have been told. If it is done in an appropriate way it will also show the patient that you have really paid attention to their story. The summary can also be used to check if everything was understood correctly, and the patient should have the opportunity to correct or to add information. 'You told me that you took care of your mother for a long time and that was very difficult because she lived 60 miles away. And you also had nobody to talk about it all this time, have I understood you correctly?'

Explaining

When explaining a patient about symptoms, a diagnosis or the treatment, make sure that you *adjust your explanation* to the individual patient building on existing knowledge. This means you have to find out what the patient already knows or believes about that subject first. Then use words that fit that individual patient and follow the patient's pace.

Create the appropriate balance between priorities between the person and the illness and do not tell too much at once, phase your information. It is better to provide "a drizzle of information rather than a hailstorm of facts". Take your time and make sure to leave space for questions. Assess how much the patient knows and wants to know. Re-assess the patient's understanding by asking the patient specific questions at each stage of your explanation.

Negotiating/Collaborating

Sometimes a patient does not agree with your view of what is the matter, or of your choice of treatment or vice versa. Then it is difficult to reach an agreement but an agreement is necessary for a good outcome. Listen actively and clarify exactly what it is that the patient wants or does not want, and why. First ask open questions. Trying to see it the way the patient does, will help you recognise his or her emotions and you can acknowledge them.

Summarise to make sure you understand the whole message. Respond to emotions in way the patient feels understood: for instance 'You are disappointed that we found no physical explanation for your headaches, and would like another scan. You are sure the investigations I did have not been thorough enough and there must be something wrong in your brain which we can only see on that scan. I understand why you want that scan now!' Then mark your position: 'It must be difficult to accept that there is no physical cause but as your doctor I feel responsible for your health. I would like to explain why I don't think a scan will help you and me in this case, and what I believe is a better option, is that ok. with you?' And then explain your point of view using your expertise, but use words the patient can understand. Try to link the two views. Then try to reach an agreement about what should be done (or not done). Ask the patient to participate: 'let's try to come up with a plan we can both agree on, do you have any idea's?' Appreciate approach and emphasise the importance of continuation of trust in each other. Sometimes it is important to give the patient (and or yourself) some extra time, or a time-out for example: 'Shall we take some time to think about possible solutions and talk about it later?'

Non-verbal communication

Throughout consultations doctors should be aware of non-verbal communication of their patients as well as of themselves. For a good relationship and for recognition of emotional distress it is important to make eye contact, to have a relaxed posture, to not just sit passively but nod now and then encouraging the patient to tell more. Watch the expression on the patients face, his or her posture and gestures when telling the story.

There is many more to be said about communication skills but this should be enough to practise the stages of Problem Solving.

The trainer can also use information in Clinical Method. Fraser RC, third edition Butterworth Heinemann chapter 6, page 91-9 and refer to this book or other books, used locally for the training of communication skills.

5. Participant paperwork

During role play in the following sessions a number of forms will be used. Explain to participants that they can find the feedback forms as handout 1 in this chapter in their manual. This handout will help giving structured feedback to their colleagues, and remind them of a few rules of effective feedback.

For the trainers the handouts of the case vignettes (handouts 2-7) can also be found in this chapter. They should be printed on handouts before the next session so they can be used by the participants during the role-play's in the following sessions.

The Problem Solving worksheets (handout 8) are meant to help health-care professionals and the patient to remember the stages of Problem Solving.

SESSION 2: Visual aid 4

SEVEN STAGES OF PROBLEM SOLVING TREATMENT

Objectives:

By the end of this session participants will be able to:

- Describe the goals of Brief Problem Solving (BPS)
- Indicate the 7 stages and the structure of Problem Solving Treatment
- Know which communication skills to use for Problem Solving


SESSION 2: Visual aid 5

Session 2:
Goals of BPS, Seven stages of
Problem Solving Treatment,
Communication skills




The Goals of BPS (1)

1. To increase the patient’s understanding of the link between their symptoms and their everyday problems.
 - Problems are an expected part of everyday living
 - The effective resolution of problems will improve how the patient is feeling
2. To enable the patient to clearly define his or her current problem(s) and determine which problem the patient wishes to work on




The Goals of BPS (2)

3. To provide the patient with a structured problem-solving procedure, and introduce and practice specific problem-solving skills.
4. To produce more positive experiences regarding patient’s ability to solve problems, thereby increasing confidence and feelings of self-control and mastery.




SEVEN STAGES OF PROBLEM SOLVING TREATMENT




Seven stages:

1. EXPLANATION AND RATIONALE
2. PROBLEM DEFINITION
3. ESTABLISHING ACHIEVABLE GOALS
4. GENERATING SOLUTIONS
5. EVALUATION AND CHOICE OF SOLUTION
6. IMPLEMENTATION
7. EVALUATION



1. Rationale

<i>EMOTIONAL SYMPTOMS</i>	<i>PHYSICAL SYMPTOMS</i>
<ul style="list-style-type: none"> • Low mood • Loss of enjoyment • Worries • Poor concentration • Irritability • Hopelessness 	<ul style="list-style-type: none"> • Sleep Disturbance • Appetite Change • Tiredness • Headaches • Aches and Pains

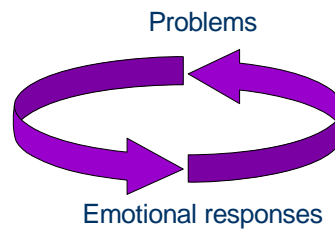


Problem list

- Relationships.....partner/spouse
- Relationships.....children/other relatives
- Relationships.....friends
- Work
- Money
- Housing
- Health
- Alcohol & drugs
- Legal issues
- Leisure activities



Linking Together



2. Definition and breakdown of problem

- State the problem in a clear concrete way
- Control
- Feasibility
- From their own list
- Very clear definition
- Design pleasurable activities or
- "Treat a Day!"



Breaking the problem down

- Helps with clearer definition
- Enables sense of control and achievement earlier
- Fact or Assumption?
- What,when,where who and how????
- Impact on their life?



3. Establish achievable goals

- | | |
|---|--|
| <ul style="list-style-type: none"> • What would they like to see changed ? • Can it be reasonably achieved? • Resources v. Obstacles | <ul style="list-style-type: none"> • Short term at the start • Medium term over time • Long term later! • Clarity without rigidity |
|---|--|

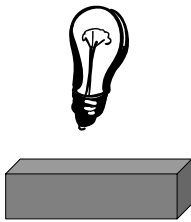


Achievable Goals

- **S**PECIFIC
- **M**EASURABLE
- **A**CHIEVABLE
- **R**ELEVANT
- **T**IMED



4. Generating solutions



- “Brainstorming”
- The more the merrier
- Mix & combine
- Avoid judgement
- PRAISE ++++
- “BRICK”

5. Choosing a solution

- | | |
|--|---|
| <ul style="list-style-type: none"> • “Pros and Cons” • Effect on family, friends and colleagues • Actual impact on problem • Ability to carry it out | <ul style="list-style-type: none"> • Avoid therapist choice unless negative impact • More than one is ok • Do the full process |
|--|---|

6. Implementing preferred solution

- Detailed, planned steps
- Minimise chance of inaction
 - Rehearse interview/confrontation
 - Go back if necessary
 - Take time
 - Be specific about time, frequency, difficulties
 - Write it down

7. Evaluating the outcome (follow-up sessions)

- Review Homework
- Recognise any steps and PRAISE
- Link task completion to symptom reduction
- Review difficulties

Potential difficulties

- Was the goal clearly defined?
- Was the goal realistic?
- Have new obstacles arisen?
- Are the implementation steps too hard?
 - What else could they do?
- Are they committed to working on the problem?

Moving on

- Return to problem list
- Follow the same process
- Stay positive
- Consider activity scheduling



Activity Scheduling

Most people will benefit; always suggest if:

1. Lack of pleasurable events identified on problem list
2. Other problems are outside person's control
3. When solution is likely to have a negative outcome in short term
4. When person insists that they have no problem



Summary

Problem Solving

- is collaborative and positive
- It follows specific steps
- It increases a person's sense of control over their lives
- It involves the person working outside the session
- IT WORKS!!



SESSION 2: Visual aid 6

Brief Rehearsal of Communication skills

Questioning

- Open questions
- Exploring, greater response questions
- Clarification questions
- Probing, focussed questions
- Closed questions
- Leading questions
- Overlapping questions

Listening and responding

- Active listening (*reflective listening*)
 - clarifying now and then, sometimes
 - repeating in your own words (*reflecting content*)
 - reacting with empathy (*reflecting feelings*)
- Summarising

Listening and responding

- Explaining
 - Adjust to individual patient
 - Follow patients pace
 - Asses understanding
 - Re-assess if necessary

Negotiating/Collaborating

- Clarify what patient wants (or not) and why
- Identify emotions and acknowledge
- Try to link the two views
- Try to reach agreement
- Win - Win

Non verbal communication

Be aware of (use of) non-verbal communications of both sides

- Professional:
 - eye contact
 - posture
 - gestures
- Patient:
 - expression on face tells about emotion
 - so does posture
 - and gestures

SESSION 2: Handout 1

Feedback form

Positive points

Be specific what was said

what behaviour was helpful

what response was good

Areas for improvement

Be specific what was said

what behaviour was unhelpful

Ideas for development:

Other comments:

Summary of the rules of effective feedback

1. Recognisability

- a. Concrete
- b. On personal title

2. Applicability

- a. To behaviour rather than to feelings
- b. Discuss alternative behaviour

3. Safety

- a. To current behaviour
 - b. Positive feedback
- No 'overdose'
 - Balance aspects for improvement with positive points:
2 things you liked and 2 things which could have been done better
 - Say what has to be said
 - Mind the dialogue

SESSION 2, 3, 4 Handout 2: Case vignette Annie

Annie

Annie is a 45-year-old nurse, who lives alone and is on sick leave because she can't cope with her work.

Symptoms:

She feels a bit low and also has some difficulty falling asleep. There are no other emotional symptoms.

Background:

She has never had a longstanding relationship and feels lonely.

She finds her work difficult and sometimes emotional, she is afraid to make mistakes, and she can't talk to her superior about this. She also hates all the paperwork that comes with her job co-ordinating a group of nurses.

SESSION 2, 3, 4 Handout 2: Problem list Annie

1. Problems at work
 - a) Work is difficult and often emotional
 - b) Afraid of making mistakes
 - c) Dislikes paperwork
 - d) Can't talk to superior

2. Feels lonely

SESSION 2, 3, 4 Handout 3: Case vignette Anja

Anja

Anja is a 40-year-old woman. She teaches the violin at a local music school.

Symptoms:

Low mood, overeating.

Background:

This job was the only one she could find but she would have liked to play in an orchestra. She feels let down by her colleagues who do not feel as responsible as she does. Although she would like to, she still does not have a partner and hates being alone. She has started eating again, something she always does when she doesn't feel good. She has gained a lot of weight and hates herself for it.

SESSION 2, 3, 4 Handout 3: Problem list Anja

1. Loneliness

2. Problems at work
 - a) would like different job
 - b) feels let down by colleagues

3. Overeating and weight gain

SESSION 2, 3, 4 Handout 4: Case Vignette Adrian

Adrian

Adrian is 42 years old, married, with 2 children. He and his family moved to this town about a year ago.

Symptoms:

He is tired, feels down, and has back pain.

Background:

The relationship with his wife is not good, he feels he does everything wrong, she is spending too much money and because of that the family has financial problems. They also never do anything nice together. He cannot bring himself to any pleasurable activities and feels worried all the time.

SESSION 2, 3, 4 Handout 4: Problem list Adrian

1. Relationship with wife

- a) Don't do anything nice together
- b) She spends too much money
- c) She always blames him for everything wrong

2. Financial problems

- a) Wife spends too much
- b) Not enough income

3. Lack of pleasurable activities in new home-town

SESSION 2, 3, 4 Handout 5: Case Vignette Beryl

Beryl

Beryl is a 35 year old unemployed, divorced mother of three children aged 16, 9, 5.

Symptoms:

She is feeling a bit low and moody.

Background:

Beryl used to be a self-employed jewellery maker but has not worked for several months and lives on benefits. She lives in a nice house but the housework is getting out of control and she also cannot cope with the garden.

SESSION 2, 3, 4 Handout 5: Problem list Beryl

1. Not enough money due to

- a) Too many bills
- b) Not enough income

2. Garden out of control – too big

3. Misses work

SESSION 2, 3, 4 Handout 6: Case Vignette Gavin

Gavin

Gavin is 22 year old male, living alone.

Symptoms:

Feeling guilty, low self-esteem.

Background:

He has recently graduated in English but does not have a job yet. His parents and tutor expected him to qualify at the top of his class but he ended somewhere in the middle. His parents feel that he has wasted his time. Gavin now feels guilty whenever he reads, or spends time doing nice things for himself and has a low self-esteem.

He has moved away from home into a flat but knows nobody there yet and feels a bit lonely.

It is also difficult to cope by himself with all the bills and no job.

His girlfriend, Ann was visited every evening and seemed interested in helping him to find temporary work. She has suddenly stopped coming. He now feels completely rejected and does not know what to do next.

SESSION 2, 3, 4 Handout 6: Problem list Gavin

1. No job

2. Needs money

3. Not sure what has happened to Ann

4. Angry with parents

5. Feels lonely

SESSION 2, 3, 4 Handout 7: Case Vignette Paul

Paul

Paul is a 45 year old male, living alone.

Symptoms:

Feeling anxious, palpitations, sweating.

Background:

Until recently he has hardly ever been ill but after an accident in which he broke his leg he now has great difficulty walking. As he used to work as a postman he is on sick leave. He feels lonely without his work and worries a lot because he does not know if he will ever be able to work again!

He is also angry because after 3 months he still has not had any sign of compassion or sympathy from his boss. The whole situation has brought on sweating and palpitations.

SESSION 2, 3, 4 Handout 7: Problem list Paul

1. Difficulty walking due to persisting problems of broken leg

2. Angry with boss

3. Lonely

4. Misses work

SESSION 2: Handout 8**Problem Solving Worksheet****1. Problem:****2. Goal(s):****3. Solutions:****4. Pro's and Cons**

a)	a) Pros (+)	a) Cons (-)
b)	b) Pros (+)	b) Cons (-)
c)	c) Pros (+)	c) Cons (-)
d)	d) Pros (+)	d) Cons (-)

5. Choice of solution:

6. Steps to achieve solution (homework):

a)

b)

c)

d)

Next appointment

SESSION 3: SESSION PLAN

TIME	METHODS
5 mins	<p>1. Introduction to stage 1, 2 and 3 – Input Show visual aid 7, Objectives of session 3. Describe Problem Solving stage 1, 2 and 3 showing visual aid 8, and basing input on background notes of session 3.</p>
20 mins	<p>2. Case Vignette Present visual aid 9, the case vignette of Gertie as an example and follow through in a plenary, inviting the participants to come up with problem definitions and achievable goals.</p>
65 mins	<p>3. 4. and 5: Consolidation – Role play stage 1, 2 and 3, including communications skills Split participants in groups of 3 (or more). Explain that during this role-play all participants will take turns playing patient, health-care professional and observer. Distribute the case vignettes on handouts 2 - 7. Each participant should choose a case vignette he or she feels comfortable with to role-play as a patient. Make sure that participants take turns role-playing patient, health-care professional and observer. Ask the participant role playing the patient to start with a brief explanation of who he/she is by giving the group some background information from the case vignette. Then the participant role-playing the health-care professional starts by asking for the reason for the encounter, enquires about emotional symptoms and problems, and links them together (stage 1). After successfully concluding the first stage of BPS the observer gives feedback on stage one, also emphasising on communication skills used by the participant, taking into account the rules of effective feedback (in the appendix of the manual and summary on handout 1. Then move on to stage 2. The health care professional starts by asking the patient to choose a problem from the problem list on the case vignette and helps the patient to define the problem more clearly, practising steps 1 and 2. After successfully concluding the second stage and after receiving feedback the health care professional can move on to stage 3, setting an achievable goal. After successfully concluding the third stage of BPS and after receiving feedback and discussing alternative options in the small group, the patient becomes the health care professional with a new patient and so on until everyone in the small group has had a turn as health care professional at least once, and time is up. Ideally the patient becomes health-care professional, the observer the patient and the health-care professional observer and so on until everyone in the small group has had a turn in each of the options. Trainers may decide to switch between the options after each stage if necessary to keep maximum involvement of all participants. Depending on the total number of participants, the number of participants per group will vary. Each trainer supervises a maximum of 6 participants (two groups of three participants) and alternates between these groups using his or her own expertise and the background notes. The trainer keeps an eye on the time avoiding that one participant takes up all, and intervenes if necessary, for instance when a participant gets stuck. Give feedback on communications skills as well as on the structure and skill of Problem Solving. Two of the case vignettes are also worked through for stages 1-6 and can be found in the case vignette background materials.</p>

SESSION 3 Aims and Objectives

PROBLEM SOLVING STAGE ONE, TWO AND THREE

AIM:

To introduce participants to the first stage (making the link between symptoms and problems and explaining the rationale of Problem Solving), second stage (defining the problem to be worked on) and third stage (establishing achievable goals for problem resolution) of Brief Problem Solving and consolidate their skills to manage stage 1, 2 and 3.

OBJECTIVES:

By the end of this session participants will be able to:

- Use adequate communications skills during the Problem Solving process
- Elicit symptoms and problems from a patient
- Establish a link between symptoms and problems
- Explain to a patient what Problem Solving is about
- Help the patient clearly defining a problem
- State the problem in a clear and concrete form
- Break down large problems into smaller and more manageable parts
- Help the patient to set an achievable goal

MATERIALS NEEDED

PowerPoint presentation of session 3, this includes:

Visual aid 7:	Objectives of session 3: stages 1, 2 and 3 of Problem Solving
Visual aid 8:	Problem Solving stage 1, 2 and 3
Visual aid 9:	Case vignette Gertie
Handout 1:	Feedback form and summary of the rules of effective feedback (p. 30-31 in participants handbook)
Handouts 2-7:	Case vignettes
Handout 8:	Problem Solving worksheets (p. 42-43 in participants handbook)

SESSION 3**Background notes for the trainer****PROBLEM SOLVING STAGE ONE, TWO AND THREE****1. Stage One: **Making the link between symptoms and problems and explaining the rationale of Problem Solving****

After showing the objectives for this session using visual aid 7, briefly explain stages one, two and three using the following background notes. After this input explain how to practise stage one, two and three of Problem Solving, using the appropriate communications skills:

Recognition of Symptoms

The health care professional starts with clarifying the reason(s) for encounter. He or she will use an open question and listen actively to what the patient says. He or she will 'follow' the patient, and summarise when necessary. He/she will encourage the patient to tell more about the problem and clarify vague or global matters said by the patient. He or she will react with empathy when required by what the patient tells. Then he/she will enquire specifically about the presence or absence of emotional symptoms using more closed questions as well, and if relevant determine the presence or absence of a clear mental disorder (for instance when this is a consultation by a General Practitioner). When the presence of a clear mental disorder has been ruled out Brief Problem Solving might be an option and it is then important to establish what problems the patient currently experiences.

Recognition of Problems

Once the health care professional has recognised symptoms of psychological distress he/she will need to establish the context in which these symptoms have developed. The health care professional will seek to establish the patients' problems by asking questions such as:

"Are there any stressful things going on in your life at the moment?"

"I am wondering if there are any problems or difficulties in your life at the moment?"

More detailed enquiries about specific problems can be obtained by enquiring about potential problems areas such as:

1. Relationships with partner/spouse
2. Relationships with children, parents, siblings and other family members
3. Relationships with friends
4. Work
5. Money
6. Housing
7. Health
8. Legal issues
9. Alcohol and drugs
10. Leisure activities

Once the presence of both emotional symptoms and psychosocial problems has been established, a link should be made between the two. The patient should understand that his/her symptoms are an emotional response to his/her problems. This might require some negotiating skills. The health-care professional can then explain that the patient can tackle his/her problems, and that successful resolution of the problems will lead to resolution of the symptoms, e.g.:

“The reason that you are feel low are and having headaches might be (is) because of the problems you are facing at work. If I can help you sort out those problems, I think your symptoms should improve”.

He/she should make sure the patient is willing to work on the problem.

Once the patient has accepted this link and has agreed to work on the problem, the health care professional can move on to stage 2: Defining the Problem.

Stage Two: Defining the Problem to be Worked on and Explaining the Concept of Achievable Goals

This stage has 2 steps:

Step 1: Stating the problem in a clear and concrete form

The patient should choose in the first instance one particular problem which is important to the patient and which the therapist and patient consider feasible for brief Problem Solving. This may not be the only problem worked on but it provides a start for brief Problem Solving.

Assessment of feasibility is primarily based upon the degree of control the patient can potentially exert over the problem. For example, the problem of having diabetes is not a feasible problem to work on because there is nothing the patient can do to make the disease go away. However, the problem of having difficulty adhering to diet restrictions necessitated by the illness, and which may influence the course of the illness, is more feasible in that the patient can potentially modify their diet behaviour.

The problem should be defined as clearly as possible. The importance of this process for guiding Problem Solving cannot be overemphasised. In the patient's daily life the nature and extent of problems are often ill defined. If consciously defined at all, they are done so in a vague manner, often without clear behavioural referents. For example, the problem definition "My daughter is rude towards me" is vague and provides no indication of what specifically needs to be changed. Whereas the problem definition "My daughter tells me to "shut up" when I ask her to do something" is much more objective and specific, and helps determine what behaviours need to be changed.

Step 2: Breaking down large problems into smaller and more manageable parts

In a related fashion, the patient may broadly define a problem theme, which is representative of several related yet distinct problem areas. This type of problem statement represents not only poor clarity of definition, but also a failure to specify discrete problems. For example, a single parent reported that she had a problem with "family relations". On further inquiry the health care professional established that she actually had several different problems with family relations. First, she was resentful of the father of her children for not helping enough. Second, she felt criticised by her mother about the quality of her housework. Finally, she had to take care of an ungrateful sister with a chronic medical illness. The therapist and patient reviewed these problems carefully and then the patient selected one specific problem to work on initially.

Patients will often describe a complex problem for which the solution is dependent upon multiple smaller problem areas being resolved. The clarity of the problem statement is not an issue, but the complexity of its resolution may be great. For example, a middle aged disabled man stated that he needed money to buy Christmas present. Further exploration revealed that the lack of free cash was related to other problem areas. First, his income was low. Second, he had too many expenses. Third, he was paying off back debt. Finally, he lacked agreement with his spouse on where money should be spent. Each of these problem areas was then established as a target for intervention in itself.

In Problem Solving, all subsequent stages flow from the problem definition. Therefore, emphasis should be placed on stating the problem in a clear and specific manner by gathering all relevant facts (being sure to distinguish facts from mere assumptions), using clear non-ambiguous language, and establishing objective behaviours for the problem. It is imperative that the therapist and patient sufficiently explore the problem to assure that they both understand and agree on the nature and specifics of the problem. In specifying the problem it may help if the patient considers the following five questions:

- 1) What is the problem?
- 2) Why is it a problem?
- 3) When does the problem occur?
- 4) Where does the problem occur?
- 5) Who is involved in the problem?

Sometimes patients will mention symptoms of their depression as problems they wish to address, such as problems with energy, sleep or motivation. Although these symptoms are “problematic” they are not objective life problems and therefore are not the best problems to identify for BPS. Nonetheless, if the patient insists that they wish to address these, or there are no objective life problems that appear to exist, then a symptom may be chosen as the problem area. The problem definition may then be considered with reference to the functional impairment rather than the symptom. For example, low energy may have the function of decreasing the patient’s ability to do housework, and in which case the problem definition becomes “trouble getting housework done”. Likewise lack of motivation may interfere with going out of the house to visit friends, and the problem definition becomes “difficulty getting out of the house to visit friends”. As the patient becomes more effective in resolving these functional problems their depression will begin to lift and the symptoms of low energy and motivation will improve. Difficulty getting to sleep may also be a problem that can be helped by the Problem Solving process.

Once the problem is clear the health care professional can move on to stage 3: establishing achievable goals for problem resolution.

Stage Three: Establishing Achievable Goals for Problem Resolution

Once the problem has been defined and clarified, the next stage is to choose one or more achievable goals. This involves establishing what in particular the patient would like to see changed about the problem. For example, the single parent set a goal of spending more time out of the house with friends, and the disabled man set a goal to decrease outgoing expenditures. An emphasis should be placed on whether the goal can be reasonably achieved. Therefore, it is important to take into account the balance between the patient’s resources and obstacles, as well as to get a sense of the time frame for its achievement.

As with the problem definition, emphasis should be placed on establishing a clear goal. However, the goal should not be stated in such detail that it generates a specific solution and prematurely aborts the solution generation process. This should be left for the next stage during which the brainstorming of potential solutions takes place. Otherwise the result is a poorly developed goal statement and a possible missed step.

For example, a patient whose problem was not going out in the evening wanted to set as a goal visiting the cinema once a week. This is a clear goal but rather limited. A better solution is to set as an achievable goal: going out twice a week, once alone and once in company.

Achievable goals are SMART goals:

Specific

Measurable

Achievable

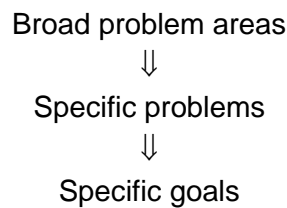
Relevant

Timed

Good questions to ask in determining the patient's goals in relation to their problem are:

- 1) What do you want to do about it?
- 2) What do you want to change?
- 3) What do you want to be different?
- 4) What would make a difference?

These questions enable the patient to move on from considering the problem to clarifying what they wish to do about their difficulties. The patient will be taken through a process of clarification and definition:



If the patient cannot come up with goals for their problem, this is something they can do at home. Patients may find it helpful to discuss possible goals with friends or family. The important message to have provided is of having SMART goals because it is SMART goals that will enable further Problem Solving to occur. Once a clear goal has been set the health care professional can move on to stages 4 and 5, generating possible solutions (brainstorming technique) and the process of choosing a solution.

2. Case Vignette Gertie

Present case vignette Gertie as an example (visual aid 9), and follow through in a plenary, inviting the participants to come up with problem definitions and achievable goals.

3. Consolidation

After the input and case vignette Gertie, the skills to manage the first three stages of Problem Solving will be consolidated in a role play using the case-vignettes on handout 2-7. For this role-play also use the description in the session plan. When observers give feedback make sure they use the rules of effective feedback (key reading text in appendix). Give the participants a copy of handout 1: Summary of the rules of effective feedback. Make sure the participants have sufficient Problem Solving worksheets (handout 8) and feedback forms (handout 1) throughout all role play sessions as these will help them remember the stages of Problem Solving and facilitate their feedback. Explain to participants that these worksheets are also helpful for patients and can be used by them as well during treatment and afterwards as a reminder of the structure of Problem Solving.

During the role play the trainers use their own examples and expertise. Trainers can also decide to use the examples in the manual. The case vignettes on Annie and Adrian have been worked through for this purpose. These examples can be used when redefining a problem clearly and breaking a problem into smaller parts and also when setting achievable goals.

Additional background information case-vignettes Annie and Adrian; stages 2 and 3

Because just like a real patient each health-care professional playing a patient role is free to choose a problem to work on first, all problems and goals are defined on the same case vignette as background information for the trainer.

In reality the patient chooses one problem to work on first, and follows through on the same problem in following visits by setting another achievable goal, which brings the long-term goal nearer in small steps. Or the patient works on this problem his or herself and chooses another problem during follow-up sessions.

Case vignette Annie stage 2 and 3

1. Problem at work: problem redefined and broken into smaller parts difficulty with my work due to:
 - a. high emotional involvement leading to stress
 - b. uncertainty about my functioning (might be symptom)
 - c. dislike of paperwork
 - d. inability to talk to my superior

Annie defined her long-term goal as: to have a job I like and enjoy work again.

In order to achieve this she sets a number of achievable goals:

- a. I want to identify ways to reduce and manage stress
 - b. sort out way of making paperwork less of a burden
 - c. need to discuss feelings towards superior
-
2. Feeling lonely. Broken down, there were 2 components:
 - a. lack of social contacts
 - b. lack of leisure activities

Goal a: increase amount of social contacts

Goal b: increase amount of leisure activities

SMART Goal: combining 1 and 2: plan at least 2 leisure activities a week, once alone and once with other people.

Case vignette Adrian stage 2 and 3

1. Problem deterioration in relationship with wife due to:
 - a. lack of pleasurable activities together
 - b. overspending (by my wife)
 - c. criticisms of wife

Long-term goal: improve relationship with wife.

Adrian set the following achievable goals:

- a. plan at least 1 pleasurable activity together every week (starting this week!)
- b. discuss with my wife overspending/lack of money and make new/alternative agreements about our family expenditures
- c. find a way to express my feelings to her about her criticisms

2. Problem: financial problems due to:

- a. overspending (by my wife)
- b. lack of sufficient income

Long-term goal was to have enough money at the end of each month without worrying all the time.

Adrian set the following achievable goals:

- Goal a: as in 1.b discuss financial situation with wife and make new/alternative agreements about our family expenditures
- Goal b: make a plan to increase income

3. Problem: lack of pleasurable activities in new hometown

Goal: increase number of pleasurable activities

SMART goal: to plan a pleasurable activity at least a once a week etc.

SESSION 3: Visual aid 7

PROBLEM SOLVING STAGE ONE, TWO AND THREE


Objectives:

By the end of this session participants will be able to:

- Use adequate communications skills during the Problem Solving process
- Elicit symptoms and problems from a patient
- Establish a link between symptoms and problems
- Explain to a patient what Problem Solving is about
- Help the patient clearly defining a problem
- State the problem in a clear and concrete form
- Break down large problems into smaller and more manageable parts
- Help the patient to set an achievable goal


SESSION 3: Visual aid 8

 Session 3: Problem solving
 stage one, two and three



1. Rationale

<i>EMOTIONAL SYMPTOMS</i>	<i>PHYSICAL SYMPTOMS</i>
<ul style="list-style-type: none"> • Low mood • Loss of enjoyment • Worries • Poor concentration • Irritability • Hopelessness 	<ul style="list-style-type: none"> • Sleep Disturbance • Appetite Change • Tiredness • Headaches • Aches and Pains



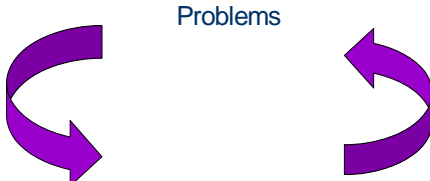
Problem list

- Relationships.....partner/spouse
- Relationships.....children/other relatives
- Relationships.....friends
- Work
- Money
- Housing
- Health
- Alcohol & drugs
- Legal issues
- Leisure activities




Linking Together

Problems




Emotional responses




2. Definition and breakdown of problem

- State the problem in a clear concrete way
- Control
- Feasibility
- From their own list
- Very clear definition
- Design pleasurable activities or
- “Treat a Day!”



Breaking the problem down

- Helps with clearer definition
- Enables sense of control and achievement earlier
- Fact or Assumption?
- What,when,where who and how????
- Impact on their life?



SESSION 3: Visual aid 9**Case vignette Gerti**

Gerti is a 26-year-old shop assistant from Germany who married an air force serviceman (Scott) whilst he was stationed in Germany. She returned with him eighteen months ago. Scott is now a postman and they live in a rented two-room apartment. They have no children and no debts.

Gerti has a three-month history of feeling low, she has lost her sex drive and has put on 20 pounds in weight because of 'comfort eating'. She dislikes her job, but does not have the qualifications to better herself. She dislikes their apartment and longs to own her own home.

She does not particularly miss Germany. Indeed her family have visited twice and this was quite stressful. She and Scott are having worsening rows about her lack of interest in sex, his shift work which keeps him away from home 3 – 4 evenings a week and her general dissatisfaction with life.

Gerti Problem list

- 1.Scott: arguments
no sex
- 2.Work: dislikes
- 3.Flat: wants to own her own home
- 4.Weight gain

SESSION 4: SESSION PLAN

TIME	METHODS
10 mins	<p>1. Introduction to stage 4, 5 and 6 – Input</p> <p>Show visual aid 10, objectives of session 4. Before describing the following stages of Problem Solving briefly summarise the previous stages, and make sure that unresolved matters are clarified. Then explain stage 4, 5 and 6 using visual aid 11 and background notes of session 4, and give an example,.</p>
70 mins	<p>2. Consolidation – Role play stage 4, 5 and 6</p> <p>The participants are split into the same small groups as in the earlier role-plays and keep to their case vignettes. Make sure case the handouts 2-7 of the vignettes and sufficient worksheets are available. The trainers swap groups. Each participant keeps to the same patient he or she has already been role-playing unless he or she feels uncomfortable with this patient. In that case he or she should choose a different case vignette.</p> <p>The first health care professional starts by repeating the achievable goal which was set by the patient in stage 3, explains the brainstorming technique and invites the patient to apply this technique in order to generate ample possible solutions. After successfully concluding the fourth stage the health care professional can move on to stage 5 and invite the patient to evaluate all possible solutions by looking at pro's and con's and choosing a (combination of) preferred solution(s).</p> <p>After successfully concluding the fifth stage, the health care professional moves on to stage 6 and makes a plan with the patient how to implement the preferred solution. This will have to be made into a clear homework assignment and the homework should be completed before the next visit. Then he or she makes a new appointment with the patient to evaluate the results.</p> <p>After successfully concluding these three stages of Problem Solving, and feedback by observer and small group discussions, the patient becomes the health care professional with a new patient and so on until everyone in the small group has had a turn, just as in the practice session of stages 1,2 and 3. And likewise the trainer may decide to switch the various roles after the various stages if necessary.</p> <p>The trainer supervises the small groups using his or her own expertise and the background notes. Two of the case vignettes are also worked through for stages 1-6 and can be found in the case vignette background materials.</p>
10 mins	<p>3. General discussion</p> <p>Clarify any subjects which are unclear at this point</p>

SESSION 4 Aims and Objectives**PROBLEM SOLVING STAGE FOUR, FIVE AND SIX****AIM:**

To introduce participants to the fourth (brainstorming), fifth (evaluating and choosing the solution) and sixth (implementing the preferred solution) stage of Problem Solving and consolidate their skills to manage stage 4, 5 and 6.

OBJECTIVES:

By the end of this session participants will be able to:

- manage the brainstorming technique and how to use it for Problem Solving
- manage the process of evaluating possible solutions and how to make the patient choose a (combination of) preferred solution(s)
- discuss with a patient how the preferred solution can be implemented

MATERIALS NEEDED

PowerPoint presentation of session 4, this includes:

Visual aid 10:	Objectives of session 4: stages 4, 5 and 6 of Problem Solving
Visual aid 11:	Problem Solving stage 4, 5 and 6
Handout 1:	Feedback form and summary of the rules of effective feedback (p. 30-31 in participants handbook)
Handouts 2-7:	Case vignettes
Handout 8:	Problem Solving worksheets (p. 42-43 in participants handbook)

SESSION 4**Background notes for the trainer****PROBLEM SOLVING STAGE FOUR, FIVE AND SIX****1. Introduction**

Before proceeding to the next stages of Problem Solving showing visual aid 10, objectives of session 4, make sure to allow some questions and discussion and summarise stages one, two and three briefly. Any unresolved matters should be clarified before introducing the next stages. After this discussion explain stage four, five and six, basing input on visual aid 11 and following background notes.

Stage Four: Brainstorming

Once an achievable goal has been set, the patient is asked to generate a range of potential solutions. Teaching individuals to creatively think of a range of possible solutions is based on the premise that the availability of a number of alternative actions will increase the chances of eventually identifying particularly effective solutions. In other words, the “first idea” that comes to mind is not always the “best idea”. Therefore, it should be emphasised to the patient that they should try to generate as many solutions as possible via “brainstorming” techniques. Potential solutions should not be discarded or prejudged, even if initially they seem to be silly or unworkable. Teaching patient to think of multiple solutions helps them to become more flexible in their perspective on problem resolution.

There are several important points to impress upon the patient. First, the quantity of solutions generated is important. The greater the number of potential solutions, the greater the chances for successful resolution of the problem. Second, the patient should feel free to combine ideas when practical to do so, and modify them as they develop their ideas. Third, the patient should never judge the ideas until the brainstorming process is completed otherwise they may prematurely abandon a potentially successful and novel solution. Finally, if the patient is having great difficulty developing solutions, they should be encouraged to think how other people might respond to the problem, or to deliberately invent a solution that is blatantly silly (although it should not be emphasised that generating silly ideas is the objective above generating multiple ideas). This depersonalising tactic often helps the inhibited patient to reduce their concern about generating foolish ideas, and therefore promotes more creative thinking and effective brainstorming for the future.

In order to facilitate brainstorming it is helpful for the health care professional to make statements such as “what else can you think of?”, “think freely”, “be playful with your ideas”, “don’t prejudge”, and “throw caution to the wind”. Therapists should steer away from statements such as “can you think of anything else?” and “can you think of any other ideas?” as these invite close ended responses such as “no”, and abruptly halt the brainstorming process. Another helpful tactic developed by Nezu and colleagues (e.g. Nezu, Nezu & Perri, 1989) is known as the “Brick Technique”. The patient is asked to think of as many uses for a brick as possible. Patients typically begin with stereotypical uses such as for building or

making a well. The health care professional then asks whether they could use it if locked out of the house, if they had a window that would not stay open, or what if they were attacked in an alley, etc. This exercise helps the patient to think “outside of the box” and they quickly catch on that they should not limit themselves to conventional rules of thinking.

Stage Five: Evaluating and Choosing the Solution

Once a range of possible solutions has been identified the health care professional teaches the patient to strategically evaluate the alternative solutions by implementing decision-making guidelines. Specifically, the patient is asked to consider the “pros” and “cons” for each potential solution.

Effective solutions are those that not only solve the problem, but also minimise negative outcomes for the self and others. As with facilitating brainstorming it is helpful to frame comments in an open-ended fashion, such as “what are the disadvantages of...?”, which implies that there are necessarily some of each dimension.

The patient should be encouraged to consider whether each potential solution will:

- 1) Make a significant impact on the problem;
- 2) Have advantages or disadvantages in relation to the patient’s time, effort, money or emotional distress;
- 3) Have positive or negative effects on the patient’s friends and family;
- 4) Have the likelihood that they can carry it out in a satisfactory fashion.

In starting the decision analysis process the health care professional may ask the patient a general query regarding any major, salient, or outstanding pros or cons associated with any one of the specific solutions. If present, this solution can then serve as a benchmark and point of comparison for the other solutions. The health care professional should then ask the patient to compare the solutions to each other, especially those sharing common themes (e.g. ways to bring in money, communicate with another person, obtain needed information). Only by understanding the relative benefits and obstacles in reference to other potential solutions can the patient be in a truly informed position for choosing the best solution(s).

As with all the Problem Solving it is ideal for the *patient* to evaluate his or her own solutions. However, there are two occasions in which it is acceptable for the health care professional to introduce information. The first is when the patient is overlooking a negative consequence, either for themselves or others, which is extreme. This would certainly include a consequence of physical or emotional harm, and may include episodes of interpersonal conflict, such as with a spouse or co-worker. The second instance is when the patient mentioned an advantage or disadvantage earlier during the session, such as during the brainstorming phase, but appears to have forgotten this in the current stage. In this case the patient is certainly aware of the issue and is only being reminded to include it in the decision analysis process.

Once the pros and cons have been considered for each potential solution, the patient selects a preferred solution or solutions. Ideally, the solution selected should achieve the stated goals while carrying the least personal and interpersonal disadvantages connected with it. Some patients find this stage of Problem Solving initially difficult to achieve alone, ruminating about possible solutions without being able to choose one, or overlooking important decision making guidelines established in the previous stage.

The health care professional should use his or her own common sense about whether the chosen solution will have a significant impact on the goal. On the one hand the health care professional does not want to overwhelm the patient with tasks they do not feel prepared to handle, but on the other hand they do not want to trivialise or even potentially insult the patient's sense of competency by allowing a solution, which is barely relevant or blatantly unsatisfactory for making progress on the problem.

Similarly, the health care professional should not emphasise the choice of a solution solely based upon whether it is the most "do-able". Although the feasibility of the solution is a definite factor, the most importance criteria for choosing the solution is whether it has a high likelihood of satisfying the goal. Therefore, the easiest solution to implement is not always the preferred solution and should not be necessarily chosen in isolation from other solutions. More than one solution may be chosen.

Stage Six: Implementing the Preferred Solution(s)

Once chosen, the steps required to achieve the solution are identified and planned. Detailed actions and specific dates, times, etc. should be determined. This step helps to assure that "good intentions" are translated into definite action. The health care professional should ask, "what is needed to be done or obtained?"; "where is it to be done?"; "whom does it involve?"; and "how will it be done?"

For example, the single parent chose to ask a friend out for dinner. The following steps for implementation were outlined:

- 1) Call a friend (call as many as necessary to secure a date for the next week); start tonight.
- 2) Make reservations at a restaurant (call as many as necessary to go without reservations); start tonight.
- 3) Call babysitter; if not available, get babysitter list from friends.
- 4) Make appointment to have hair styled; call first thing tomorrow.

The patient must identify and choose tasks that they feel comfortable implementing but the therapist should assure that the tasks are sufficient to satisfy the requirements of the solution as well. Sometimes this means that the solution may need to be broken down into more simple sub-steps. In its extreme form this may mean going back to the original problem definition and beginning the process again. (Note: this again points out the necessity of establishing a clear problem definition and manageable goals at the start of the session). A

new solution may be chosen if the original solution requires an action that patient feels unable to carry out.

If the patient lacks confidence but wishes to proceed with a particular plan of action, then steps may become detailed as to specify exactly what the patient is to say, where to sit, and otherwise how to behave. Thus, the patient and the health care professional may rehearse an interview in an unemployment office, a discussion with a spouse, a telephone call about a bill complaint, etc. By the end of this stage, the patient should have a clear set of tasks that are assigned for completion between treatment sessions. These tasks can be referred to as “homework” should probably be written down and given to the patient.

2. Consolidation

After the input practice the stages 4, 5 and 6 using the case vignettes on handouts 2–7. Make sure the participants have sufficient feedback forms (handout 1) and Problem Solving worksheets (handout 8) throughout all role play sessions as these will help them remember the stages of Problem Solving. They should also use the patient leaflet as this leaflet helps patients with the structure of Problem Solving, and explains for example how brainstorming should be done at home. Explain to participants that worksheets are also helpful for patients and can be used during ‘treatment’ as well as afterwards as a reminder of the structure of Problem Solving.

During the role play the trainers use their own examples and expertise. For trainers who prefer using an example case vignette about Annie and Adrian have been worked through for this purpose. The examples below can be used for stage 4, 5 and 6.

Additional background information for case vignette Annie stage 4, 5 and 6

Problem 1: Problem at work

Annie’s goals were:

- a. I want to identify ways to reduce and manage stress
- b. Sort out way of making paperwork less of a burden
- c. Discuss feelings towards superior

Brainstorming goal a:

1. Talk stress over with superior
2. Find out if there are courses which might help increase my skills
3. Discuss alternative ways of doing this work with a colleague
4. Talk with job-supervisor
5. Start looking for another job

Pro’s

1. She might have a good suggestion
2. I might even enjoy a course

Con’s

Difficult, I have difficulty communicating with her
She might make a fool of me
Lack of time, difficult to find

- | | | |
|----|--|---|
| 3. | Might come up with new ideas | I only have one colleague and her work is quite different |
| 4. | She is on my side | ---- |
| 5. | Solves a lot of stress if I can find it
feel like giving in too quick | Might be difficult finding, might |

Annie's choice of solution(s) was a combination of 4 and 5.

Plan:

Make an appointment with job supervisor tomorrow for some time this or next week. If she is not available tomorrow, find out when she will be and make sure to make the appointment this week!

Start looking on the internet and in my newspaper today for some ideas about what I might like to do. Call job centre tomorrow. Make a list of available jobs. Etc. etc.

She gave goal a priority and did not follow through with b, and c because she did not feel this was relevant any more as she found another job.

Outcome:

She arranged a meeting with the job supervisor and discussed the problem. Together they made a plan to look at the availability of jobs in the hospital where she already worked and for which she was qualified. It turned out that there were a few options. She applied for them and after three months started in another job (where she still enjoys working a year later).

Problem 2: Feeling lonely

SMART goal: plan at least 2 leisure activities a week, once alone and once with other people.

Brainstorm:

1. go shopping
2. see a movie
3. for a swim
4. visit a friend
5. play music
6. rent a nice video

Pro's

- like shopping
- like going to movies
- relaxing
- pleases me
- like it
- like movies

Con's

- might spend too much
- friend might not
- costs time
- I might intrude
-
- might feel lonely

Choice of solution(s):

Rent a video and listen to music at home at least once or twice a week and going for a swim or shopping with a friend at least once a week.

Plan:

Call my friend tonight and ask her if she wants to join me shopping, set a date, make sure to tell her my financial limits, suggest that we go for lunch together as well. If she is not home tonight then call again tomorrow until date is set. If she wants to but cannot come this week then set date for next week and call another friend to see if she might want to go this week. Make the plan sound good! Find out opening hours of local swimming pool as well before I call friends. Go to the video-shop on Wednesday and choose a nice video, make sure I create a cosy atmosphere, pull out phone.

Outcome:

First friend was surprised but pleased by initiative and they went shopping together and more or less arranged to do this and other things on a regular basis at least once a fortnight. Another friend with whom she tried doing the same was more difficult and she did not succeed there. She remembered that her sister-in-law (brother's wife) loves swimming and had had plans to go for some time. She called her, they went for a swim and do so almost every week and both love it.

Listening to music does not work, she starts 'thinking' too much, it does not relax enough but watching a video does. They are more distracting and she made a list of video's she might want to see in coming weeks. She also planned other creative activities in the months following and is doing much better!

Additional background information for case vignette 3, Adrian stage 4, 5 and 61. Problems with wife**Goals:**

- a. plan at least 1 pleasurable activity per week together
- b. discuss financial situation with my wife and make new/alternative agreements about our family expenditures
- c. find a way to express my feelings to her about her criticisms

Brainstorming goal a:

1. go to gym together
2. see a movie together
3. go out for a meal
4. play games with children together
5. go cycling together + kids

Pro's

1. each on own level, but still together
2. both like movies, out of house together
3. both enjoy nice meals
4. nice, kids will be thrilled because it is unusual
5. nice and active, kids will love it

Con's

- might be too individual, too out of breath to talk
- cannot talk, perhaps too individual
- too expensive
-
- difficult to plan

Choice of solution(s):

1 and 4

Plan:

Talk gym plan (1) over with wife in weekend and set a date; phone gym about opening hours and costs; make an appointment; (4) Talk with wife tonight or tomorrow, agree on a time when children are back home from school, plan what we will do together; arrange follow-up immediately if it is nice.

Outcome:

Talked with wife, they made an achievable plan for the same week, they did a number of games with children and it was fun! Planned with children to do this on regular basis. Talked with wife about gym plan. She agreed, have not been yet.

Adrian worked on this problem for some time and it was certainly a first step in improving their relationship.

2. Financial problems due to:

- a. overspending (by my wife)
- b. lack of sufficient income

Goals:

Goal a: as in 1.b discuss financial situation with my wife and make new/alternative agreements about our family expenditures

Goal b: make a plan to increase income

Brainstorming goal a:

1. make a list of incoming money
2. make a list of my and her expenditures
3. discuss list with wife

4. ask expert (social worker?) advise
5. make sure I set aside an amount of money early in month out of her reach
6. buy necessities before she can get hold of the money

Pro's

1. easy, clear
2. clear
3. necessary, might help
4. makes it easier for me
5. leaves money at the end
6. at least priorities are taken care of

Con's

-
- she will not believe it
difficult, she might not want to
she will not want to involve someone else
wife will be very angry
will only work once, she will be very mad

Choice of solution(s):

1,2 and 3 first, possibly 4

Plan:

Start making list of income and expenditures when she is out tomorrow, go on working on it this week and make sure I finish Friday. If I can't manage Monday at the latest. Use bank copies and be very concrete. Tell my wife, when I have completed my list, that I want to discuss our financial situation as soon as possible and set a date and time with her, make sure that she does not put it off. Then show her the lists ask her for suggestions how we can cut down on expenditures. Discuss my own suggestions. If it does not work, suggest asking advice.

Outcome:

Unknown

Brainstorming goal b

1. look for a different job
2. find an additional job
3. ask wife to start working

Pro's

1. might enjoy a change
2. -----
3. would really help, she might enjoy it
she could spend less

Con's

- difficult to find
no time
she might not want to

Choice of solution(s):

1 and 3

Plan:

Start looking for ad's in newspaper and internet tomorrow, make a list and start phoning a few every-day. While I am working on this also talk with my wife, in the weekend after the kids are in bed. Tell her about my actions and ask her how she thinks about starting to work as well now the kids are at school. Think through how to raise the subject in a positive way, pointing at the advantages for all of us having a bit more of a margin each month and what we could do with it.

Outcome:

Made a list, not very much jobs available.

Told wife he wanted to talk their financial situation over in the weekend and she agreed reluctantly. Reacted positive to his own initiative in finding an additional job. She was surprised with his suggestion that she started working as well and raised some problems about what to do with the children then. They decided that both were going to look at possible solutions for this problem as well and make a plan. Then they would discuss both plans as next step. She would also start looking if there was any work available in her line of business, they would discuss this before deciding if it was a good idea. Adrian decided he knew now what steps to make and it was no longer necessary to do this with a therapist.

Problem 3: Lack of pleasurable activities in new home-town

Goal: increase number of pleasurable activities

SMART goal: plan a pleasurable activity at least a once a week etc.

Brainstorming

1. go to village hall for information
2. enquire at local and neighbour city community centre
3. look for leisure activities in phone book
4. ask new neighbours for suggestions
5. surf the internet

Pro's

1. easy
2. easy and around the corner
might meet some one as well
3. easy
4. might have nice suggestions
perhaps nice doing things together?
5. easy, might give bunch of new ideas

Con's

- don't expect much
probably no activities I like

not sure he is my type
probably not locally

Choice of solution(s):

2, 4 and 5

Plan:

Go to community centre tomorrow. Friday, when I know my neighbour is at home early, pop in with one of the kids and ask for advice and suggestions. Surf the internet today and if I don't manage tomorrow and look for nice things like a theatre group etc. Call immediately or the day after if I find any phone numbers. Etc.

Outcome:

Idea 4 went well. Neighbour had lots of suggestions. One was jogging together and they agreed they would both like that and arranged a time. Was fun, he is a nice guy, they do this regularly now. Community centre did not have much. Still working on other options, but is quite happy with this first step and decided it was enough for him. He knew now to make smaller steps with short-term goals and that works fine for him.

SESSION 4: Visual Aid 10

PROBLEM SOLVING STAGE FOUR, FIVE AND SIX


Objectives:

By the end of this session participants will be able to:


- Manage the brainstorming technique and how to use it for Problem Solving
- Manage the process of evaluating possible solutions and how to make the patient choose a (combination of) preferred solution(s)
- Discuss with a patient how the preferred solution can be implemented

SESSION 4: Visual Aid 11



Session 4: Problem solving
stage four, five and six



4. Generating solutions




- “Brainstorming”
- The more the merrier
- Mix & combine
- Avoid judgement
- PRAISE ++++
- “BRICK”


5. Choosing a solution

<ul style="list-style-type: none"> • “Pros and Cons” • Effect on family, friends and colleagues • Actual impact on problem • Ability to carry it out 	<ul style="list-style-type: none"> • Avoid therapist choice unless negative impact • More than one is ok • Do the full process
--	---



6. Implementing preferred solution

- Detailed, planned steps
- Minimise chance of inaction
 - Rehearse interview/confrontation
 - Go back if necessary
 - Take time
 - Be specific about time, frequency, difficulties
 - Write it down



SESSION 5: SESSION PLAN

TIME	METHODS
25 mins	<p>1. Summary of where we have got so far and goals of BPS - input Show visual aid 12, objectives of session 5. Briefly repeat the goals of BPS, pointing to the summary on handout 9 in the manual and using the first slides of visual aid 13. Discuss where we have got so far by very briefly summarising the stages of Problem Solving, and point out that the skills which have been practised up to now, will have to be managed in the context of everyday practice. This will be discussed in this session, and practised in session 6.</p>
5 mins	<p>2. Introduction to stage 7 – Input Describe stage 7, basing input on visual aid 13 and background notes of session 7, and give an example.</p>
20 mins	<p>3. How to manage BPS in every-day practice – brainstorm Ask the participants to brainstorm in pairs or groups of three about how they think they could use the Problem Solving technique within a 10 – 15 minute appointment system. Present visual aid 14, the vignette of Philippa and invite the participants to work out in their small group the number of appointments and outline of what to achieve (stages of PS) in each appointment.</p>
20 mins	<p>4. How to manage BPS in every-day practice – discussion When the groups are ready list and discuss the various ideas that have come out of the brainstorm session, and present the views expressed on this issue in the manual, basing input on background notes of session 5. Show visual aid 15 as an example of how it could be done and also point participants to handout 10 in the manual, how to manage BPS over 3 to 4 visits.</p>
5 mins	<p>5. Patient paperwork Discuss the paperwork briefly, point to the worksheets again (handout 8) and to the patient leaflet on BPS and Activity scheduling on handout 11. Explain how and when to use this paperwork using the background notes of session 5 as reference.</p>
15 mins	<p>6. Instruction to prepare a personal case-vignette. Ask participants to prepare a short case vignette, using a patient from their own experience, and handout 12, an empty vignette. Ask them to keep it simple, a patient with a few symptoms and 1 or 2 problems is enough for the afternoon session. They should be able to role play this patient over session 2 and 3 of BPS. This means they have to come up with one SMART goal, a (combination of) possible solution(s) and a plan as well. It should not take them more than 10 minutes to prepare.</p>

SESSION 5 Aims and objectives

WHERE HAVE WE GOT SO FAR, GOALS OF BPS, PROBLEM SOLVING STAGE SEVEN AND HOW TO MANAGE BPS IN EVERYDAY PRACTICE

AIM:

To summarise where we have got so far, to come back to the goals of BPS, to introduce participants to the seventh stage of Problem Solving and consolidate their skills to manage stage 7. To explain how the 7 stages of Problem Solving can be managed within a ten to fifteen-minute appointment system.

OBJECTIVES:

By the end of this session participants will be able to:

- Describe the goals of BPS
- To manage the process of evaluating the plan, stage 7
- Make a decision about the necessity of addressing a new problem together with a patient
- Describe how they can manage BPS in an every-day practice setting

MATERIALS NEEDED

PowerPoint presentation of session 5, this includes:

- | | |
|----------------|--|
| Visual aid 12: | Objectives of session 5 |
| Visual aid 13: | PowerPoint presentation 'Goals of BPS, stage 7, managing BPS in everyday practice |
| Visual aid 14: | Case vignette Philippa |
| Visual aid 15: | PowerPoint of the summary of the 4 visits (how to manage BPS in everyday practice) |
| Handouts 2-7: | Case vignettes |
| Handout 8: | Problem Solving worksheet (p. 42-43 in participants handbook) |
| Handout 9: | Summary of the goals of Brief Problem Solving (p. 60 in participants handbook) |
| Handout 10: | How to manage BPS over 3 or 4 visits (p. 61-62 in participants handbook) |
| Handout 11: | Patient leaflet (p. 63-64 in participants handbook) |
| Handout 12: | Personal case vignette (p. 65-66 in participants handbook) |

SESSION 5**Background notes for the trainer****GOALS OF BPS, STAGE SEVEN, MANAGING BPS IN EVERY-DAY PRACTICE****1. Summary of where we have got so far and goals of BPS**

Show visual aid 12, objectives of session 5 and then briefly repeat the goals of BPS, using visual aid 13 and pointing to the summary on handout 9 in the manual. Explain that the skills which have been practised up to now, will have to be put into the context of everyday practice. This will be discussed later during this session. But then proceed with an explanation of stage 7 using the next slides of visual aid 13 and the following background notes

2. Introduction of stage seven of Problem Solving: evaluation and next steps

During stage seven the patient should have completed or attempted to complete the tasks set in the previous session. The health care professional should ask the patient about their success with the homework, and praise any progress. The health care professional can then discuss problems and difficulties, bearing in mind that patients may selectively attend to failures. Therefore, it is important to praise all successes however small, without lapsing into a patronising attitude. For successes, statements such as “well done”, “I knew you could do it”, etc. will suffice.

This should be followed by asking about the impact of the success on the patient's symptoms. This reinforces the explanation of the Problem Solving process and its rationale.

In discussing failures, the therapist should always communicate that they see the patient's potential for effective coping, and this facilitate a positive Problem Solving orientation. If difficulties have arisen, the reasons should be examined:

- Should the goals be defined more clearly?
- Are the goals realistic?
- Have new obstacles arisen?
- Are the implementation steps difficult to achieve? If so, why?
- Is the patient truly committed to working on the problem?

The answers to these questions will guide the consultation. If the problem is simply too difficult to tackle (usually due to the patient not having sufficient control over the source of the problem), then it is reasonable to go onto another problem or to modify the goal to focus on aspects of the problem over which the patient has more control. It is important to keep in mind, however, that the goal of BPS is not to solve all of the patient's problems in living, but to use the problems as a vehicle for teaching more effective Problem Solving skills in general. Toward that end, the important point is that using the BPS approach will enable the patient to gain a sense of control over their life and thereby alter their perception of all their problems, whether resolved during the sessions or not.

If the patient has not completed the homework tasks they may not have understood the central role of homework for BPS. It should be emphasised that progress occurring between treatment sessions is more important than progress achieved within a session. Acting on problems is the chief mechanism by which BPS exerts control over mood state. The health care professional should stress that the goals and solutions are chosen by the patient, not by the health care professional, and lead the patient in a discussion of their feasibility. If the patient has successfully completed the homework tasks then, if necessary, a new problem may be chosen and discussed following the same process.

How many full cycles of BPS the health care professional needs to work through together with the patient will depend on the number of problems the patient has and the understanding and ability to take over control and move on with Problem Solving independently.

Next Steps

The problem might be solved after the first cycle. If not the patient may wish to keep working on the same problem, choosing new goals and generating new solutions.

Alternatively the patient may wish to use the technique to help with a separate and unrelated problem. The health-care professional and patient may wish to reinforce and discuss BPS in further sessions or may agree that the principles have been appropriately grasped and the patient does not need further guidance.

In the full treatment protocol of Problem Solving Treatment a maximum of 6 sessions is set, going through all 7 stages 6 times. If the patient has not acquired Problem Solving skills by then, a different method or treatment is needed for that patient. In using BPS, this limit should be kept in mind to prevent a 'treatment' without end and without effectiveness. Patients with only one or a few symptoms might acquire Problem Solving skills more quickly.

After having gone through all 7 stages of Problem Solving and discussing the goals of BPS and relation between Problem Solving Treatment and BPS, start the discussion on how to manage these 7 stages in a 10 to 15 minute appointment system. If this method is to be used successfully by primary care professionals, physicians/general practitioners (GP's) (and others working within a same kind of appointment system), the success will depend on the feasibility of BPS in every-day practice.

3. Brainstorm 'How to manage BPS in every-day practice'

First ask participants for their own ideas about how this can be achieved by spreading the seven stages out over 3 to 4 consultations. With this aim present visual aid 14, the case-vignette of Philippa and invite the participants to brainstorm in pairs or groups of three. Ask them to work out the number of appointments they think they need for this and to outline what stages of BPS they believe they could achieve in each appointment.

4. Discussion 'How to manage BPS in every-day practice'

When the groups are ready list and discuss the various ideas that have come out of the brainstorm session. In essence, there are many possible solutions. They are correct as long as the professional follows the stages of Problem Solving as well as the patients pace in a way that is feasible in his or her own practice..

Then, as an example, discuss the plan outlined in the manual showing visual aid 15, and using the structure explained in the following section of the background notes. Also point to handout 9 and 10 in the manual.

Visit 1 - Stages 1 and 2

During the first consultation the health care professional will take a history asking for the patients reason for encounter. When emotional symptoms are brought up, he or she should specifically ask if the patient is experiencing problems in everyday life.

After having established the existence of emotional symptoms as well as current problem(s), a link should be made between the symptoms and the problem(s) as explained in the manual. This means that it should become clear that problems are an expected part of everyday living, and that effective resolution of such problems will help to improve how the patient is feeling. When the patient has accepted this explanation and is willing to work on these problems a follow-up appointment should be made, taking home a homework assignment. This includes, when relevant, making a list of current problems and choosing one to work on first. To facilitate this homework the list with potential problem areas can be used on the bottom of the patient leaflet.

Another homework task will be to try to define the problems more in detail, using the following five questions:

- 1) What is the problem?
- 2) Why is it a problem?
- 3) When does the problem occur?
- 4) Where does the problem occur?
- 5) Who is involved in the problem?

Visit 2 - Approximately one week later – Stages 2 and 3

During this session the health care professional can manage stage 2 and 3 and explain the stages 4,5 and 6 which stages might be used as homework assignment.

The health care professional will look through the problem list briefly and if necessary ask for clarification. Then he or she will ask which problem the patient has chosen to work on first, and looks at the problem definitions made by the patient. The health care professional will have to assist the patient in making sure this problem is clearly defined and that it is a problem under the patient's control. If the chosen problem is large or complicated it will be necessary to break the problem down into smaller and more manageable parts.

When the problem is clearly defined an achievable goal should be set. It is important to make a difference between long-term and short-term goals, because it is important that the

patient experiences success early in the process. Therefore when the goal the patient mentions is long term goal, a SMART goal should be formulated as well. This means the goal should be specific, measurable, achievable, relevant and timely (details in the manual).

After setting an achievable goal the health care professional explains the brainstorming technique. Brainstorming can be done at home and the patient must feel free to discuss possible solutions with others. The whole idea is that the availability of a number of alternative actions will increase the chances of eventually identifying particularly effective solutions, and the more possible solutions are generated, the greater the chances for successful resolution of the problem. Explain to the patient not to discard any possible solutions at this stage and come up with as many solutions as possible before considering pro's and con's. Explain the process of evaluating the possible solutions as well, and ask the patient to make a plan for implementation, clearly planning and defining all necessary steps. Hand over the patient leaflet and encourage the patient to read it at home before starting with brainstorming. Ask the patient to come back with this plan to the next appointment.

Visit 3 – One/ two weeks later – Stages 4 - 7

Sometimes patients will come back having put this plan into action already. If this has been done evaluate the result (explanation how, see visit 4). If the patient has a plan, evaluate this plan together. If the choice of possible solution(s) has any flaws, the health care professional might have to go back to stages 4 and 5, looking at the list of possible solutions using a lot of positive reinforcement and evaluating the pro's and con's of the possible solution(s) together. A new choice of preferred solution(s) will be made, balancing pro's and cons and taking into account the relevance in achieving the SMART goals.

When this has been achieved the detailed plan to implement the preferred solution will be evaluated making sure the steps needed are specified, as well as the dates and times when these steps should be made. The patient will go home with this plan as homework.

Visit 4 - Approximately 2 weeks later

If this has not been achieved during the previous session stage 7 will be completed here and the first full cycle of brief Problem Solving is completed.

The results of the plan will be evaluated following the process described in the manual. If the patient has not succeeded make sure it becomes clear where the patient has got stuck and what stage(s) went wrong. It is important to establish if the SMART goal was achieved and to discuss the impact on the symptoms with a lot of positive re-enforcement. If relevant, a new problem will be chosen to work on, going through the same stages and steps during follow-up consultations

5. The Patient paperwork

Discuss the patient paperwork briefly. Point to the worksheets again (handout 8) and explain that these sheets are helpful for a patient to remember the stages of Problem Solving at home when Problem Solving by one-self. When filled out by patient and professional during visits they will help to remember specific the data of each visit.

Also discuss the patient leaflet on BPS and Activity scheduling on handout 11. This leaflet is handed out to patients when BPS is started. The patient can read about the seven stages of Problem Solving at home and the handout can act as a reminder of the structure and the rationale of Problem Solving.

6. Instruction to prepare a personal case-vignette.

Ask participants to prepare a short case vignette, using a patient from their own experience, on handout 12, an empty vignette. Ask them to keep it simple, a patient with a few symptoms and 1 or 2 problems is enough for the afternoon session. They should be able to role play this patient over session 2 and 3 of BPS. This means they have to come up with one SMART goal, a (combination of) possible solution(s) and a plan as well. It should not take them more than 10 minutes to prepare.

SESSION 5: Visual Aid 12

GOALS OF BPS, STAGE SEVEN, MANAGING BPS IN EVERY-DAY PRACTICE

Objectives:

By the end of this session participants will be able to:

- Describe the goals of BPS
- To manage the process of evaluating the plan, stage 7
- Make a decision about the necessity of addressing a new problem together with a patient
- Describe how they can manage BPS in an every-day practice setting

SESSION 5: Visual aid 13

Session 5: Goals of BPS, Stage 7, Managing BPS in everyday practice



The Goals of BPS (1)

1. To increase the patient's understanding of the link between their symptoms and their everyday problems.
 - Problems are an expected part of everyday living
 - The effective resolution of problems will improve how the patient is feeling
2. To enable the patient to clearly define his or her current problem(s) and determine which problem the patient wishes to work on



The Goals of BPS (2)

3. To provide the patient with a structured problem-solving procedure, and introduce and practice specific problem-solving skills.
4. To produce more positive experiences regarding patient's ability to solve problems, thereby increasing confidence and feelings of self-control and mastery.



Stage 7. Evaluating the outcome (follow-up sessions)

- Review Homework
- Recognise any steps and PRAISE
- Link task completion to symptom reduction
- Review difficulties



Potential difficulties

- Was the goal clearly defined?
- Was the goal realistic?
- Have new obstacles arisen?
- Are the implementation steps too hard?
 - What else could they do?
- Are they committed to working on the problem?



Moving on

- Return to problem list
- Follow the same process
- Stay positive
- Consider activity scheduling



SESSION 5: Visual aid 14**Case Vignette Philippa**

Philippa is a 54 year-old married woman. John, her husband, lost his job as manager of a supermarket a few years ago. They decided together that she would be happy to go back to work, and she has worked in 'IT' to earn their family income since. They have 2 'nearly' grown-up children living at home.

Philippa has been feeling a bit low lately and too tired to go to her bridge-club evenings and going out with friends, which she both enjoyed before. She describes her social life as currently non-existent.

Her main problem is her job. After a merge of 2 firms she was made redundant a year ago. She found a new job quickly, but now finds the work boring and without any challenge. Her colleagues are all much younger and she feels uncomfortable with them.

At home she snaps at John, who does his best to run the house-hold smoothly but not as efficient as she used to do, and at the children and feels guilty about it afterwards. She also has some difficulty falling asleep.

Philippa Problem list

1. Work: boring, doesn't get on with colleagues
2. Social life: currently non-existent
3. John: criticizes his house-keeping and feels guilty
4. Children: snaps at them

SESSION 5: Visual Aid 15

SUMMARY OF THE FOUR VISITS



Visit 1

Visit 1, stage 1:

- Listing of emotional symptoms
- Start listing of current problem(s)
- Establish a link between symptoms and problems

Homework assignment

- Making a list of current problems
- Choose one to work on first and try to define it clearly



Visit 2

Visit 2, one week later, stages 2, 3, explain 4, 5, 6

- Clear problem definition
- Set an achievable goal (SMART-goal)
- Explain the brainstorming technique

Homework assignment

- List possible solutions, using brainstorming technique
- Evaluate pro's and con's
- Make a choice of preferred solution(s)
- Come back with a plan



Visit 3

Visit 3 stage 6, 2 weeks later:

- Discuss plan (or outcome of plan) in detail
- Discuss any possible obstacles in stage 4 and 5



Visit 4

Visit 4, 2 weeks later, stage 7:

- Evaluate the results of the plan



SESSION 5: Handout 9**SUMMARY OF THE GOALS OF BRIEF PROBLEM SOLVING**

- a. To increase the patient's understanding of the link between his or her current symptoms and current everyday problems.
Understanding that problems are an expected part of everyday living.
Effective resolution of such problems will help to improve how the patient is feeling.
First visit and homework: make a list of problems and try to define a problem to work on first.
- b. To enable the patient to clearly define his or her current problem(s).
Determine which problem/problems the patient wishes to work. **Homework and Second visit.**
- c. To provide the patient with a specific Problem Solving procedure in an attempt to solve their problems in a structured way. Introduction and practising of specific Problem Solving skills. **Homework assignments, second, third and if necessary fourth visit.**
- d. To produce more positive experiences regarding patient's ability to solve problems, thereby increasing confidence in Problem Solving ability and feelings of self-control and mastery. **Third and subsequent visits.**

SESSSION 5: Handout 10

How to manage BPS over 3 or 4 visits

Visit 1

Stage 1

- Clarifying reason for encounter and listing of emotional symptoms
- Listing of current problems in everyday life.
- Establish a link between the current symptoms and these current everyday problem(s). Explain that problems are an expected part of everyday living and that with effective resolution of problems, symptoms will decrease.

Make a follow-up appointment for approximately 1 week later, taking home a *homework assignment*:

- If relevant, making a list of current problems
- Choose one to work on first
- Try to define the problems more in detail, using the following five questions:
 - 1) What is the problem?
 - 2) Why is it a problem?
 - 3) When does the problem occur?
 - 4) Where does the problem occur?
 - 5) Who is involved in the problem?

Visit 2 - Approximately one week later

Stage 2 (steps one and two), 3, start Stage 4

- If relevant, go through problem list briefly together and ask for clarification if needed.
- Make a clear problem definition of the problem to work on first
- Make sure it is under the patient's control
- If necessary break the problem down into smaller and more manageable parts
- Then set an achievable goal (SMART-goal)
- Explain the brainstorming technique
- Give next homework assignment to complete before the next visit:

Homework assignment:

- List as many possible solutions using the brainstorming technique, **Stage 4**
- Evaluate pro's and con's and make a choice of possible solution(s), **Stage 5**
- Come back with a plan, **Stage 6**

Visit 3 - One/ two weeks later

- Discuss plan (or results of plan) together taking into account the relevance in achieving the SMART goals
- Make sure steps are specified and the dates and times when these steps should be made
- Discuss obstacles if encountered (go through stages 4,5 and 6 together)
- Play the devil's advocate and or practice if necessary

Make follow-up appointment (in about 2 weeks)

Visit 4 - About 2 weeks later and subsequent visits

Stage 7

- Evaluate the results of the plan
- Discuss
- Establish if SMART goal was achieved
- Discuss impact on symptoms with a lot of positive re-enforcement.
- In failure to achieve goals discuss reasons why and if necessary set a new goal
- If relevant, choose a new problem to work on, going through the same stages and steps during follow-up consultations

SESSION 5: Handout 11
Patient Leaflet: 'How to Use Problem Solving Skills'

Emotional symptoms are very common. They are often caused by problems of living. Problem Solving is a systematic, common sense way of sorting out problems and difficulties. If you learn how to problem-solve, you can lessen your emotional symptoms. The health care professional will explain the details of Problem Solving and provides encouragement and support, but the ideas and plans come from you. Problem Solving will be useful not only now, but in the future if problems arise.

There are 7 important stages:

1. Write down a clear description of the real problem
 - What is the problem about?
 - When does the problem occur?
 - Where does the problem occur?

Try to break up complicated problems into several smaller problems and consider each separately.

2. Decide on your goals.

Choose achievable and definite goals. These goals should be **Specific, Measurable, Achievable, Relevant and Timed (SMART)**.

3. List as many solutions as you can. Use brainstorming tactics considering that the "first idea" that comes to mind is not always the "best idea".

Advice's for brainstorming

- Do not discarded or prejudge, even if initially some solutions seem to be silly or unworkable. The quantity of solutions generated is important, the greater the number of potential solutions, the greater the chances for successful resolution of the problem.
 - Feel free to combine ideas when practical to do so, and modify them as you develop your ideas.
 - Never judge the ideas until the brainstorming process is completed otherwise they may prematurely abandon a potentially successful and novel solution.
 - Finally, if you have difficulty developing solutions, think or ask others how they might respond to the problem, or deliberately invent a solution that is blatantly silly to help you reduce any concern about generating foolish ideas.
4. Consider the advantages and disadvantages (pros and cons) for each potential solution.
 5. Choose the solution(s) that best solves the problem but minimises negative outcomes.
 6. Set out clear steps to achieve the solution and indicate exactly what you are going to do and when you will do it. This is your plan!
 7. Review your progress and continue your Problem Solving efforts.

Problem Solving may not solve all your difficulties, but it can help you to start dealing with your problems. As your symptoms improve you will feel more in control of your problems and your life.

.....

Before writing down a clear description of the real problem (1) it might be helpful to make a list of your current problems using the following problem areas for this list. This will help you decide which problem you want to work on first.

Potential problem areas

- Relationships with partner/spouse
- Relationships with children, parents, siblings and other family members
- Relationships with friends
- Work
- Money
- Housing
- Health
- Legal issues
- Alcohol and drugs
- Leisure activities

Activity Scheduling

Why is it Important to Do More Pleasurable Activities?

When people get depressed they do not feel up to doing the kinds of things they typically enjoy. By doing fewer enjoyable things they begin to feel even worse. As they feel worse, they do even less, and get caught up in a vicious cycle of doing even less and feeling even worse.



A simple and effective introduction to some Problem Solving techniques is to take the problem of reduced pleasurable activity, and set a goal of doing one pleasurable activity each day. In other words, arranging to provide yourself with "a treat a day".

The positive benefits are:

1. You can work through the steps of Problem Solving using a simple problem;
2. The tasks can usually be easily arranged and managed;
3. You will start to assert control over your life in a positive and beneficial way.

SESSION 5: Handout 12

Personal Case vignette

Name:

Age:

Sex:

Marital Status:

Housing situation:

Work:

Hobbies:

Symptoms:

Background:

Problem list X, with definition

1. –
–
–

2.

Choose a problem you are going to work on first:

Goal:

Possible Solutions: at least 3

Preferred Solution(s):

Plan:

SESSION 6: SESSION PLAN

TIME	METHODS
5 mins	<p>1. Introduction</p> <p>Show visual aid 16, objectives of session 6. Explain that participants will now practice visit 2 and 3 of BPS, taking 20 minutes for role-playing of the 2 visits and receiving feedback from the group and trainers for 10 minutes each. Make sure they use feedback forms and worksheets.</p>
85 mins	<p>2. Consolidation – Role play visit 2 and 3</p> <p>The participants are split in groups of 3. See background notes and appendix for details and other options. The objective is to give all participants the opportunity to practice BPS and receive feedback. All participants have prepared a patient case vignette for this session (handout 12).</p> <p>The participants will role-play visits 2 and 3 of BPS with the same participant as patient in both visits.</p> <p>The role-play practice starts with visit 2 when the patient explains which problem he or she wishes to work on. Visit 2 ends after the professional has explained the brainstorming technique and invited the patient to evaluate the possible solutions and prepare a detailed plan to implement the chosen solution as home-work, and to come back with this plan for a follow-up visit (visit3). The health care professional should hand over the patient leaflet (hand-out 11) to be used at home as a aid-memoir for all stages of Problem Solving, and encourage the patient to read it before starting brainstorming. After this role play continues with visit 3. The patient pretends to have done his or her homework between visit 2 and 3.</p> <p>Visit 3 starts with a brief summary of the homework assignment of the previous session by the health care professional, and by asking for the plan. It continues from there until the next 10 minutes have passed.</p> <p>After the role-play the participant in the role of health care professional receives feedback for 10 minutes. The feedback is given by the observer using the feedback forms and respecting the rules for effective feedback. He or she will make one or 2 positive remarks about the health care professional and 1 or 2 points for improvement. Each trainer supervises two groups of 3, and gives additional feedback and suggestions about the area's for improvement.</p> <p>After about 30 minutes, roles change and this happens again until all participants have had a turn as health care professional and have received feedback.</p>

SESSION 6 Aims and Objectives

BRINGING IT ALL TOGETHER, PRACTICE SESSION OF VISIT 2 AND 3 OF BPS

AIM:

To consolidate BPS-skills by practising visit 2 and 3 of BPS and receiving personal feedback.

OBJECTIVES:

By the end of this session participants will be able to:

- Manage two visits of BPS in the context of the 10-15 minute appointment system
- Identify their personal strength and weakness in Problem Solving

MATERIALS NEEDED

PowerPoint presentation of session 6, this includes:

Visual aid 16: Objectives of session 6

Handout 1: Feedback form and summary of the rules of effective feedback (p. 30-31 in participants handbook)

Handout 11: Patient leaflet (p. 63-64 in participants handbook)

Handout 12: Personal case vignette (p. 65-66 in participants handbook)

SESSION 6**Background notes for the trainer****BRINGING IT ALL TOGETHER, PRACTICE SESSION OF VISIT 2 AND 3 OF BPS****1. Introduction to role-play of visits 2 and 3 of BPS**

Show visual aid 16, objectives of session 6.

The objective of this session is to give all participants the opportunity to practice BPS in the context of the 10-15 minute appointment system and receive personal feedback. Participants have prepared a personal patient case vignette for this session (Handout 12) .

2. Consolidation – Role play visit 2 and 3 with twelve participants and 2 trainers

Split participants in groups of 3. Each trainer supervises 2 groups. In each of the groups there will be 3 role-plays successively. During each role-play one participant is role-playing patient, one the health care professional and one is observer. Each role-play lasts 20 minutes, with each participant role-playing visit 2 and 3 of BPS followed by 10 minutes of feedback. All participants will take turns in playing health-care professional, patient and observer.

The participant playing health care professional goes through problem list very briefly with the patient and asks for clarification if needed. Then:

- Makes a clear problem definition of the problem the patient wants to work on first
- Makes sure it is under the patient's control.
- If necessary breaks the problem down into smaller and more manageable parts.
- Then sets an achievable goal (SMART-goal)
- Explains the brainstorming technique and
- Gives a **homework assignment** to complete before the next visit consisting of:
 - Listing as many possible solutions using the brainstorming technique
 - Evaluating pro's and con's and making a choice of possible solution(s)

This visit ends by inviting the patient to

- Prepare a detailed plan to implement the chosen solution, and to come back with this plan for a follow-up visit (visit 3)

The patient then pretends to have done his or her homework and the health care professional moves on with visit 3 by summarising the homework assignment of the previous session and asking for the plan.

After the 20 minutes are up the health care professional receives feedback. The patient and health care professional give their opinions first and then the observer gives feedback, all respecting the rules for effective feedback (use handout 1). For each new role-play the observer gives one or 2 positive remarks and 1 or 2 points for improvement. Then, if present in this group during the feedback, the trainer gives additional feedback.

Then the same process is followed until all participants have role-played as professional and received feedback.

If the number of participants requires this, or all participants need personal feedback by the trainer, there are alternative ways of conducting this session. How to conduct this session will need attention before the training starts because the objective - all participants practising a visit of BPS and receiving personal feedback – needs to be met, and the length of the training depends on how this session is conducted. Alternatives can be found in the appendix.

SESSION 6: Visual Aid 16

BRINGING IT ALL TOGETHER, PRACTICING BPS VISITS

Objectives:

By the end of this session participants will be able to:

- Manage two visits of BPS in the context of the 10-15 minute appointment system
- Identify their personal strength and weakness in Problem Solving

SESSION 7: SESSION PLAN

TIME	METHODS
15 mins	<p>1. Ice breaker, repeating the framework and introduction to the Interventions</p> <p>The first part of this session is meant to change thinking and make a switch to managing symptoms after working on problems with BPS. After the ice-breaker show visual aid 17, objectives of session 7. Use the PowerPoint presentation of session 7 and the background notes. Start with the first slide of visual aid 18 'Explaining about anxiety', explaining the framework again. Then explain that four effective interventions to manage symptoms are included in the training programme. Which intervention should be used with a patient depends on the symptoms you want to tackle.</p> <p>An alternative way of conducting session 7 can be found in the appendix.</p>
15 mins	<p>2. Managing Anxiety – input</p> <p>Education and reassurance is needed to manage symptoms of generalised anxiety. Distraction and exercise are also helpful for patients with anxiety. Use background notes of session 7 and visual aid 18 and 19 for a brief explanation.</p>
15 mins	<p>3. Avoidant behaviour - input</p> <p>Then discuss the next symptom to deal with: avoidant behaviour. Explain the intervention simple exposure and response prevention, basing input on background notes of session 7 and visual aid 20. Bring together using visual aid 21 the case vignette of Helga.</p>
40 mins	<p>4. Managing Anxiety and Avoidant behaviour. Consolidation – practising in pairs</p> <p>After the input move on and practice in pairs what should be said to a patient with generalised anxiety. Each trainer moves between pairs and supervises 3 pairs. For this session a checklist is available on handout 13. Then go on to practice the intervention simple exposure and response prevention in the same pairs, participants taking a turn as health care professional and patient.</p>
5 mins	<p>5. Questions</p> <p>Invite questions and discuss them in the groups.</p>

SESSION 7 Aims and Objectives**GENERALISED ANXIETY AND AVOIDANT BEHAVIOUR****AIM:**

To summarise briefly what anxiety is about, to repeat the framework and introduce management of symptoms. To introduce education and reassurance, distraction and exercise as management for generalised anxiety, and exposure for avoidance.

OBJECTIVES:

By the end of this session participants will be able to:

- Explain to a patient what anxiety is
- Educate and reassure the patient with symptoms of anxiety
- Explain how to cope with anxiety
- Explain about distraction and exercise
- Explain what avoidance behaviour is
- Manage simple exposure

MATERIALS NEEDED

PowerPoint presentation of session 7, this includes:

Visual aid 17: Objectives of session 7

Visual aid 18: PowerPoint presentation 'Explaining about anxiety'

Visual aid 19: PowerPoint presentation 'Managing anxiety: coping with anxiety, distraction and exercise'

Visual aid 20: Avoidance and simple exposure

Visual aid 21: Case vignette Helga

Handout 13: Checklist for explanation of anxiety (p. 79 in participants handbook)

Handout 1: Feedback form and summary of the rules of effective feedback (p. 30-31 in participants handbook)

SESSION 7**Background notes for the trainer****GENERALISED ANXIETY AND AVOIDANT BEHAVIOUR****1. Ice breaker, introduction to the interventions repeating framework**

The first part of this session (5-10 minutes) is meant to change thinking and make the switch from working on problems with BPS to managing symptoms. The ice breaker can be managed as the trainer decides. A suggestion could be showing a small piece of a 'scary' video in order to generate some 'symptoms of anxiety/fear' in the participants as the following session is about management of anxiety symptoms.

After the ice-breaker show visual aid 17, objectives of session 7. Then explain the framework again using the first slide of session 7, and then explain that four effective interventions to deal with symptoms are included in this training programme.

Go back to the symptoms of anxiety which have been discussed during the first session of the training. To summarise use visual aid 18, the PowerPoint presentation 'Explaining about anxiety' and the following explanation.

Anxiety symptoms are divided in cognitive, behavioural and physical symptoms.

The cognitive symptoms of anxiety are the worries that accompany the physical symptoms. Typical worries include worries about health, worries about relatives. The worries may be rational worries or irrational worries.

The behavioural symptoms include predominantly avoidance behaviours. Avoidance behaviour describes the avoidance of tasks that increase worry. This may be an entirely normal behaviour such as the putting off of a task which the patient feels worried about or may be a developing symptom of mental illness such as the avoidance of going into shops because of fear of panic. The other key behavioural symptoms in anxiety disorder are the rituals found in obsessive compulsive disorder. These rituals are in place to reduce anxiety.

The physical symptoms found in anxiety are those physiological symptoms found in "flight or fight" reactions including racing heart, sweating etc.

Pull together with the last slide of the presentation 'the circle of anxiety'.

Which intervention for the management of anxious symptoms will depend on the presenting symptom.

2. Managing anxiety, education and reassurance, distraction and exercise – input

Move on to a brief input about generalised anxiety using the following information and visual aid 19 the PowerPoint presentation 'Managing Generalised Anxiety'.

To explain the symptoms of anxiety to a patient the following education and simple advice can be used:

- | | |
|---|--|
| 1. Stress and worry have both physical and mental effects | |
| 2. Anxiety is... | worrying thoughts
physical symptoms
avoiding situation |
| 3. Anxiety symptoms are... | normal symptoms
not harmful |

Fear is an emotion understood by most people. When we are fearful we usually have a good idea of what is making us feel scared. We have some understanding of the physical symptoms and can also understand behaviours that we carry out or think about to help reduce the fear. Fear is a normal and an understandable reaction. Anxiety, which may produce an almost identical physiological, and behavioural reaction is often not understood. An individual may either not be able to identify a “threat”, or they may not realise that their reaction to a perceived threat is irrational or exaggerated. To fill this gap in understanding individuals may make sense of what is happening by concluding that they have a serious physical illness or they are on the verge of losing control, and about to become seriously mentally ill. Perhaps the most important skill for a health care professional helping a patient with anxiety is the ability to listen, reassure and to help fill the “gap in understanding”.

It is often helpful to have a well-rehearsed explanation for anxiety symptoms which is not overly complicated.

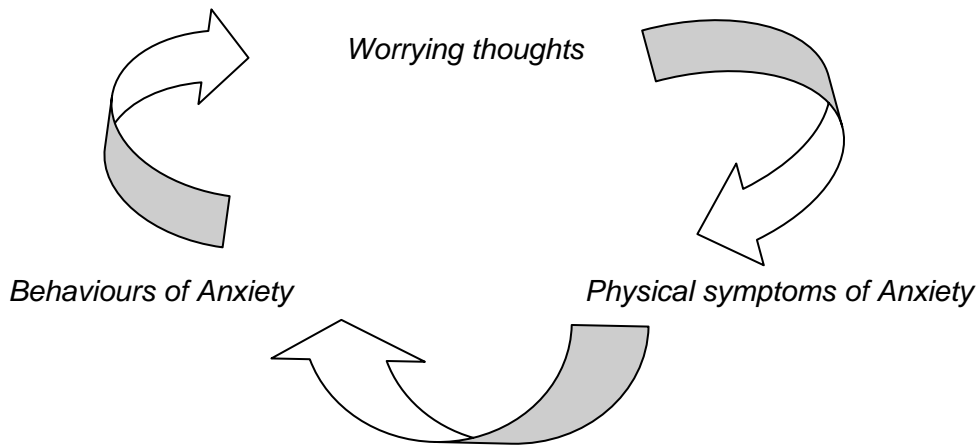
The health care professional should also explore with their patient factors which may be important in understanding the onset and the maintenance of the anxiety disorder. Often this will involve asking about relationship difficulties, problems at home or difficulties at work. Beginning to talk can often on its own suggest changes, highlight Problem Solving strategies or assist in coming to terms with problems or issues which will not change.

Useful advice about coping with anxiety, to help the patient the next time it occurs, can be found in the slides of visual aid 18 the PowerPoint presentation ‘Management of generalised anxiety’.

Then move on to explain participants how they can give advice about distraction using the information below and the next slides of the PowerPoint presentation visual aid 19.

Distraction

Worrying thoughts lead to anxious symptoms which in turn often worsen worrying thoughts. Distraction is a method which can be used to empty the mind of worrying thoughts and replace them with neutral thoughts. Pull together by explaining the circle again.



Then explain briefly that there are several ways to distract from worrying thoughts:

1. Physical activity/exercise
2. Mental refocusing
3. Relaxation

1. Physical activity

Physical exercise can be a useful way of distracting from worrying thoughts. If patients are focused on a physical activity, this will remove the focus on physical thoughts. The activity will also help overcome the physical feelings of tension. On occasions, such activity might take the form of vigorous exercise. This may not always be appropriate and in these situations, simply doing something e.g. getting up, washing up or the vacuum cleaning will, if the patient is asked to focus on that activity, reduce the worrying thoughts.

2. Mental Refocusing

Patients are asked to describe in detail to themselves a picture of you or a story. The purpose of this is to place the worrying thoughts with neutral thoughts. The patient needs to focus in detail on the distracting image, be this the details of a row of books on a bookshelf, cars passing in the road or a mental image.

3. Simple Relaxation

Patients need to imagine a restful, relaxing image, for example the seashore or the flapping wings of an albatross or a tree blowing in the wind. The patient needs to shut their eyes and bring this image into their mind. Whilst breathing slowly through the nose, the patient needs to keep the image in their mind. This exercise is best done for about 15

minutes in a quiet place. Once the technique has been learnt, it may be used in stressful situations.

There are other relaxation techniques, for example progressive muscle relaxation. If the patient is focusing on tensing and relaxing muscles, or a particular image it is more difficult to be simultaneously worrying. There are a number of different techniques and a number of relaxation tapes available. Many local departments of clinical psychology will be able to provide copies of tapes, or recommend a commercially available tape. As with slow breathing the patient should be encouraged to practice the relaxation techniques twice a day and implement them before and after anxiety provoking situations.

3. Avoidant behaviour – input

Discuss the intervention to use for avoidant behaviour: simple exposure. Explain about avoidance and simple exposure using the following background notes and visual aid 20.

Simple exposure

Explain that avoiding feared situations is an important factor in a large number of anxiety disorders. Each time a situation is avoided the idea is further strengthened in an individual's mind that they would have been overwhelmed by anxiety.

Patients should be advised to face the feared situation and remain in it until either the anxiety subsides, or until they can convince themselves that being in a situation will not lead to them losing control or being unable to deal with the anxiety. Patients should be encouraged to repetitively place themselves in the feared situation. Use visual aid 20 'Avoidance and simple exposure' for your explanation. Explain that avoiding feared situations allows the fear to grow stronger and that confronting feared situations will reduce the fear.

The essential feature of exposure based psychological treatments involves persuading the patient to stop avoiding the feared situation. Patients are told this will initially result in heightened levels of anxiety but will enable them to put "to the test" predictions about losing control, going mad etc. Repetitive exposure to the feared situation and a repetitive invalidation of feared consequences leads to a reduction in anticipatory anxiety, avoidance and disruption to an individual's life.

Once patients have been given advice about exposure they can often take themselves through several tasks. In the initial stages a friend or relative can often assist in the process, however care should be taken that dependence does not develop or that being accompanied is not an avoidance.

An example of when exposure would be useful would be for a patient who has begun feeling anxious when in the town centre. The patient might also feel anxious in the supermarket. The following steps might be agreed with the patient:

1. To go to supermarket at less busy times and remain until anxiety passed.
2. To go to supermarket when busier, perhaps accompanied by husband on first occasion.
3. To go into town at quiet times.

4. To go into town at busy times.

The important point to emphasise is that the task must be repeated regularly. The patient should not go onto the more difficult tasks until they have stopped being anxious at the easier tasks.

Bring together using visual aid 21, the Case-vignette of Helga.

4. Managing anxiety and avoidant behaviour: Consolidation – practising in pairs

After explaining both interventions go on to practice in pairs. Each trainer moves between pairs and supervises 3 pairs, giving feedback and answering questions as they come up. Feedback forms can be found on handout 1.

Start with what should be said to a patient with generalised anxiety. For this practice session a patient with anxiety from the participants own experience can be used. The explanation involves a description of anxiety as already learnt, that:

- anxiety is a normal response
- it is not harmful
- symptoms include physical symptoms, thoughts and behaviour
- when anxiety starts the patient should do not add to it by worrying and
- anxiety will pass

A checklist is available on handout 13.

After about 20 minutes, move on to the next intervention, simple exposure. Ask participants to practice this intervention, taking a turn as health care professional and patient again. For this practice session Helga may be used as an example, as well as examples of patients with avoidant behaviour from the participants own experience.

Move between pairs again, supervising 3 pairs, giving feedback and answering questions as they come up.

5. Questions

Allow 5 minutes for questions and discuss them in the groups.

SESSION 7: Visual aid 17

GENERALISED ANXIETY AND AVOIDANT BEHAVIOUR


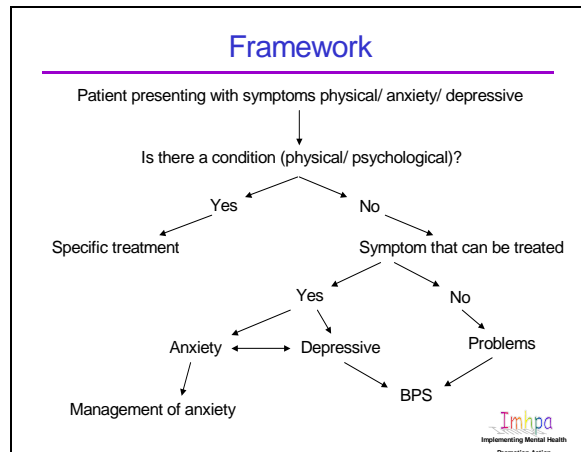
Objectives:

By the end of this session participants will be able to:

- Explain to a patient what anxiety is
- Educate and reassure the patient with symptoms of anxiety
- Explain how to cope with anxiety
- Explain about distraction and exercise
- Explain what avoidance behaviour is
- Manage simple exposure


SESSION 7: Visual aid 18

Explaining about anxiety


Common Physical Symptoms of Anxiety

<p>Gastrointestinal:</p> <ul style="list-style-type: none"> • dry mouth or difficulty swallowing • diarrhoea • abdominal discomfort • nausea • "butterflies" <p>Genitourinary:</p> <ul style="list-style-type: none"> • frequency/urgency micturition • menstrual pain/disturbance • erectile dysfunction <p>Neuromuscular:</p> <ul style="list-style-type: none"> • aching muscles, incl. chest pain, headaches • tremor / shaking • tingling sensations 	<p>Cardiovascular:</p> <ul style="list-style-type: none"> • palpitations, pounding/racing heart • dizziness/light headedness <p>Respiratory:</p> <ul style="list-style-type: none"> • hyperventilation • difficulty inhaling, feeling short of breath <p>Other features:</p> <ul style="list-style-type: none"> • sleep disturbance • derealisation • depersonalisation • sweating
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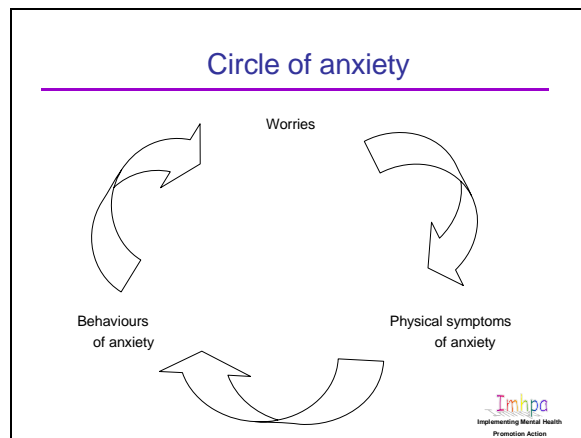
Common Cognitive Anxiety Symptoms

- Anticipatory fear
- Excessive worry
- Tension, feeling on edge, keyed up
- Difficulty concentrating
- Irritability
- Tiredness, easily fatigued
- Fear of losing control/going mad




Common Behavioural Symptoms:

- Avoidance
- Smoking more
- Nail biting
- Restlessness

SESSION 7: Visual aid 19


Managing anxiety



Coping With Anxiety

- 1 These feelings are normal bodily reactions
- 2 They are not harmful
- 3 Don't add more frightening thoughts
- 4 Describe to yourself slowly what is happening
- 5 Wait for the anxieties to reduce or even pass, they will!
- 6 Notice when it does actually fade and


REMEMBER: anxiety is unpleasant but not dangerous



Distraction (1)

Patients are asked to:


- Describe in detail to themselves a picture, a view, a story etc.
- Think of a relaxing image, the seashore, lake mountains
- To save up worries to a circumscribed "worry time" each day



Distraction (2)

To distract from worrying thoughts:

- Physical activity/exercise
- Mental Refocusing
 - ask the patient to describe in detail to themselves a picture (of you), a story
- Simple Relaxation
 - ask patient to think of a relaxing image, i.e. the seashore, lake, mountains.



SESSION 7: Visual aid 20

Avoidance and Simple Exposure

Avoidance:

- Avoiding feared situations allows the fear to grow stronger
- Confronting feared situations will reduce the fear

Simple Exposure:

- Draw up list of avoided situations
- Start with easier tasks and build up to harder tasks
- Face feared situation as often as possible
- Remain in the situation
- Experiencing anxiety allows prediction of "loss of control" to be challenged

SESSION 7: Visual aid 21

Case vignette Helga

Helga is a 52 year old mother of three grown up children. No marital problems. She works part-time at the checkout of a local supermarket.

Three weeks ago she felt faint at the till and had to go and rest. She felt embarrassed and foolish about what happened and even talking about it makes her blush.

She has been off work since the incident and feels anxious at the thought of going back. She has avoided seeing friends from work.

She is sleeping and eating well.

SESSION 7: Handout 13

Checklist for Explanation of Anxiety

1. Anxiety is a normal response

2. Anxiety is not harmful

3. Anxiety symptoms include :
 - physical symptoms

 - thoughts

 - behaviours

4. When anxiety starts do not add to it by worrying

5. Anxiety will pass

SESSION 8: SESSION PLAN

TIME	METHODS
30 mins	<p>1. Unexplained physical symptoms – interactive plenary Show visual aid 22, objectives of session 8. Then discuss reattribution, the intervention to use for unexplained physical symptoms. With this aim invite participants to brainstorm about what they would do with a patient with unexplained physical symptoms, using visual aid 23 the case vignette of Odette as an example. List and discuss the participants' ideas. Bring everything together using background notes and visual aid 24. For this session a checklist is available on handout 14.</p>
30 mins	<p>2. Insomnia – interactive plenary The last symptom this manual deals with is insomnia. Use background notes of session 8 and visual aid 22, the PowerPoint presentation about insomnia for a brief explanation on simple sleep hygiene. This session is also conducted as an interactive plenary. Use a vignette from your own experience or invite the participants to come up with a patient example. Invite the participants to offer their solutions to manage insomnia. The trainer discusses these solutions adding more solutions if needed using his or her expertise.</p>
10 mins	<p>3. Summarise Use the last two slides of the PowerPoint presentation of session 8 to summarise all skills that have been practised in the two-day training programme.</p>
20 mins	<p>4. Questions, evaluation and wrap-up Ask for any remaining questions and answer these questions using your own experience and background notes. Then ask the participants to fill out the evaluation forms and make sure the participants hand them in. Thank participants for their active contribution and send them home.</p>

SESSION 8 Aims and Objectives**UNEXPLAINED PHYSICAL SYMPTOMS AND INSOMNIA****AIM:**

To introduce and practise reattribution as management for unexplained symptoms. To explain sleep hygiene and stimulus control for insomnia. To evaluate the course.

OBJECTIVES:

By the end of this session participants will be able to:

- Manage the three steps of reattribution
 - ensuring the patient feels understood.
 - changing the agenda
 - explain to a patient how stress and tension lead to physical symptoms, making a link between physical and psychological symptoms
- Identify causes for insomnia
- Manage simple sleep hygiene and stimulus control

MATERIALS NEEDED

PowerPoint presentation of session 8, this includes:

Visual aid 22: Objectives of session 8

Visual aid 23: Case vignette Odette

Visual aid 24: Reattribution: intervention for unexplained physical symptoms

Visual aid 25: PowerPoint presentation 'Insomnia: simple sleep hygiene and stimulus control'

Handout 1: Feedback form and summary of the rules of effective feedback
(p. 30-31 in participants handbook)

Handout 14: Checklist for explanation of how stress and tension lead to physical symptoms
(p. 89 in participants handbook)

UNEXPLAINED PHYSICAL SYMPTOMS AND INSOMNIA

1. Unexplained physical symptoms – interactive plenary

To conduct this last session invite participants to brainstorm about what they would do with a patient with unexplained physical symptoms, using visual aid 23 the case vignette of Odette as patient. List and discuss the participants' ideas. Bring together using visual aid 24, the PowerPoint presentation 'Reattribution: intervention for unexplained physical symptoms' and the following information. For this session a checklist is also available on handout 14.

Unexplained physical symptoms are common in general practice and secondary care. Psychological distress is frequently presented through physical symptoms and somatising patients are high utilizers of medical care.

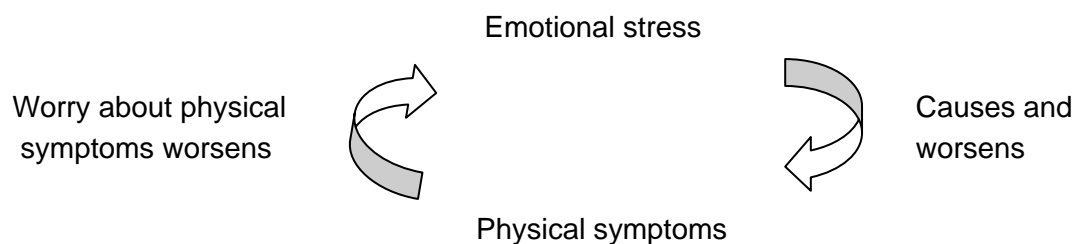
It is important for primary health care professionals to determine whether or not there is a medical cause for the physical symptoms before reassuring the patient there is not. This is even more important in somatising patients as they are not easily reassured.

- The first step is to ensure the patient feels understood. This can be achieved by taking a full history and carrying out a focussed physical examination. Doing this accurately and taking enough time for this step helps to reassure the patient. However, for many somatising patients this is not enough.

In that case the next steps of the reattribution technique could be helpful

- Reassurance as described above should then be followed by changing (or broadening) the agenda from a discussion of physical to psychological/emotional symptoms. This can be done by asking specific questions about any other problems.
- Making a link between physical and psychological/emotional symptoms is the next step. Acknowledge that symptoms are real and that just because there is no physical cause this does not mean there is nothing wrong or that there are no symptoms. Explaining how stress and tension lead to physical symptoms will make it easier for a patient to understand this link. For this explanation use the slides of visual aid 24 (the explanation for the patient).

In simple terms a vicious circle can be set up:



The management of *acute* somatic symptoms is simpler than when the symptoms have become chronic. The explanation above might be enough to reassure the patient with acute symptoms.

When working with chronic somatising patients, more time and patience is needed. Such patients are often very sensitive to being dismissed as “there is nothing wrong with you”. A suggestion that the patient might benefit from a psychiatric referral is often seen as rejecting. The principles of changing (or broadening) the agenda and making the link between physical symptoms and psychological problems applies with chronic just as with acute somatic symptoms. However, a slower pace is needed and goals should be more limited. During the first step, and in addition to a focussed physical examination in some cases further testing might be necessary before moving on to changing/broadening the agenda. In some of these patients it might also help not to talk about problems but about ‘circumstances’, or ‘life-style matters’ or ‘what is going on in your life’. If the patient doesn’t see a link, or is very sensitive about it, it might help if the health care professional offers to try and find this link together. The patient is invited to keep a journal which should include data of ‘when the symptoms are present’ and ‘what the patient was doing/thinking’ as well as ‘how he or she reacted to the symptoms’. The patient is invited for a follow-up visit bringing the journal, and patient and health care professional look at the journal together. This might help patient and professional to find patterns and making the links needed to change the agenda together. If the patient has accepted the link but the explanation about how stress and tension lead to physical symptoms is not reassuring enough for a more chronic patient, it is important to then discuss how to move from there. Goldberg and colleagues (1992) set out key ideas for the management of acute and chronic somatisation in primary care.

Point to handout 14 in the manual: ‘Checklist for Explanation of How Stress and Tension Lead to Physical Symptoms’ and to the PowerPoint presentation for the explanation how stress and tension lead to physical symptoms

2. Insomnia – interactive plenary

Insomnia is a common symptom in primary care. It may be temporary or longstanding. It may be a symptom alone or may link with other disorders.

Brainstorm causes of insomnia and bring together using the following information:

Causes of Insomnia in Primary Care

Depression:

- Approximately 30% of patients with insomnia have a moderate depressive disorder
- Insomnia is an important symptom in depressive disorders
- Untreated insomnia leads to an increased incidence of depression

Substance Abuse:

Substances to consider include:

- Alcohol
- Hypnotics
- Caffeine
- Illicit drugs

Physical Illness:

- Painful illnesses
- Chronic medical illnesses
- Nocturnal asthma
- Movement disorders

Many mental health professionals hand their patients little pamphlets filled with “sleep hygiene rules”. Quoted from Hauri 1979: ‘This is no more effective, in my experience, than handing a neurotic patient a list of “rules for healthy emotional living”. The therapist should keep the sleep hygiene rules in his or her own mind and use them judiciously when discussing the particular sleep problem with a patient. I have rarely found a patient who can benefit from more than three or four individually tailored rules at any given time.’

Explain about simple sleep hygiene and stimulus control using the PowerPoint presentation 25 about insomnia. Explain that if simple sleep hygiene does not work one should move on to stimulus control.

Stimulus Control

This is a set of instructions designed to reduce sleep incompatible behaviours and to develop a consistent sleep-wake cycle. Combining the results of about twenty studies indicates that the time taken to fall asleep and the time awake after falling asleep is reduced by half. The rationale underpinning the treatment is that the bedroom has become associated with a frustrated desire to sleep and performance anxiety has set in about sleep. Stimulus control acts to change this. Both sleep hygiene and stimulus control instructions can be found in the PowerPoint presentation about insomnia, visual aid 25. Point participants to the print of this presentation in their manual.

3. Summarise

Use the last two slides of the PowerPoint presentation of session 8 to summarise all skills that have been practised in the two-day training programme.

4. Questions, evaluation and wrap-up

Ask for any remaining questions and answer these questions using your own experience and the information in the background notes. Then ask the participants to fill out the evaluation forms and make sure the participants hand them in. Thank participants for their active contribution and send them home.

SESSION 8: Visual aid 22

UNEXPLAINED PHYSICAL SYMPTOMS AND INSOMNIA

Objectives:

By the end of this session participants will be able to:

- Manage the three steps of reattribution
 - ensuring the patient feels understood
 - changing the agenda
 - explain to a patient how stress and tension lead to physical symptoms, making a link between physical and psychological symptoms
- Identify causes for insomnia
- Manage simple sleep hygiene and stimulus control

SESSION 8: Visual aid 23**Case Vignette Odette**

Odette is a 36 year old mother of four children between 8 and 16 years of age. Her husband works very hard as a salesman and is often away from home. She quit school at the age of 16 to help her parents in their busy shop. She married young, had her children and takes care of her family since.

She gradually took on some voluntary work through the school of the kids and their various clubs, and recently started a computer course as well. She believed computer skills might come in handy if she needs to find a paid job to be able to pay for the children's education in the future. She now finds it hard to keep up with the homework for the course, her voluntary work and all other competing demands of her household.

Her father is not well at the moment and she feels responsible for his welfare as well as she is the only sibling living nearby. She has visited the GP a number of times over the past 4 months with abdominal discomfort and pain. She is very worried she has a serious illness like some kind of tumour.

SESSION 8: Visual aid 24

Reattribution: Intervention for Unexplained Physical Symptoms



Reattribution: Intervention for Unexplained Physical Symptoms

- Ensure the patient feels understood
 - take a full history
 - carry out a focussed physical examination
 - in chronic cases further testing might be needed
- Change/broaden the agenda
 - in chronic cases keeping a journal might help
- Make a link between physical and psychological symptoms



How stress and tension lead to physical symptoms (1)

- **First** - worry and tension can cause you to tighten up your muscles. When this lasts for some time these muscles can become painful (remember what it was like the last time you carried heavy bags for a long time – your arms will have been hurting). When this happens to the muscles at the back of the neck it leads to headache. When muscles around the bowel contract it leads to stomach pains. Tightening of muscles may also cause fatigue.
- **Second** - when you get tense and anxious this causes a substance called adrenaline to be released into your body. This can be very helpful in making you more alert and prepared to deal with problems, but unfortunately it can cause many physical symptoms e.g. racing heart.



How stress and tension lead to physical symptoms (2)

- **Third** - breathing too quickly and/or deeply (also known as hyperventilation) decreases levels of carbon dioxide. Symptoms include dizziness, light-headedness, breathlessness, feelings of unreality, pounding heart, tingling sensations and so on.
- **Fourth** - if you are feeling down or fed up, you are much more likely to focus on your bodily sensations and worry about them than when you are feeling cheerful. If you have played sport remember the difference between how much an injury hurt when you were on the losing side compared to when you were winning!




How stress and tension lead to physical symptoms (3)

- **Finally** – we focus in and worry about some symptoms more than about other symptoms. If a member of your family or a friend has had a life-threatening illness which began with the symptoms that you are experiencing now you will tend to worry more about this.




SESSION 8: Visual aid 25

**Insomnia:
Simple sleep hygiene and
Stimulus control**




Simple sleep hygiene

1. Reduce time in bed
2. Avoid cigarettes/alcohol/nicotine
3. Avoid exercise before bedtime
4. Set regular bedtime
5. Eliminate bedroom clock
6. Avoid stimulating/upsetting activities before sleep
7. Get the environment right for sleeping
8. Avoid heavy meal, eat light bedtime snack before sleep




Stimulus control


1. Use bedroom only for sleep and sex. No reading, TV or eating in bed, do not use the bedroom for work
2. Go to bed only when sleepy
3. If you are in bed for more than about 15 minutes without falling asleep you should get up and try again later
 - Go to another room and stay up as long as you wish, engage in undemanding activity e.g. reading, watching TV
 - Return to your bedroom only when sleepy
 - Goal: to associate your bed with falling asleep quickly
4. Repeat step 3 as necessary. Once your mind has accepted the association of the bedroom with sleep, repeats will be less necessary .
5. Set your alarm and get up at the same time every morning regardless of the amount of sleep you have got during the night
6. Do not nap during the day



Interventions in the Circle of anxiety



Summary



SESSION 8: Handout 14

Checklist for Explanation of How Stress and Tension Lead to Physical Symptoms

1. Worry and tension cause muscles to tighten. This can lead to:
 - a) Pain
 - b) Stomach pains
 - c) Fatigue

2. Tension and anxiety leads to adrenaline release:
 - a) This can cause a racing heart

3. Breathing too quickly can cause:
 - a) Dizziness
 - b) Breathlessness
 - c) Feelings of unreality
 - d) Tingling sensations

4. When you are down you focus more on physical sensations.

5. We focus more on some symptoms than others, e.g. if we know someone with a serious illness.

Evaluation of the IMHPA- training of BPS and Anxiety

Course materials

	<i>not at all</i>			<i>certainly</i>	
	1	2	3	4	5
Have you had the opportunity to read most of the materials during the training?	1	2	3	4	5
Was it too much?	1	2	3	4	5
Was the content relevant?	1	2	3	4	5

Comments

.....

Presentations

Was the content of the presentations clear?	<i>not at all</i>			<i>certainly</i>	
	1	2	3	4	5
'Prevention and promotion'	1	2	3	4	5
'Seven stages of Problem Solving'	1	2	3	4	5
An example of BPS (DVD)	1	2	3	4	5
'Rehearsal of communication skills'	1	2	3	4	5
'Explaining about anxiety'	1	2	3	4	5
'Managing anxiety'	1	2	3	4	5
'Avoidance and simple exposure'	1	2	3	4	5
'Reattribution'	1	2	3	4	5
'Insomnia'	1	2	3	4	5

Comments

.....

Other materials

	<i>not at all</i>			<i>certainly</i>	
	1	2	3	4	5
The visual aids were clear	1	2	3	4	5
Comments.....				
The handouts were clear	1	2	3	4	5
Comments				
The vignettes were clear	1	2	3	4	5
Comments.....				

Role-plays and & personal feedback

	<i>not at all</i>			<i>certainly</i>	
	1	2	3	4	5
Were the introductions of the role plays clear?	1	2	3	4	5
Was role-playing instructive?	1	2	3	4	5
Did you benefit from observers feedback	1	2	3	4	5
Did you benefit from the trainers feedback	1	2	3	4	5

Comments

Role of the trainers

	<i>not at all</i>				<i>certainly</i>
Were the trainers competent?	1	2	3	4	5
Were the trainers inspiring?	1	2	3	4	5

Comments

.....

General questions

	<i>not at all</i>				<i>certainly</i>
BPS skills are relevant for every-day practice	1	2	3	4	5
The trained anxiety management skills are relevant for every-day practice	1	2	3	4	5

	<i>not at all</i>				<i>certainly</i>
Do you feel confident to apply BPS in your practice?	1	2	3	4	5
Do you expect problems with BPS in every day practice?	1	2	3	4	5

If yes: which problems?.....

.....

Do you feel confident to apply anxiety management in your practice?	1	2	3	4	5
---	---	---	---	---	---

Do you expect problems with anxiety management in every day practice?	1	2	3	4	5
---	---	---	---	---	---

If yes: which problems?.....

.....

Where there any particular parts in the training that needed more attention?

.....

Was the length of the two modules (BPS and anxiety management) fine? Would you suggest differently?.....

Was the English use of language easy to understand?.....

What have you missed in this training?

What could be left out?

What would you like to be changed?.....

Other comments/ suggestions

.....

Thank you for participating and evaluating this course. Have a safe trip home!

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Appendix

The appendix contains the following issues:

- The website address of IMHPA: www.imhpa.net
- Rules of effective feedback
- Instructions about alternative ways of conducting session 6: practice of BPS, bringing it all together

RULES OF EFFECTIVE FEEDBACK: FEEDBACK AS DIDACTIC SKILL

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Introduction

In almost every training of practical skills, the teacher gives the student feedback by telling the student to what extent the latter has acquired a certain skill and what is still lacking in such a way that the student can benefit from this information in the future. For that purpose, feedback has to meet three conditions: recognisability, applicability, and safety. If the student does not recognise himself in the feedback, then he will not be able to alter his behaviour. The same is true for applicability: feedback that is substantially correct may well correspond with the student's own impression, but nevertheless not contain enough elements from which the student may later benefit.

If the teacher pays attention to the recognisability and the applicability, then there are usually no problems with practical skills such as for example percussion of the thorax and measuring blood pressure. However, regarding social skills and attitude, there is a complicating factor: in that case, the teacher does not only base his feedback on theory and knowledge, but also on his own experiences and impressions, and these are to a certain extent inevitably subjective. A solution might be to withhold the subjective element as much as possible. If, however, the feedback is stripped of vital impressions and of the experience connected with it, then the feedback is in fact emptied of meaning: paradoxically, the most instructive part of feedback about communication skills is its subjective content. The student gets the unique opportunity to learn what impression he makes on others, what his personal style is, what he picks up from his interlocutor, and what he ignores.

But if we choose to include the teacher's subjective impression in the feedback, the question arises how to make subjective impressions recognisable and also applicable. If feedback is successful depends both on the teacher and on the student. This requires some explanation. Feedback on social skills and attitude implies a more or less subjective judgement about personal aspects of the person involved. Students may react to feedback very differently in this field. Some students - and often exactly those who are most motivated - can be shaken by critical comments, whereas others begin to justify themselves, start to challenge the comment, or think up excuses, or criticise the simulated patient, etc. In order for feedback to be effective, it is necessary that the teacher creates a safe learning environment. Recognisability, applicability, and safety are the most essential characteristics of effective feedback.

Rules of effective feedback:

Recognisability

Feedback should be recognisable. This can be realised in several ways:

1. Concrete feedback

Often feedback is global, i.e., it contains too little specific information and has a summarising character. Students are often so fixed on the task they set themselves in the conversation, that they only remember a few parts of the interview afterwards. What is said during feedback must be as factual and as concrete as possible. The teacher should preferably offer the student specific parts of the conversation/interview on which he bases his impressions. An example of global feedback is:

"You ignored too much of what the patient indicated."

An example of concrete and specific feedback about the same topic is:

"When the patient asked: 'It is nothing serious, is it, doctor?', you just continued with the standard questions of the gastrointestinal organ system."

Such incidents are irrefutable, and therefore optimally recognisable. Furthermore, they are easy to trace if an audio-visual registration of the interview has been made.

2. Feedback on personal title

Feedback often has an interpretative character, i.e., the teacher makes a statement suggesting that he knows what's going on in the student's mind. It is advisable to refrain from such statements. They suggest a certain objectivity, whereas the teacher cannot see what goes on in the other person's mind. Furthermore, if the student does not agree with the interpretation, or, what happens more often, if the student swallows the statement without any reflection, there is no recognisability, and the student will not learn anything at all. The teacher should not speculate about what moves the student, but should confine himself to a personal evaluation of the student's behaviour, and refer to the above-mentioned specific material. He quotes that material and adds what impression it has made on him, preferably with sentences beginning with the word "I". In this way, the student recognises that this evaluation is a subjective one. Consequently, the discussion about who is right or wrong is off at once: a subjective evaluation is by definition impossible to be labelled as right or wrong. An example: "You were so busy with yourself."

An alternative formulation might be: "While the patient was telling you something about his admission to the hospital, you were turning over the pages of the file all the time. If I had been sitting on the patient's chair, I would have thought that this doctor was only busy with what mattered to himself."

Applicability

Feedback has to be applicable. This can be realised in several ways:

1. Feedback to behaviour rather than to feelings

Feedback may well be correct, but may not contain enough elements that can be used for a following consultation. The risk increases if the teacher mainly concentrates on feelings and emotions. An example:

"When the patient put pressure on you to give medication, you became completely blocked. I got the impression that you do not know how to handle aggression."

For a student who recognises himself fairly well in this feedback, this is not very helpful to cope with a similar situation next time; on the contrary: he will recognise this mistake as an inability that fits his character. And what can he do about that, after all? Therefore, it is better to focus the feedback on behaviour rather than on emotions, as in the following alternative:

"When the patient put pressure on you to give medication, you suddenly started to speak faster and to gesticulate. You did not finish your sentences anymore and jumped from one subject to another. This behaviour would not encourage me as a patient to sing another tune; on the contrary."

This does not mean, that the teacher should speak exclusively about concrete behaviour (see "safety"): if the student himself comes up with emotions, the teacher may join him, but this will be more effective when he focuses on the corresponding behaviour simultaneously.

2. Alternative behaviour

If the teacher focuses primarily on concrete behaviour, it is easy to switch to alternative behaviour subsequently. Talking about alternative behaviour is very helpful for the student because he can use this in the future: he learns that there usually are a variety of behavioural patterns he can use in one and the same situation. Here too the student is usually better off with alternative types of behaviour, presented in a concrete way. The teacher may ask the student to consider alternative behaviour himself and to give it a go with the patient on the spot by role-playing it. If the student does not have any ideas himself, other students might come up with alternatives or the teacher himself can present some alternatives, and ask the student to indicate which alternative types of behaviour fit him best. In a complex case, the teacher may demonstrate alternative behaviour in a role play in which the roles are reversed.

Safety

Feedback has to be safe. Taking into account the following rules might help.

1. Feedback to current behaviour

Feedback focussing on concrete behaviour is considerably less threatening and less difficult than feedback directed to feelings, experience or personality. After all, the latter refers to "deeper layers" of the personality. The student is more willing to accept criticism if it is restricted to the first instance to the surface layer. It is better not to include the student's behaviour in general in the feedback but only the current behaviour. This does not

implicate that the teacher always has to confine himself to current behaviour but it is wise to start with it: during a feedback session it will soon become obvious whether or not the feedback elicits resistance in the student.

2. Positive feedback

The best way to start the feedback is to ask the student how he feels about the interview with the patient himself, and then to recall some positive points of the interview altogether. Exclusively negative criticism is counterproductive. Feedback is not only intended to criticise, but also to reinforce effective behaviour of the student by referring to parts of the interview that went well. Students long for positive feedback of their teachers. This is particularly appropriate when the student has just demonstrated to be a gifted communicator and is able to relate to a patient as a gentle, authentic and committed personality. Furthermore, positive feedback usually enhances the student's susceptibility to more critical comments.

3. Avoidance of loss of face

Feedback focussing on real blunders may be experienced as so shameful, that the student feels embarrassed during a feedback session, especially when fellow students are present. This has to be avoided at all cost, because students who are left with the impression of being a total failure do no longer learn anything at all. In such a case, the following phrases may be helpful:

"Above all you are here to learn from your mistakes", or "I also had to learn it this way." The teacher should emphasise that a blunder is only a solitary incident that usually does not have a large impact for the future; self-irony on the part of the teacher works magic.

4. Avoidance of resistance

It is important to be alert to resistance. Resistance of students can manifest itself in various ways. In most cases they challenge the validity of the feedback, argue that the patient is not representative, or dismiss criticism referring to everyday practice ("as a physician, you only have ten minutes"). If the student tries to justify himself to the teacher, resistance quite often provokes it. Such "feeble excuses" in turn irritate the teacher; he will repeat his criticism over and over, and with a preponderance of arguments. However, one can usually not turn around resistance in this way, on the contrary, it only increases. Actually, the teacher does not know what tender spot the resistance covers. Not surprisingly, a discussion with a recalcitrant student sometimes turns into an unexpected crying-fit that is very embarrassing for the student. Therefore, the teacher should select alternative ways to say what must be said. An example: if a student is not willing to accept the feedback, do not insist any longer, but ask him to imagine himself as the patient being addressed by a physician in the way he addressed himself the patient in the role of physician. If this intervention fails, then the teacher should make a meta-communicative intervention and raise the matter of getting stuck and stagnation as such. An example: "I do not know what's the matter, but I feel our conversation is getting a bit awkward. Do you think so, too?" How to phrase such an intervention requires precision, for there is much temptation to blame the student, as in the following example: "I do not know what is the matter, but all the time I have the impression that you cannot stand me criticisms." By a meta-communicative intervention,

the teacher leaves the ongoing conversation alone for a moment and invites the student to work out why the conversation is stuck together. In doing so, the stalemate of who is right or wrong can be left behind, and both interlocutors can consider together why the conversation so far did not go smoothly and on what conditions they can continue to talk together fruitfully.

Additional tips:

Mind the dialogue

Since the teacher is the expert, a feedback session between a teacher and a student often is a monologue by the teacher telling the student what is right and wrong. From a didactic point of view, the question arises whether or not a student benefits from such a unilateral conversation. A monologue implicates the directive "If you do exactly what I told you to do, it is alright." Whether or not the student agrees, understands the rationale, etceteras, is no subject of discussion. A disadvantage of the monologue is that it does not stimulate self-reflection, because the right way to do something is already indicated by the teacher. In case of self-reflection, the student himself analyses his performance guided to do so by critical questions of the teacher. Eventually, he accepts the comments of the teacher, not because the latter is the expert, but because he himself recognises these comments as correct and useful on the basis of his own reflection. No doubt, the didactic output of the reflection-directed teaching is greater and more enduring than that of the classical top-down approach in teaching. In a dialogue, the teacher continuously stimulates the student to react to what he has brought up. He may even play the devil's advocate just to ascertain that the student is thinking autonomously, instead of pleasing the teacher. This implicates, that a student is allowed to disagree with the teacher. In such a case, both have to make an effort to reach an agreement in the end.

Say what has to be said

Quite a few teachers are inclined to conceal negative comments, or to present these so cautiously that what they intended to say is lost. These teachers do not like to confront a motivated student, who nevertheless did not make perform up to a certain standard, with negative remarks. Sometimes, the teacher fears to disturb the balance in a sensitive student, or to hurt him. However, a teacher should not confuse his role with that of a therapist. Even if a student feels really uncomfortable because of negative criticisms, it never should be a reason to withhold these from him. The primary responsibility of the medical teacher is to deliver competent doctors, who are willing to learn from each experience, no matter whether it is positive or negative.

BRINGING IT ALL TOGETHER, PRACTICE SESSION OF VISIT 2 AND 3 OF BPS

Alternative ways of conducting session 6

Twelve participants and 2 trainers

When there are 2 trainers and twelve participants and trainers have decided all participants need personal feedback from the trainer, the best way to achieve the intended goal is to split the participants in two groups of 6. The session is conducted as an exercise with the whole group. Each trainer supervises three successive role-plays of 20 minutes followed by 10 minutes of feedback in one group of six.

During the exercises each participant role-plays one visit of BPS as professional (either visit 2 or visit 3) and receives feedback. Two participants will give feedback as observer (one for each health-care professional). Three of the 6 participants will get to role play a patient for the two successive visits by two participants roll-playing as health care professionals during that round.

In each round the first of the 2 health care professionals goes through problem list briefly with the patient and asks for clarification if needed.

- Make a clear problem definition of problem to work on first
- Make sure it is under the patient's control
- If necessary break the problem down into smaller and more manageable parts
- Then set an achievable goal (SMART-goal)
- Explain the brainstorming technique and
- Give a **homework assignment** to complete before the next visit consisting of:
 - Listing as many possible solutions using the brainstorming technique
 - Evaluate pro's and con's and make a choice of possible solution(s)
- Health care professional 1 ends visit 2 by inviting the patient to prepare a detailed plan to implement the chosen solution, and to come back with this plan for a follow-up visit (visit3)

The patient pretends to have done his or her homework between health care professional 1 and 2 (visit 2 and 3).

The second health care professional takes over and starts visit 3 by summarising the homework assignment of the previous session and by asking for the plan and then goes through visit three.

After the 20 minutes are up (10 for each professional) both health care professionals receive feedback one after the other, using the rules for effective feedback and the feedback process used before. For each health care professional invite one observer(s) to give one or 2 positive remarks about health care professional 1, and 1 or 2 points for improvement. Then give your own additional feedback. Then the same process is followed for participant 2. Each participant gets 10 minutes of feedback.

After 30 minutes one of the 2 health care professionals who has role-played as health-care professional is invited to role play the patient during the next round for the next pair of participants practicing their role as health-care professionals, and the same process as in round 1 is followed for 30 minutes. After this round this process is repeated once again. In the end all 6 participants will have had their turn in role playing as health care professional during 1 visit of BPS (2 or 3) and have given and received feedback.

Three participants will have played the patient as well.

First round 30 minutes: Role play 20 min + FB 10 min

HP 1 = role play visit 2

HP 2 = role play visit 3

HP 3 = patient 1

HP 4 = observer + feedback HP 1

HP 5 = observer + feedback HP 2

HP 6 = time management

Second round 30 minutes: Role play 20 min + FB 10 min

HP 3 = role play visit 2

HP 4 = role play visit 3

HP 5 = patient 2

HP 6 = observer + feedback HP 3

HP 1 = observer + feedback HP 4

HP 2 = time management

Third round 30 minutes: Role play 20 min + FB 10 min

HP 5 = role play visit 2

HP 6 = role play visit 3

HP 1 = patient 2

HP 2 = observer + feedback HP 5

HP 3 = observer + feedback HP 6

HP 4 = time management

Other alternatives

There are a number other alternatives to conduct this session, for example having one or more extra trainers/supervisors in for this session or videotaping consultations and spreading them out over a longer time or more sessions etc. etc.

How to conduct this session will need attention before the training starts because the objective - all participants practising a visit of BPS and receiving personal feedback – needs to be met, and the length of the training depends on how this session is conducted.

Session 7 GENERALISED ANXIETY AND AVOIDANT BEHAVIOUR

Alternative way of conducting session 7.

After the Icebreaker trainers should decide what will work best for that particular group of participants. There is a lot of role-play during the Problem Solving sessions. Sometimes it is better to conduct sessions 7 (and 8) as interactive plenaries instead of practicing in role-plays again.

In this way the participants will still be actively involved but without having to role-play again. This can be achieved by asking the participants how they would 'treat' patients with generalised anxiety before giving the presentation about anxiety.

List and discuss the first few suggestions and encourage the whole group to come up with alternatives.

After having discussed their ideas show the presentation 'Explaining about anxiety' to highlight suggestions which have been made and to fill in the gaps. A total of about 35 minutes is available for their ideas followed by the trainer's explanation.

Do the same with avoidant behaviour. Use visual aid 21 the case vignette of Helga and ask the participants how they would treat her. Discuss and list ideas. Bring everything together adding your explanation about simple exposure and response prevention, basing input on background notes of session 7 and visual aid 20. This part also takes up about 35 minutes.

This leaves 5 minutes for final questions about these subjects.

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