GUIDED SELF HELP IN MENTAL HEALTH

An application of LI (Low Intensity) or Brief CBT (Cognitive Behaviour Therapy)

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PART 1. Background

Introduction

8 years ago the ESEMED (European Study on the Epidemiology of Mental Disorders) showed that 7% of the population in Europe suffered from serious mental disorders (Alonso et al, 2006).
The concept "serious" in this study was defined as:

- the manifestations of the problems / the symptoms were covered by a DSM (Diagnostic and Statistiscal Manual) classification
- the problem lasted for more than six months
- the problem reduced normal functioning in society
- patients expressed their desire for professional help

This percentage proved to be quite stable in the different European countries. In the US similar figures were found (Druss, et al. 2007)

Besides the percentage of people suffering from mental problems, the study also indicated that less than 50 % of this group of patients obtained professional mental help. This did not only refer to personal suffering and substandard functioning. It also had an impact on personal relationships of those suffering. As a consequence of reduced functioning, it also caused a huge economic loss. In a small country like The Netherlands, the economic loss due to reduced functioning of people with moderate common mental health problems has been estimated at more than 15 billion € each year (Cuijpers, 2012).

This negative situation / lack of treatment stems from:

- The unbalance between demand and supply in mental health. This causes long waiting lists which is very discouraging for most patients.
- (If not paid by insurance companies) people cannot afford psychotherapy / psychological costs.
- Generally speaking, the image of mental help and its suppliers is not positive ("they follow their own agenda, they don't listen").
- Different from controlled studies, the outcome of psychotherapy / psychological help in routine practice is poor and the drop out figure is high (Lambert & Ogles, 2004).
- Despite growing evidence about the effective and non effective psychotherapy ingredients, the majority of psychotherapies are not evidence based (Waller, 201...)
- Traditional psychotherapy requires many sessions. This means a large investment in time and in money.

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Therefore, much more has to be done to improve this negative situation. A lot can be done but this will take time. For example, mental help image needs to be improved. It also requires a fundamental change in the attitude and methodology applied by professionals.
In the UK, Low Intensity CBT is developed as a means to improve access to psychological therapies and to shift the attitude of mental health professionals from a static and "sitting on the fence" approach to a more dynamic one that helps create hope and prospective, coaching and stimulating the active involvement of the patient in the treatment.

Low Intensity CBT

LI CBT is a concept developed in the UK (Bennett-Levy et.al, 2010) to become an alternative method to the traditional one-to-one therapy in the treatment of common mental health problems. It aims to reach many more people as well as to prevent waiting lists. The general focus is on the delivery of therapy based on self-help, by means of brief, cost effective therapy combined with activities that prevent the onset of mental health problems. Besides short forms of CBT, LI CBT covers a wide range of care delivery, including group work, phone, sms and email contact but also newsletters, computer aided programs, brief face to face therapy, brief advice clinics, walk-in clinics and educational workshops.

This book describes the development of a specific way of delivering LI CBT in a rural area in the Netherlands. This method started back in 2002. Before that, like in most places in the world, mental help was being delivered at psychiatric centres. Patients often had to cover long distances and patients were not very familiar with mental health institutions. This resulted in a high threshold. Local GPs (General Practicioners) often complained that, though they daily met in their offices people with psychiatric / common mental health problems, in the majority of cases they failed referring those people for treatment. The reasons they gave were aforementioned: long distances (literally and figurative), stigma and bad image of mental help institutions.
In 2002, in response to the demands of the GPs, our mental health institution changed its policy: "*If patients cannot come to us, we will then have to go to them"*. This became our slogan. Mental health professionals, formerly doing their job in centralised institutions, started to do their work in the office of local GPs at schools or community centres. The instruction for the professional was: work without a waiting list, do screenings / assessment of patients referred to you by the GP or the paediatrics expert Try to make a quick but realistic concept of the problem / complaints the patient can understand and that are specific enough to start a treatment. Give the patient advice about how he or she can carry out treatment on his/her own as much as possible with the support of the therapist as a coach in the background. (Also to prevent waiting lists) If the therapist was convinced that the problem was too complex for a simple supportive therapy, then he should refer the patient to the specialised (second line) centre and facilitate that step as much as possible.

From the start, this methodology was a success. GPs as well as patients were satisfied with the service and the quality (Merks, 2004, 2010). The amount of people referred doubled (and kept doubled over time). This was the other side of the coin because we had to deliver treatment to twice as many patients as before on the same budget.
Based on scientific research concerning therapy effectiveness, we focussed on several non-specific components to increase the self-reliance in fewer sessions and improve the patients

coping repertoire. In addition, a new method named “Interapy” was tested. It was a method to deliver online treatment.

Interapy

“Beating the Blues” and “Fear Fighter” (Marks, 2009) are examples of successful computer assisted CBT. There is growing evidence that computer assisted psychotherapy is effective and efficient (Barak et al, 2008. Spek et al, 2007).
In the Netherlands, Interapy is a fully Web delivered CBT protocol addressing most of the common mental health problems. There is no face to face contact between the patient and the therapist. Although the therapist and patient never meet, they are in some way in contact with each other. The treatment starts with a brief phone interview. The patient and therapist meet, discuss and talk about how to proceed with treatment and how often they will get in touch by email. Then, the therapist coaches the patient, reacts on the homework the patient does and gives instructions and support. At the beginning the therapist gives the patient some personal information about him/herself (name, age, gender, etc,).
Interapy is a stepwise executed CBT protocol. There are different protocols targeting different complaints / symptoms. Some of them are panic disorders, mood disorders, post traumatic stress disorders, phobia, obesity, etc.
In the majority of cases, patients are referred by GPs or by teams from mental health institutions. It is also possible that a patient enters Interapy simply by logging on the Interapy Website. (Interapy is an authorised health care organisation in the Netherlands).
Treatment starts immediately. The first thing the patient has to do is to fill in some questionnaires. Those questionnaires give the therapist an idea of the type of symptoms the patient suffers from and the severity. The therapist reacts on the outcome within 48 hours and recommends the best treatment plan / Interapy protocol and outlines the first steps. This is mainly a recommendation to write about the complaints / symptoms (the onset date, provoking circumstances, consequences on daily functioning, ideas about the cause of the onset, etc).
The protocol can have 12 to 18 steps depending on the type of complaint. All steps contain CBT elements. It is possible to follow more than one step a week.
There is growing evidence supporting the effectiveness of Interapy (Lange).

Unexpectedly, the number of patients that started Interapy was low (5000 in 10 years in the whole country). In general, patients who did finish Interapy were satisfied about the results though some needed more sessions and face to face therapy.

We can only guess the reasons for this lack of use, possibly due to ignorance, patients’ discomfort or hesitation as well as referrers. Cavanagh (2010) outlines the factors that have to be taken in account when it comes to improvement of adherence and implementation of computer assisted therapy.

In addition to Interapy, a brief CBT protocol has been developed. This protocol is described in the following sections “Brief CBT protocol: an overview” describes how the protocol was designed, the basic concepts and its implementation. Part 2 includes the guidelines for the

therapist. Part 3 is the English version of the manual for the patient. This is the booklet the patient uses during treatment. This part will be translated into different languages.

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Brief CBT protocol: an outline

General Standpoint

Scientific research shows that effective and efficient therapy is always based on the next elements: agreement between therapist and patient about the nature of the problem and the targets and the steps to follow to solve the problem. These elements became the core of a protocol in 5 steps:

1. Preparation
2. Conjoint problem definition
3. Targets and steps
4. Behaviour change
5. Completion of treatment and relapse prevention

The steps are also described as chapters in a manual / booklet the patient can use during treatment. The manual describes in a simple way the psychological problems, cure and coping style. The manual follows the protocol steps. Patients are advised to read the relevant texts in advance and also after every session. The manual also includes exercises the patient can do in-between sessions on the basis of what has been described or discussed.

The patient can also do all the treatment alone with the help of the manual. On the basis of our experience and for the majority of patients, 2 to 6 sessions are needed for the patient and therapist to co-create the problem definition, the rationale, the targets and the treatment plan. The therapist's role is that of a coach, no more involvement is usually needed.

Target group

The brief CBT protocol is trans-diagnostic. It can be used to help patients solve problems (complaints, symptoms) of all kinds. The main focus is not on the symptoms, but on the (failing) coping repertoire. The latter is considered to be the core of the problem.

The conditions benefiting from the protocol are:

- Ability to consider his/her own position in the coming into being of the problem / complaint. This means that there must be ability and motivation to explore (in cooperation with the therapist) the behaviour (coping style, habits, cognitions) that could be responsible for the onset of the problem.
- At least, some motivation to work in order to change the behaviour that is thought to be responsible for the problem.
- Social conditions which are not too bad for the patient to reflect upon his/her behaviour.

Measurement

Measurement with the OQ-45 (Outcome Questionnaire) indicates that patients with a T – score below 90 (220 on the SCL-90 (symptom check list)), in general, have enough psychological and social capacity at their disposal to benefit from brief CBT if this protocol is applied.

As there is a strong accent on the coping repertoire of the patient, it is recommended to use also a questionnaire that portrays the coping repertoire in terms of strengths and weaknesses, such as tendency to avoiding, impulsivity, self-directedness, etc.

It goes without saying that there are different questionnaires in different countries.

The steps

Step1. Preparation

Once the patient has accepted to enrol in the programme, he/she is asked to fill in the OQ-45 or the SCL-90 (*Measurement 1*). The patient is asked to read some texts explaining how psychological problems should be understood and can be cured. As a preliminary exercise (guided by an outline), he/she should reflect upon the quality of some of his/her life domains (health, relationships, economics, neighbourhood, work. See table 1 and 2 in the patient's manual).

Step 2. Conjoint problem definition

Step 2 aims to help the patient restore the overview over his/her situation and his/her coping repertoire (by breaking the problem down into manageable bits). With the support of an outline (see below) the patient is helped to differentiate the problem in 3 main aspects: the manifest symptoms (S), the provoking circumstances or life events responsible for the problem (L) and the coping skills (C) (see table 1 below). To portray the coping repertoire, the patient is asked to work out an outline in which different ways of reacting to situations are represented on a continuum (table 2 below). For example: selfish versus altruist, individualist versus social animal, leader versus follower. This is used (besides the coping questionnaire) as a guided exploration about one's coping strategies, the weaknesses and the strengths.

After portraying these aspects, both patient and therapist discuss how these bits are interconnected. Namely, a hypothesis can be constructed to explain that the combination of life events and failing coping style is responsible for the coming into being of the problems. This is expressed by the **formula: S = L x C,** which is the basis of the diagnosis.

Step 3.Targets and pathway

Based on this formula, targets and pathways to reach the target are jointly defined. This is the starting point of the treatment plan. This is when the therapist and the patient agreed on a potential diagnosis.

Based on the idea that the coping style (detected lack of some skills) is the main element of the problem, the focus of treatment is the development or improvement of coping skills. This lack of skills is defined in terms of habits. In the second stage of the treatment, the patient is stimulated to improve his/her skills repertoire by means of social learning techniques, behavioural experiments and cognitive strategies.

*Measurement 2.*At the end of step 3, the patient is asked to fill in again the OQ-45 or SCL-90. This helps him have an idea on the improvement (or lack of improvement) reached and what we can learn from this.

Step 4.Behavioural change

The patient is helped to improve his / her coping skills by using techniques from the social learning theory combined with behavioural experiments. Stress reducing techniques are used to help the patient gain control over the manifestation of his / her problems. Social learning can also be helpful to translate inadequate coping style in terms of cognitions / thinking failures. Typical thinking patterns are investigated and the patient is stimulated to turn inadequate ways of "thinking" into more adequate ones.

Measurement 3. Before the last session, the patient is asked to fill in again the OQ-45 or the SCL-90. The results are discussed in the last session during which the patient is told how to continue improving his/her skills and what to do when there is a threat of relapse.

Step 5. *Completion of treatment and relapse prevention*
Improvements reached are outlined as well as patterns to continue making headway and how to recognise and cope with possible pitfalls.

Table1 (supporting tool for steps 1, 2 and 3)

S: symptoms	What symptoms is one suffering from?
L: life events	Which stressful events could trigger symptomatic functioning?
C: coping skills	What are the patient's coping skills / habits (adequate and inadequate)?

Table2 (supporting tool for step 4)

Far too little	Too little	Skills in balance	Too much	Far too much

Evidences
There are two randomised controlled trials (RCTs) supporting the evidence of this protocol. Van Straten et al (2006) showed that the brief CBT protocol was as effective as traditional care and traditional CBT following Beck's protocol (Beck et al, 1979) in the treatment of patients with anxiety and / or mood disorders. Effectiveness was expressed as the percentage of patients that, at completion of treatment, had no more symptoms according to the results of validated questionnaires. This percentage was the same for every condition: 53. The average amount of sessions needed to reach this result was different: 12 sessions for traditional care, 10 for traditional CBT and 8 for Brief CBT. Follow up (18 – 24 months after

completion of treatment) showed that brief CBT patients had a lower relapse percentage than traditional CBT patients and a much lower one than traditional care.
Van Orden et al (2009) compared 165 patients with common mental health problems. Half of this group got treatment (traditional care) in a traditional (second line) mental health centre. The other half was treated with brief CBT at the GP's local office. General results were the same as the ones highlighted in Van Straten (2006) Research. Equal results were obtained for both conditions. But in the case of the brief CBT condition, the results were reached in 25% less time than in the traditional one.

The Van Straten Research showed that most common psychological problems can be conceptualised in a simple and transparent way, namely, as a combination of bad luck (life events and losses) and failing coping. The treatment is as simple as the concept: establishing the clear relationship between life events, coping style and symptoms and helping the patient improve his/her coping repertoire.
The communication technique is also different from the traditional method: explanation, psycho-education and social learning. Much more than in traditional psychotherapy or traditional CBT, in this case the therapist submits his/her hypothesis about the connection between failing coping repertoire, life events and complaints to the patient. The aspect of "failing" is preferably expressed in terms such as a quality that has been overshoot in a "pitfall" or "a quality that is too much of a good thing". The patient is invited to reflect and to react on hypothesis like this. This guides analysis and increases self-motivation.

The patient's manual is separately edited in different languages. It follows the five steps of the protocol. The instructions for the therapist are described below (page 18).
The next section includes two study cases (one regular referral and one semi crisis case) illustrating how the brief CBT protocol can be put into practice.

Mr. A's Study Case

Mr A. is referred by his GP. He visits the GP because of complaints such as fatigue and sleeping problems. His asks for a sleeping pill. The GP recommends CBT as a better option.

Background:
Mr A. is 35 years old. He is married (12 years). They had their first child four months ago: a daughter. The onset of his sleeping problem seems to be a quarrel with his parents. Although his parents did not recommend it, the couple bought a house. His parents were upset and broke off all contact. Though their environment (his sister, friends, his wife's parents, colleagues) supported them in their purchase and told them that they did not approve the reaction of his parents, he could not stop thinking about this "loss". He felt this loss even deeper because one of his weekly leisure activities was the weekly ride on motor cycle in the countryside with his father.
Other recent life events were: four months ago his daughter was born. She is a healthy little girl. They both were very happy with her, he said, but sometimes he questioned his skills and competences as a father.
Talking about this subject, he recognised that "worrying" was an attitude more proper to him than "being carefree" / "being self-confident".

He has been working as a construction worker for 15 years. He has always worked for the same company. He loved his job and felt safe in the working environment. Now that he had bought a house that needed some reconstruction, it was hard after daily work to do extra work in the evenings and during the weekends. When we discussed this issue, he also immediately added that he hoped that the therapist did not think he was a complainer.
His wife was working part time at a fashion shop as a shop assistant.
They both came from a working class background. They had married 12 years ago and waited long to have their first kid because he questioned his skills and competences as a father. In fact, it was his wife's wish to have a kid. He was not so willing.

Development and education: rather normal. He saw his social role more as a follower than as a leader. During primary school he got assertiveness training after a period of being harassed at school. He could not remember many details about that period.

Step 2. Overview and connections
During the first appointment, Mr. A read the text belonging to step 1 from the patient's manual. He also filled in the questionnaires and table 1 where he highlighted the type of complaints he was suffering from (table 1 in the patient's manual).
The OQ-45 showed that there was a T- score of 69. This indicates mild to moderate psychological dysfunctioning. There was a high score on interpersonal relationships. This could be an indication of problems or conflicts with people close by like his parents.
There was also an indication for impulsiveness. When we talked about this, he did not recognise it as a problem but rather the opposite, namely, lack of assertiveness.
The coping questionnaire indicated under-developed coping skills on expression of emotions and active handling, over-developed coping style on worrying / doom mongering.
In the table about complaints in the patient's manual (table 1) he highlighted three problems: tiredness, a conflict with his parents and hopelessness.

After talking about what he had read and what he had done for preparation, we discussed the outcome of the questionnaires. We talked about the onset of the problem and how it could be understood on the basis of his way of functioning (coping repertoire). It became clear that worrying and "playing a waiting game" were attitudes strongly present in his repertoire.
We discussed if worrying could be the basis of a sleeping problem and subsequently of fatigue.
In the S L C – outline (see tables 3, 4, 5 and 6 in the patient's manual) we first outlined the remarks of the three elements. See table 3 below.

Table 3. Mr. A's S, C, L outline

S (symptoms)	Sleeping problem, fatigue
L (life events)	Conflict with parents; loss of leisure activities Starting fatherhood New house, working day and night and weekends
C (coping repertoire)	Worrying Concerned about other people's judgments A tendency to isolate himself

	Sitting on a fence

Once the problem is divided into manageable bits it becomes possible to start formulating hypothesis about how the elements of the scheme influence each other. This is an important task for the therapist because most people are not used to establishing such connections. The advice is to keep it as simple as possible. Use comparisons or metaphors to establish a link between the elements. It can be helpful for the patient to understand how the elements are interconnected. For example, under extreme conditions (not enough light, no water) even the strongest flowers have difficulties to survive.
It is important that the comparison shows the scope to which the elements are in or out of balance with each other. The more they are out of balance, the greater the chance of symptoms.

Back to Mr. A's case: with his doubtful attitude and his tendency to isolate himself, he could manage his life well as long as life events were normal, predictable and supportive. As soon as life events became difficult and support ceased, his coping failed. The result of it all was stress, restlessness, distress and dysfunctioning which then gave way to his symptoms.
The relationship between the elements is expressed by **the formula: S = L x C.**
Once the relationship between life events, failing coping and symptoms is clear for the patient, targets can be defined.
The most important targets are in the coping area, though it is also important to consider which targets should also be pursued in the area of symptoms or life events.
Targets on coping style are also important because improved coping is an important factor to prevent relapse in the future.

The next step (step 4 in the manual) allows us to identify the actual coping style or coping repertoire of the patient. This can be done by reproducing the patient's coping style as a position on a scale that goes from one extreme expression of an activity to the other opposite extreme expression. For example, absolute selfish versus absolute altruist, shy versus extrovert, etc...
In the case of Mr. A. his interactive behaviour can be situated on a line, starting on the one hand in the position of isolation (one extreme) and finishing on the other hand (extreme) in the position of a permanent need for social interaction. This is the graphic reproduction on a scale:

Abs Isolation----------(position Mr A).----------(M)----------permanent social need..

Another example of his coping repertoire could be expressed on the scale between: always worrying about…. versus always acting carefree. Graphic reproduction:

Abs. worrying---------(position Mr. A.)----------(M)----------abs carefree.

Techniques from the Social Learning Theory

Once the position on the scale is clear, the therapist and the patient can discuss and exchange opinions on this position, its consequences and alternatives. This can be done from

different points of view. For example: is this his everyday position or are there any exceptions? If there are exceptions to the rule, which ones, when do they occur, under which conditions? If one observes or thinks about the position other people have on the same scale, what are the differences? What is the consequence of that position?
It is easy to ask the patient, as homework for the next stage, to observe his position on the scale. May be he / she can also observe if there are exceptions to the rule and the consequences.
Visualisation and discussion helps the patient become aware of his/her own position, the limits or vulnerabilities and alternatives.
After discussion, the next step aims to consider the alternatives that could help the patient improve his/her coping repertoire and in turn reduce the symptoms.
Improving is discussed and visualised by (stepwise) shifting the current position on the scale to a position closer to the centre (M) of the scale.
Once the patient and the therapist have agreed with this procedure, advancing along the scale is discussed in terms of behavioural change. Which behaviour belongs to the current position? For example, only passive participation in discussions with peers. Which (slightly different) behaviour belongs to or characterises the desired position?
In the case of Mr. A. his current behaviour defined as “too long sitting on a fence” was operationalised in terms such as only / mostly participating in a passive way in social situations. Withdrawing instead of participating or expressing what he desired or thought or wanted. Or when asked to do something extra, always and immediately accepting the task, instead of sometimes reacting in the following way: I would like to…, but at the moment I can’t help you.
The first step in this methodology to change behaviour by means of social learning identifies the people who in their environment comply with the new / desired behaviour, observing how they manage it and the different behaviour resulting from it.
The next step is to choose a situation for the patient to start an experiment to try react from the new position. In the case of Mr.A. an example of new behaviour was defined as asking his sister how she would react to her parents when faced with the same situation and how her reaction would be different from his reaction. Instead of waiting till she gave him some advice, he should take the initiative. When the patient succeeds in changing his behaviour, it is important to discuss success as the consequence of slightly changing / adapting habitual behaviour / patterns of reacting. Give the patient the credit for this and discuss in what other new situation the patient can continue experimenting with alternative behaviours. Don’t hesitate to work this out as detailed as possible for example by role playing during the session.
Besides this, to help him gain more control over his sleeping problem the therapist introduced some relaxation exercises and showed Mr.A. how to practise them to sleep better.
When problems in the area of Symptoms or Life Events are addressed, it is important to tackle them in the context of the formula: C x L = S.

Measurement.
More often than not, these simple guided analysis and social learning exercises contribute to the improvement of the patient’s mental position. It is important to conclude improvement by re- measuring with the help of a questionnaire. If improvement can also include this questionnaire, translate it to improvement in the current coping repertoire. If there seems

to be no improvement, discuss with the patient the potential reasons and what can be done to solve the problem.
In the case of Mr. A. after 2 sessions there was an improvement (though not significant yet) on the OQ-45: from 69 to 59. The coping list showed that he had improved on active behaviour.

Other techniques besides social learning: Quality quadrant and thought control
The patient should learn to become familiar with the concept of "the scale". In the patient's manual, extra exercises (tables 8 and 9) are constructed to stimulate thinking about his /her position from the perspective of scales and how this can be used for the gradual onset of behavioural change.
If social learning based techniques work, one option is to cease treatment with the therapist. If so, the patient is encouraged to keep using the guidelines and do weekly exercises alone. Special attention (step 5) should be paid to relapse prevention (namely, how to use the manual again if new problems occur in the future).

When the patient and the therapist jointly decide that it would be better to continue with the therapy, the next step is thought control.
In the case of Mr. A. the second measurement showed a reduction on symptomatic behaviour, though it was not significant (less than 12 points). In this case we used the Quality Quadrant (Ofman, 2006).It is a well defined outline (see tables 4 and 5) that helps someone become better aware of the different qualities or remarks that can be applied to the same behaviour.

Table 4. Quality Quadrant

Quality	Pitfall
Allergy	Challenge

In the case of Mr. A. "isolating oneself" and "doom mongering" could be referred as follows in the quality quadrant:

Table 5. Mr.A's Quality Quadrant

Quality Autonomy Careful Behaviour	*Pitfall* Isolation Doom mongering
Allergy	*Challenge*

Too dependent on people Recklessness	Socialise without losing autonomy Give the benefit of the doubt

In general terms, the pitfall is the most striking element at the moment of referral. It causes distress and dysfunctioning.
Once the pitfall is worked out as just one position (between others) on a scale, it is possible to search for a variation in the behavioural repertoire of the patient. It often becomes clear that the current behaviour can be defined as an exaggeration of former quality behaviour which under the pressure of provoking circumstances / life events has become more striking and evident.
People with, for example, a highly developed sense of responsibility can, under pressure, blow up. Excess of responsibility then comes to the surface and can be expressed as panic, concern, control in excess or obsession. This could result in sleeping problems, fatigue, panic disorders or conflicts with other people.

As a matter of fact, people with a sense of responsibility that is above average are allergic to people whose sense of responsibility is underdeveloped, expressed as a negligence, irresponsibility or selfishness.
When the patient becomes aware that more variation in his behaviour repertoire is needed, it is helpful to observe people who behave just slightly differently (in this case a bit more moderate with regard to responsibility). On the other side one can also learn from observing and reflecting upon the behaviour of people who behave very differently (in this case irresponsible).
It can be one of the challenges to consider if one can learn something from people whose behaviour is situated in the "allergic quadrangle" of the quality quadrant.
In the case of Mr. A., the quality quadrant was as useful as the scale outline to identify examples (people with a slightly different behaviour than his own) he could learn from to modify his behaviour and get closer to a balance position.

Thought control
The scale is a tool to identify the strengths and the weaknesses of the patient's coping repertoire. In the format of a holistic theory (S = L x C), it shows the relationship between failing coping, provoking life events and symptoms.
The scale reflects the patient's position in terms of Social Learning techniques or techniques related to the Quality Quadrant. It is also possible to match a specific position on the scale with habitual ways the patient "thinks" about his own possibilities, his vulnerabilities and the quality of the world around him/her (supportive, hostile, reliable or unreliable).
In the case of Mr A., it is always interesting, by means of a guided analysis, to investigate how his position on the scale can be understood and translated into habitual ways of "thinking". For example, what is the basis of his tendency to withdraw or isolate himself? Is it the best way he has found to cope with "the world" / "the majority of people" because too often they have proven to be unreliable? Or, does it have a narcissistic ground? Is it the result of a lack of trust in his possibilities?
Guided analysis (if possible supported by questionnaires) helps the patient better understand his/her basic assumptions / cognitions about one self and about the quality of

the surrounding world. It then becomes possible, with the help of outlines like Beck (1979) (see table 17 in the patient's manual) or Ellis ( ) to investigate one's basic assumptions and correct them if necessary.

Measurement

From the point of view of guided analysis and self help, it is important to use milestones. Milestones provide reliable information on the state of affairs and the distance between the current and the desired positions.

In psychological help, it is also the reference point to translate information in terms of social learning development and control improvement about one's way of conceptualising / thinking.

The third measurement (after 4 sessions in week 11) with Mr A. showed that in comparison with the first measurement there had been a significant improvement. Improvement was also significant in terms of OQ-45 and the coping questionnaire.

The problem with his parents still existed. Attempts to discuss the new situation did not work. This was still a painful event for him. However, now it did not prevent him from "normal" functioning in other life domains. He succeeded better in using the support in his environment. This gave him relief. He could also take better distance from his parents' position. In terms of Jim White (2010) he managed, better than before, "to keep the head above the water". With the support of the exercises, his trust in his capacities as a father, husband and employee improved. So did his trust in his peers.

Mr. B's Study Case

Mr B. is a 47 year old accountant. He is married. They have two children: a son (22 years old) who lives in another city where he is studying Economics, and a daughter (18 years old). Two months ago the daughter left moved out for the same reason as her brother: to study. Though the kids are doing fine, last year many problems came up. Mr B. suffers from arthritis. This prevents him from playing football, his hobby and his main leisure activity. His wife suffers from Crohn's disease. She soon gets exhausted. Last year she needed surgery twice. A week ago his 15 year old dog died.

Mr B.'s GP asks for urgent help because during consultation hours, that morning, Mr B. told him that sometimes he felt so desperate that he was afraid to lose control over himself and commit suicide.

The GP has had Mr B. as his patient for many years. He thinks the current situation is very serious. He immediately prescribes an anti depressant and asks for psychological support.

On the day of the first appointment, the total score on the OQ-45 was 107 which is an indication for serious mental dysfunctioning. There was also an indication for risk on suicide. The coping questionnaire showed some striking scores: high on "avoiding", very high on "doom mongering" and low on "social support".

The first session was dedicated to create overview and to break the problem down into manageable bits with the help of the S, L, C outline. As a matter of fact, attention was given to signals of despair and – in this case- the risk on suicide. This is done by means of discussion and detailed analysis of the risks, the amount of self control and the possibilities to use support. The results of the session are shown below in table 6.

Table 6. Mr B's S, L, C outline at the beginning of therapy

	Description	Targets	Action
Symptoms	Despair/ Hopelessness Loneliness Getting exhausted Worrying	Organising peer/ partner's support Inventory of relaxation exercises	Discussion (therapist and partner)
Life events	Empty nest Good marriage, though vulnerable (partner's disease) Good relationship with children Successful in his job but too repetitive Dog died recently		
Coping style	Persistent / go-getter Lone wolf Perfectionist Worrier	Analysis in terms of qualities and pitfalls	Reading appropriate chapters in manual + doing home work

The creation of the S, L, C outline is supported by information gathered during the interview, the reaction of the patient on information and hypotheses presented to the patient by the therapist, the information from the specialist who referred the patient and the information from the questionnaires.
Dialogue and co-creating / shared decision making is an important tool (Van Audenhove, 1995. Norcross, 2002).
Mr B. said that regaining overview gave him relief. This was supported by the promise of the therapist to contact Mr B's wife to explain and discuss what was needed for the next days (support, control and, if needed, immediate action).
The whole session was dedicated to the creation of overview and discussing what had to be done urgently (for example, informing his wife and discussing suicide preventing activities).
The second appointment would take place three days later. Mr B. promised that in between he would read the chapters of the manual, do the exercises and discuss the situation and the information from the manual with his wife.

For the second session he comes with his wife, following the therapist's desires. Though his wife's input can be summarized as concerned and critical, the atmosphere in the session is less tense than it was in the first session. For both, with the help of the S, L, C –outline, it became clear that Mr B. was an overburdening victim because many life events had sprung up. Also, for both it was clear that his unilateral coping style (go-getting, acting like a lone-wolf) could also be an important factor causing his symptoms.
This brought us to the Quality Quadrant. Both were asked to complete the Quality Quadrant of Mr B. and to think about how he could prevent that good qualities, like "carrying on' and "never annoying someone else", could turn into pitfalls under the pressure of life events.

It was remarkable to compare both Quality Quadrants. In Mr. B's reproduction the focus was on the positive side of those remarks: never give up means that you are reliable and people can trust you. While Mrs. B's reproduction focused more on elements like being vulnerable, exhausting yourself, a risk to get low.

In the discussion both reproductions were tackled together so that both qualitative aspects of the remarks / coping repertoire / habits as well as the pitfalls became visible.
The next Quality Quadrant was reproduced conjointly (table 7):

Table 7. Mr. B's Quality Quadrant

Quality: Vitality / go getter Purposeful Reliable Autonomous	*Pitfall:* Exhausting oneself Giving others the idea of being useless Lone-wolf
Allergy: Dependent people Being a nuisance to others People who first ask and then think	*Challenge:* A balance between being active and relaxed Learning from other people

This reproduction helped us – in terms of social learning – to design a balance that could function as the starting point of observations, reflection and exercises / behaviour experiments:

Table 8. Mr. B's scales

An absolute go-getter----------Easily gives up
An absolute lone wolf----------Dependent.

For both balances Mr B's position was clearly too much on the left side.

An absolute go-getter----------X----------Easily gives up
An absolute lone wolf----------X----------Dependent.

The first thing we agreed to do was that Mr B. should make observations in the coming days. One thing he should observe was the percentage of his own behaviour that could be described as a pitfall (go-getting, never taking a rest, acting in isolation). The other thing he should observe was the extent to which the behaviour / reaction of people he was familiar with was remarked by absolute autonomy, cooperation, asking for assistance or dependency.
Our aim for this exercise is, on the one hand, that the patient becomes more aware of his stereotyped and extreme coping pattern and, on the other hand, he starts to realize that an alternative behaviour is possible.

Measurement

As usual, after some sessions, especially when it becomes clear that a conjoint problem definition arises, the patient is asked to fill in again the OQ 45.

After two sessions Mr B's score came down from 107 to 85. Still indicating a high level of dysfunctioning, but, significantly reduced if compared to the situation at the beginning of treatment.

It is important to check the meaning of this change. Mr B reported that he was feeling a little less tense than before for several reasons: the fact that he realised how concerned other people (his wife, his GP, his children) were about his situation convinced him that there were more important things in life than working. Open discussion about his position in life and the possibilities of alternatives gave him some ray of hope.

Patient and therapist concluded that they were on the right path. They agreed to continue working by observing and using models to try to turn habitual (non adaptive) behaviour gradually into a more moderate / adaptive position. They also agreed that homework should be an important ingredient and his wife's support would be very welcome. The therapist should behave more and more as a coach ready to help only when the patient or his wife thought it was necessary.

The basis for the homework was the scale, co-created during former sessions and based on the characteristics made visible with the help of the Quality Quadrant outline.

From the moment the patient becomes aware that his habitual pattern of reacting or coping (the "C" in the S = L x C outline) deviates too much from average and that this way of reacting (in connection with too much burden) is responsible for the coming into being of the symptoms, the diagnosis and the treatment plan are made. This is the starting point for behaviour change. There are different ways to make this start:

- *Observing one's own pattern of reacting and comparing it with other people's pattern.*

  This simple technique helps the patient put his own patterns in perspective. Observing and comparing helped Mr B. understand that his way of reacting was quite unilateral and more stereotyped than the habitual behaviour of other people in his environment.

- *Observing exceptions in one's own behaviour patterns*

  Often it becomes clear that if one observes carefully one's behaviour / reactions, there are more exceptions to the rule than expected. This is a hopeful basis to start developing new behaviour patterns. Stimulating the patient to become aware of exceptions in his habitual patterns increases the possibility of the patient's understanding that other patterns are possible.

- *Scaling / successive approximation.*

  When the habitual position is defined and compared with other people's positions – or one's own position in exceptional situations – the patient realizes it is possible to react in different ways. This is a good starting point for a course of study in which, step by step, habitual (non adaptive) patterns of reacting shift to more adaptive ones.

- *Exposure / experimenting with alternative behaviour.*

  Once the patient and the therapist have agreed on the desirable behaviour and the steps to make between the current behaviour and the desired one, they can decide the type of new behaviour that will be tried out in a real situation. Once they have agreed about trying out new behaviour, it is important to describe in detail the situation in which the patient will try out his new behaviour. Practising or rehearsing by role playing at the

therapist's office is a good tool to help the patient become aware of the pitfalls and the possible results, and to become familiar with the desired behaviour.

Two aspects should be highlighted. On the one hand the change has to be significant, but small. This means it is better a small successful step than too big steps and then one of them fails. On the other hand, the patient has to be aware that changing one's own reactions will always provoke a reaction. It is important that the patient notices this reaction and is able to understand that other people sometimes react with astonishment when one reacts differently.

- *Cognitive schemes*

Making habitual patterns of behaviour visible is a good tool to help people realise that cognitions, in general, are the basis of their reaction patterns. This is often defined as the way someone has learnt to consider his / her position in life. This can be expressed as follows: Do you consider yourself more vulnerable than strong? Or more beloved than neglected? etc... The same applies to the way one considers "the attitude of the world towards him / her". Is the world safe or unsafe? Kind and helpful or unkind and hostile?

When these aspects were discussed with Mr B. he identified an important cognitive element that was fundamental for his way of considering his position in life: "Only if I am perfect, will I be treated with respect".

Once such cognitions are discovered and it is clear that such hypothesis lead to one's way of reacting, they can again be made visible by placing them on a scale. Once this is agreed, the same methods described before can be used to manage this information (observations, Quality Quadrant, social learning, exposure).

Table 8 in the patient's manual is a useful tool to discover which (non adaptive) cognitions will guide the patients' behaviour (see appendix.).

- *Position*

Each position on the scale triggers a counter reaction from other people. Generally speaking, extreme positions provoke extreme reactions. Leary's outline (Leary, 1957) helps us make interactive patterns visible for the patient. For example, Mr B.'s extreme go-getting / acting as a lone wolf could provoke in other people a feeling of being useless or not having to assume responsibility because Mr B will always be the one solving the problems.

It is often the case that more than one dimension or position on the scale proves to be relevant to understand the patient`s habitual reaction patterns. For example, an extreme position between "perfectionism" and "slob" sometimes are the superficial layers of other dimensions, for example "fear of failure" or "caring about other people's (negative) judgement". The dimensions on table 8 in the patient's manual (see appendix) is a useful tool to discover which dimensions or scales are important bases shaping the patient's coping style.

In the course of six months, therapist and patient met face to face four more times and they also held two sessions over the phone. At completion, Mr B still behaved more on the single side and on the "hard working or go-getting side" of the dimension. However, he was much more aware of his qualities and the associated pitfalls which resulted in a more moderate behaviour. As a consequence his, symptoms were reduced.

Summary

This methodology is based on the notion that most of our patients can take the lead and do some of the therapy alone (if possible supported by a buddy in the natural environment like a partner or a friend).

There are currently two controlled studies (Van Straten et al, 2006; Van Orden, et al, 2009) that show that the aforementioned way of delivering psychotherapy provides equal results (percentage of patients whose symptoms at completion disappeared or reduced significantly) as traditional CGT or Care as Usual. (In each condition this percentage was a slightly above 50, which is a good result taking NICE criteria as a reference).
Studies have also shown that the amount of sessions needed to reach this result was significantly lower with the guided self help method. The same positive results counts for the relapse percentage 18 months after completion of treatment.

This success, we strongly believe, lies in:

1. Simplicity
   This method corresponds better with the conceptual capacities of the majority of patients than traditional psychotherapy models. This is even enhanced by the use of outlines that are so simple that even the patient can easily understands them and can also explain them to other people.
2. Cooperation
   The treatment is carried out with the support of a manual. A protocol is followed. The guide starts with some information for the patient and with a chart that helps the patient better understand what is causing the symptoms. The S, L, C outline highlights the notion that the conjoint problem definition is not only the definition elaborated by an expert but the definition created in close cooperation between the patient and the therapist. The manual becomes more “my manual” than “a manual”. This increases commitment, self-motivation and self-coping.
3. Natural way of problem solving
   The 5 steps of the protocol (preparation, conjoint problem definition and diagnosis, targets, behaviour change and relapse prevention) correspond with the basic steps to follow when a problem has to be solved, whatever the field or the environment. For example when someone’s car breaks down, the first step is to get informed and make preparations (find a safe spot, stay calm, look for help). The second step is to identify the problem. Then a decision has to be made (what to do and who will do it) to fix the problem. Finally, it would be commonsense to find out the cause of the problem and take preventive measures.
4. Making the problem visible
   The use of outlines getting closer to the conjoint problem definition will increase understanding. They are also a useful tool for in between two sessions. The patient can then continue with the therapy without having to see/speak with the therapist. This saves time and stimulates self-motivation.
5. Variation of techniques (“different roads to reach Rome”)
   Once the problem is made visible, several techniques may be applied depending on the skills and the theoretical background of the therapist. In other words, this protocol is

trans-diagnostic and trans-theoretical, suitable for cognitive, behavioural, family and client-centered therapists, with a variation in techniques according to expertise.

6. Support from the patient's environment

Besides co-creation / shared decision making, self-motivation and stimulation of self-coping are also important targets. When the problem is broken down into manageable bits, made visible by outlines, the patient can explain his/her problem to other people in his/her natural environment and (following the therapist's advice) ask them for support.

7. Different tools

The traditional one-to-one / face to face therapy is mainly based on spoken dialogue. On the contrary, guided self help focuses on empowering the patient to the point that he/she is able to carry out his/her own therapy plan. Open discussion and open dialogue are complemented with other tools such as manuals, email or telephone consultation and e-health tools.

PART 2. Guidelines for the therapist / Guided Self Help

Introduction

This manual includes guidelines for the therapist treating people with common mental health problems and using the self help manual. The patient uses his/her self help manual (in printed version or as a computer supported program on which the patient can log in).

The manual for the patient is divided in 5 chapters. They follow the five basic steps for this treatment methodology.

Contrary to other manuals or guidelines, this guideline integrates didactic principles. Important ingredients are psycho education, guided analysis by means of questionnaires, scales, tables and guided self help. This stimulates the patient to do as much work as possible on his / her own, with the support of the manual and (if possible) with the support of people in the natural environment of the patient.

In fact, with the support of this manual the patient can carry out therapy without the support of a professional therapist. The manual is edited in two versions: printed and online. Whatever the version, the patient chooses between executing the therapy completely on his / her own (with the help of the booklet or online edition) or the traditional one –to - one / face - to - face setting. There is a third possibility which is a combined way: the therapist acts as a coach, explains the steps to be followed by the patient and comes in to provide support if the patient asks for it. Support can be given on demand in different environments: a walk-in clinic, a face-to-face setting, over the telephone or by e-mail.

Experience has shown that the best option is the blended or combined therapy. The therapist acts as a kind of back office or help desk, ready to help if needed.

In the blended therapy, the therapist should take a more active role in the following situations:

1. When the S, L, C outline is confirmed as the basis of the treatment plan. Also when the information retrieved from questionnaires is included in the S, L, C outline.
2. Diagnosis confirmation and design of treatment plan.
3. Post-evaluation of the treatment (once completed)

Therefore, the therapist acts as a coach providing support to design the working framework and clarifying the patient's doubts. The therapist stimulates and motivates the patient.

To profit from this methodology the patient has to meet some criteria in terms of the capacity to cooperate in a project (motivation, capacity to reflect upon one's current standpoint / habits, capacity to tolerate some frustration).

As mentioned before, there are five steps to be followed and summarised in table 9.

Table 9. Guided Self-Help Steps

Step	Content
Introduction and preparation	Information the patient reads before starting the therapy (psycho education and outlines) Questionnaires to support assessment, diagnosis and evaluation

Overview and connections	S L C outline Scales to make "C" visible S = L x C formula (descriptive diagnosis)
Targets	Targets differentiated in the three elements of the S L C outline Agreement on the course of the treatment (one or more pathways)
Behaviour Change	On the basis of one or more scales ("C "): - social learning by observation - social learning by sociograms - quality quadrant - cognitive strategies - interactive strategies
Completion and relapse prevention	Vulnerability (identify potential pitfalls) and prevention methods

During the course of treatment and with the help of questionnaires, the state of affairs and progression and/or failures are measured.

Here follows a description of the steps and the targets for each step, what the patient should do to reach the targets and the potential therapist input.

Step 1: Introduction and preparation

In principle, this step is carried out by the patient without any involvement / support of the therapist.
This step focuses on the background and onset of psychological problems and on what can be done to solve them. (See booklet for the patient pages…).
In this step the patient is asked to fill in some outlines and questionnaires. He then sends them back to the therapist before the first session when treatment is carried out in a blended or in a face-to-face format.

This is the first opportunity (besides the information handed over by the referring person) to formulate hypothesis about the nature of the problem and the patient's strengths and weaknesses. It could also be appropriate to elaborate a differential diagnosis.

Questionnaires
Questionnaires support the good course of the therapy in several ways:
- *Degree of severity and risk factors*

There are useful questionnaires such as the Outcome Questionnaire (OQ-45) (Lambert et al, 1996) and the Symptom Checklist (SCL-90) (Derogatis, 1977) that provides reliable information on the severity of the problem (the OQ-45 also highlights whether or not the patient runs a risk of suicide or has impulsive or addictive problems). Generally speaking, Total Scores at the beginning of therapy higher than 90 (OQ-45) or higher than 220 (SCL-90) indicate that the psychological strengths of the patient at that moment are insufficient to participate in / profit from a therapy that demands some reflection and active participation of the patient. (According to ESEMED, 65 % of the patients suffering from serious mental health problems show a score below 90 on the OQ-45 or 220 on the SCL-90 at the beginning of the treatment).
The same applies for questionnaires that refer to the structure (strengths and weaknesses of the personality of the patient). Such questionnaires, for example the Trait and Character Inventory (CTI) (Cloninger, 1987), indicate the extent to which personality remarks (such as "novelty seeking", "reward dependency", "self-directedness") are present: very low, low, average, high, very high. If more than 3 items of such a questionnaire get a very high or a very low ranking, this indicates that there might be a high level of inflexibility or rigidity in the patient's reaction patterns. In such a case, there is little chance that the patient will benefit from this type of psychotherapy.
In such cases it is advisable to refer the patient to other settings that are better equipped to treat patients with severe mental problems.
- *Input for the diagnosis*

Depending on how they are constructed and validated, questionnaires like the OQ-45, the SCL-90 or the TCI, also indicate what the core elements of the symptoms are (for example mood, anxiety, somatisation, obsessive compulsivity, etc). They also indicate the extent to which co-morbidity has to be taken into account.
- *Progression*

Measuring by means of questionnaires gives the therapist and the patient information on the advances and progress made (or stagnation). Visibility of progress is an excellent tool to motivate the patient (Lambert, 2007). Early conclusion of lack of progress is a

signal of warning for both patient and therapist and they have to look into the situation, investigate the possible reasons and take due action.

Inclusion and exclusion

As mentioned before, not everybody has the skills and competences to benefit from a psychotherapy model that demands active participation. There are important indicators that may help the professional decide whether a patient is "ready" for this kind of therapy: scores, questionnaires, motivation and quality of life (QoL).

Motivation

Prochaska (Prochaska et al, 1992) identifies five motivation stages. Depending on the stage of motivation, different advice from the therapist is expected.

The *pre-contemplative stage* indicates that intrinsic motivation is absent. The only motivation comes from outside ("if I do not stop …. my wife will leave me"). There is no intention to reflect on one's own behaviour or to change. In this stage the best thing the therapist can do is to investigate what can be done to behave differently to avoid a disaster.

The *contemplative stage* indicates that the patient, to a certain extent, accepts that his /her behaviour could change. There is reflection without commitment. In this stage the S, L, C outline can help the patient become more aware about weaknesses and vulnerabilities and how they could be repaired.

Once the *preparation stage* is reached, the patient starts thinking about how to change. It is important, with the help of the S = L x C formula, to help the patient identify specific targets and the pathway to reach them.

In the *action stage,* it is important to encourage the patient and suggest him/her how new behaviour can be integrated in his/her routine.

The final stage is *relapse prevention*. The patient is guided to become aware of his/her pitfalls, the life events triggering pitfalls and what has to be done to prevent relapse if it occurs.

Quality of life (QoL)

Sometimes the problems or setbacks that suddenly happen in someone's life can be so overwhelming that reflection is inhibited. At that moment it is difficult or sometimes impossible for the patient to benefit from regular therapy. It is always important to obtain accurate information about the quality of the problems, setbacks or disasters and how the patient copes with them. This gives the therapist an idea of the weaknesses and the strengths of the patient's coping repertoire. Sometimes those events prevent or deprive someone from reflecting or adaptive reaction. In that case, the best thing the therapist can offer is material, legal or any other kind of support, urgently needed.

Provisional S, L, C outline

Before the first appointment takes place (no matter if this will be face to face, by telephone or by email) the therapist should make a first, provisional S, L, C outline. The material that can be used is the information gathered from the referral, the outlines the patient has already filled in and forwarded and the information from the questionnaires. Such a provisional outline organises knowledge and makes the therapist aware of the missing information to elaborate hypotheses. The provisional outline is described in table 10.

Table10. Provisional S, L, C outline

Item	Information about	To obtain more information about
Symptoms		
Life events		
Coping style		

Step 2: Overview and Connections (conjoint problem definition)

This is the crux of the treatment. This step creates the foundation upon which the treatment is built. The step has to flow into a conjoint / constructed definition of the problem. On the one hand, it will provide the patient with a logical and realistic explanation about the problem, the onset of it and the elementary aspects, in the context of provoking life events or circumstances and the failures in the patient's coping repertoire. And on the other hand, it will give perspective on recovery by means of getting better control over life events and the development of the patient's coping style.

A conjoint theory is a prerequisite to start therapy

The main target is the co-creation of a problem definition. The outline used is the S, L, C. Firstly, the problem is re-structured into manageable bits. Secondly, the formula (S = L x C) that establishes visible and workable connections is worked out. Once the patient and the therapist have agreed on this formula, they can decide on the goals and targets of the therapy.

As mentioned before, from the conceptual background of this concept the main focus will be on factor "C". On the one hand, because this is understood to be the core element of the pathology. On the other hand, because stronger coping repertoire prevents the patient from problematic reacting if life events worsen in the future. But also factors "S" and "L" have to be considered from the perspective of treatment. Often the treatment is carried out as a two tier activity: training to improve the patients coping repertoire and training to help the patient improve control over the symptoms (for example, with relaxation exercises / mindfulness exercises or self-control exercises) and / or over the life events (by learning to make better use of support in the natural environment or helping him/her improve relational functioning).

Aspects of particular interest in this step:

- Make sure that the patient has done his/her homework. (Step 1 in the patient's manual). Pay attention to the way in which the patient has constructed his / her provisional S, L, C outline (tables 4 and 6 in the patient's manual) and what he /she has learnt from that.

Explain the outcome of the questionnaires. Discuss them with the patient and include the information in the S, L, C outline.

Take note: if the patient has not done his/her homework, ask why (motivation, life events, incapacity) and react consistently (explanation, encouragement and/or referral).

- Connect this information with what the patient has already done and help him/her complete the S, L, C outline. Adapt to the level of abstraction the patient uses and to the patient's speed. If digression is too large, try to keep focused, namely, bring subjects back to an item included in the S, L, C outline.
- Pay attention to the balance between main and secondary issues. This can be done by frequent summaries (S = L x C): what has been discussed until then and submit your hypothesis.
- Try to postulate your hypotheses or summaries in the format of a question, for example: "I can imagine that, under such conditions……", or "if I understand well, you usually react in this or that way, I imagine that if you had reacted differently…..what do you think?"
- If possible, discuss the elements of the problem in terms of qualities. This means that rigid coping behaviour can also be seen as an exaggerated expression of (in origin) good behaviour.

- Pay attention to relevant issues included in the patient's manual (page 8, 9 and 10 in the patient's manual) and the explanations about those items. Ask the patient to study them carefully and to do the matching tasks (p.10 and 11). Decide conjointly how they will be discussed (telephone, email, face to face) and fix a deadline.
- Finally, help the patient find the connection between the elements (S = L x C). This is the basis for step 3: diagnosis and targets.

Step 3. Diagnosis and Targets

The connection is the diagnosis foundation. On the other hand, the diagnosis is the starting point for the treatment.
In this framework, the diagnosis is built on the basis of the combination of three elements: the nature and severity of the symptoms, the provoking life events and the (assumed deficit of) the coping repertoire. Each of these elements can be targeted in the treatment plan although for reasons aforementioned the coping style is the core element.

Aspects of interest in this step:

- Start by defining the diagnosis on the basis of the connection between the elements (S = L x C. See tables 10 and 11 in the patient's manual). This can be expressed by the therapist as follows: *After discussing and exercising, it seems to me that your complaints (S) …….. have stemmed from setbacks (L) such as…….. that have happened in your life / happened last year. But I do think that that's one side of the coin. I also suppose that the way you have been trying to cope with those setbacks (C) has failed because it was characterised in excess by ……(for example by being aware of the setbacks brought along)…….. and too less by …… (for example, due to the possibility that often things prove to be better than expected). If I describe the situation this way, do you think it makes sense?* It is important that both patient and therapist finally agree about the diagnosis.
- Stress as much as possible that the coping repertoire is the core element. If possible translate it in terms such as habits, habitual pattern of reacting. Habits or habitual patterns can easily be described in terms of too much or too less, and in terms of qualities (= in the right proportion) and pitfalls (= qualities that have been exaggerated).
- Do use table 8 from the patient's manual to put the diagnosis in operation (appendix). If this way of conceptualising the problem is accepted by the patient, try to introduce the concept of the balance or the scale (see page 9 and page 14). Make the scale visible by using the pages in the patient's manual or by drawing it on a piece of paper or a white board.
- On the basis of the description of "C "in the diagnosis (table 8), start the discussion with the patient about his/her position on the scale, the way it deviates from more average / moderate ways of reacting.
- Furthermore, try to discuss with the patient how the positions of other people (relatives, friends, colleagues) have to be situated on the same scale. Generally, this shows that there are more possible ways of reacting than the stereotyped way the patient is used to. This kicks off the discussion on change in the field of social learning.
- To practise the use of the quality quadrant of step 4, it would be wise to start discussing with the patient about how his habitual patterns can be seen as qualities and in what way or under which circumstances they can become pitfalls.
- Use table 12 (see appendix) from the patient's manual to start the discussion on targets
- Discuss the homework that can be done. For example and at this point, ask him to read the text that belongs to table 12 (p. 1 and 3) (see appendix).
- Ask the patient to fill in the questionnaires again and return them to the therapist.

Metaphors

Stott et al (2010) describe how the use of metaphors supports good CBT practice. Generally speaking, this means that if it is possible to define the patient's habits (C) in the way of a metaphor or a prototype, distance and reflection will be stimulated. Using metaphors to describe the problem generally gives relieve. Metaphors also make it easier to remember what was discussed in the former session.

Here follow some examples of metaphors:

- In the case of mood disorders, anxiety disorders or somatisation, one of the general remarks of all patients suffering from such symptoms is that they have a very unilateral view on the world and on their capacities to cope with the world. There is absence of versatile views. In the format of a metaphor this can be summarised as follows: you are looking at reality only through black-coloured spectacles. Or, always listening to the same radio station. No more being aware that another station or other spectacles provide another image and other possibilities. Once such a metaphor is accepted as a correct summary of the patient's enrooted habits, it is possible to discuss about alternatives using the same metaphor. For example, turning to another radio station or looking through white-coloured spectacles.
- A patient whose habitual repertoire was summarised as shy, polite and awaiting, during the discussion about these traits he realised that he behaved like Richard, Hyacinth's husband in the series: "Keeping up appearances". Once this was agreed as the correct summary of his habits, a discussion was started about what kind of behaviour he had to learn and the other characters in the series tat could be used as a model to learn different behaviours.

Step 4: Behaviour Change

In this step the patient works out the treatment plan actively and as independently as possible with the support of his/her manual.
As mentioned before, the core of the treatment is the failing elements in the coping repertoire. But attention is also paid on how to get better control over the symptoms and the provoking (burdensome) life events. The patient's manual describes some exercises on page 15.

Aspects of interest in this step:

- Second measurement with questionnaires

This measurement, at the end of the construction of the conjoint problem definition, provides information on the progress made. Discuss the results with the patient and integrate these in the S, L, C outline. If there is improvement congratulate the patient. If there is no progress, study the possible reasons (motivation, severity, etc) and discuss what has to be done and by whom to obtain some improvement.

- Improving control over "S "and "L ".

See, as mentioned before, p. 15 in the patient's manual. Ask the patient to read this carefully and to work out the instructions as carefully as possible.

- Improving the coping repertoire.

"C "is the core element. It is the main common denominator in the habitual way of reacting of the patient. Pay careful attention to the role exaggerated habits play in the coming into being of symptoms. Use the scale (table 8 in the patient's manual) to make it visible. Use table 13 in the patient's manual to discuss which behaviour has to be changed and how to proceed.It is helpful to stress the impact of "C " by demonstrating (out of the material / information gathered from the patient) that in different situations the patient usually reacts in the same stereotyped way; always avoiding instead of acting; always starting from a pessimistic expectation instead of giving oneself the benefit of the doubt*. In the case of Mrs. Johnson, as described in the patient's manual, it is clear that one of the reasons why she became exhausted was her inclination to care for other people and always serving the interests of others and forgetting to care for herself.*
Stress that gradual / step by step learning to react in a more moderate way is the best way to reach permanent change. This is best done by observing how other people react to identify the different ways of reacting and the results.
Stress that the process is always the same: *observing* (one's own behaviour, exceptions, and other people's behaviour), *comparing and considering* what aspects of behaviour could be translated into alternatives, *acting / experimenting*. (Take note: after considering and deciding what should be changed, start practising this new behaviour by role playing in the office). *Acting:* new insight sticks best when the insight is directly expressed. Discuss with the patient in what specific situations the patient will consciously behave just a little bit different than he / she is used to do. Do rehearse this in the office and warn the patient about 'unexpected reactions" from the environment when he /she changes his /her reaction patterns.
The patient's manual describes different ways to learn to change behaviour (p. 15 and further). Ask the patient to read this carefully. Discuss these methods with the patient and help the patient choose the best suitable method.

Make the patient realise that too common or uncommon habits in the patient's behaviour repertoire, under stress shift to non adaptive reactions and symptomatic behaviour. Do use "the scale" as a tool to make visible the deviating position the patient reacts from. Methods to learn new patterns of reacting are derived from the social learning theory (Bandura, 1997). They have proven to be very helpful. In addition, the Quality Quadrant and methods derived from traditional CBT can be used. All these methods are described in the patient's manual (p. 15 and further in the patient's manual).

Take note: most step 4 activities can be done by the patient alone without any therapist support. Support – if wanted by the patient - is possible and can be delivered in different ways: telephone, e-mail, face to face, walk-in clinic/ visit without appointment.
The key element of success of this step lies on the fact that it is based on mutual agreement about the connection between the elements of the S, L, C outline, the diagnoses and the agreed targets.
Another factor involved in the success of this kind of therapy is the extent to which the therapist can transform traditional care-giving attitudes into coaching ones, restricting oneself to the streamline of the treatment: giving recommendations/ advice, evaluating and providing support from the distance.
Take note: when progression is made clear, introduce step 5 and ask the patient, before the last appointment and independently of the format, to fill in the questionnaires and send them back to you together with the measurement.

Step 5. Completion and relapse prevention

The treatment will come to an end when there is obvious progression (on the basis of observation, patient's remarks and outcomes of questionnaires).
Discuss with the patient how he/she can handle new life events that may bring about stress. These stressful moments can be handled by the patient with the support of the manual to help him/her recover overview and cope in an adaptive manner. See page.....on the patient's manual.

Aspects of interest in this step:

- Identify the risky pitfalls when stressful events do happen again.
- Use the outline, prototype or metaphors to make them visible.
- Discuss the triggers to be handled with care.
- Discuss on what way support from the environment can be demanded and used.

Take note: if progression is insufficient follow the next recommendations:

- Discuss with the patient the elements of the S, L, C outline and highlight the barriers.
- Analyse what has to be done to do away with the barriers and who should do it.
- Make an inventory of the patient's expectations.
- If desired or necessary, facilitate the referral.

PART 3. The patient's manual

Five steps: from symptoms to solutions

Introduction

Many people suffer from mental problems such as tiredness, anxiety, depression, dependency, etc. In most cases the patient can solve these problems on his/her own with the right supportive people or with a little support from their environment or a therapist.
This manual can help you solve your problems.

There are two reasons why mental problems arise. On the one hand, when there is a high percentage of bad luck simultaneously. On the other hand, the way we cope with our life events can be part of the problem when our solutions don't sufficiently fit in with the situation. More often than not, the coming into being of mental problems is due to the combination of these factors.
People who act too carefully or who worry too quickly or people who have a high degree of responsibility are the first ones who, under the pressure of setbacks or bad luck, suffer from mental problems.

This manual is not a plea for irresponsibility or selfishness. It aims to provide tools to learn how to keep or recover a good balance between tension and relaxation, between worry and trust or between go-getting and throwing in the towel.

The treatment consists of five steps. Each chapter of the manual addresses one step. By reading carefully and following the instructions it is possible to overcome your problems without professional help.
On the basis of our experience the majority of people need some professional support to keep going in the right direction. Contact with the therapist can take place in many different ways: scheduled appointments, walk-in clinic, telephone or e-mail.

In five steps we go from problems to solutions or from start to finish.
The first step is *preparation*. In this step we explain what mental problems are, how they can be addressed and what you can do to restore overview and regain some control.
In the second step, *overview and connections*, the basis for the treatment (behaviour change) is laid. In this step, with the support of some simple outlines, you will learn what the background of your problems is and what is causing them. The kind of bad luck that can be causing them and the type of habits (your regular ways of coping with situations) that might have failed.
In step three, *targets*, the overview is taken as a basis to identify what should be done to solve the problems. How can you learn to cope with situations or problems just a little bit more adaptive to get rid of the problems?
Step four, *behaviour change*, focuses on some simple but powerful methods that can help you adapt / develop new habits.
The last step focuses on relapse prevention. We help you anchorage what you have learnt during the treatment so that when new setbacks happen you will be better armed to cope with them in an adaptive way.

STEP 1 PREPARATION.

Definition of mental problems

It was mentioned in the introduction that many people suffer from mental problems. In the course of one year, 25 % of the people suffer from this kind of problems to a greater or lesser extent. Problems can be mild and of a temporary nature. They can also be severe and long lasting. They can cause some inconvenience or trouble and sometimes they totally disorganise someone's functioning. Anyway, mental problems always disturb normal functioning at home, school, the workplace or wherever.

Mental or psychological problems are often the result of the combination of bad luck and failing coping. They can manifest themselves in many different ways: prolonged periods of fear or sense of insecurity, extreme and or prolonged anger, prolonged sense of being depressed, burnt out, the feeling of not being capable, being constantly tired, having difficulties in keeping diet under control (food disorders), drinking, gambling, prolonged stress, problems with personal relationships, suffering from nasty recollections, etc.

Take note: think that everybody feels at some point in his/her life fear, anger or insecurity. Per se, that is not a signal of being mentally ill. Mental problems that need treatment are problems that **last long** and that **more and more hinder normal daily functioning.**

What problems do you suffer from?

It is not often easy to identify exactly the problems you are suffering from. To start making an inventory it is useful to fill in the outline below (table 1). You are required to tell whether you are suffering from one of the mentioned complaints and to what extent (no problem at all, a little bit, etc).

Use the boxes to write down other complaints or problems you are suffering from and not listed.

Table1. List of possible complaints

complaint	No problem	A bit / sometimes	Regularly	Much / often	Always
Anxiety					
Depression					
Conflicts with others					
Crying fits					
Anger					
Problems with alcohol					
Food disorders					
Hopelessness					
Tiredness					
Problems in your personal relationships					

In the table below, in your own words describe what you think are the causes of your problems or complaints. If there is more than one reason, list them in order of importance.

Table 2. The causes of my problems

1.

2.

3.

How can this manual help you?
This manual is a useful tool for you to learn to regain control over your complaints and your way of reacting in stressful situations. The tool helps you regain overview and get insight and control about the strengths and weaknesses in your habits or coping repertoire.
We do not only focus on complaints, but rather the background (causes). That is to say, we investigate how the ways you have learnt to cope with problems are not sufficient enough to cope with them and to what extent they have failed. By learning how to improve your way or ways of coping you will regain control over your behaviour and your complaints.
Questionnaires are very useful in this stage.

What questionnaires are available and what can they do for you?
Questionnaires are useful tools. Like a carpenter uses useful tools to carry out his job with accuracy, so do questionnaires in this kind of therapy. They help you and the therapist map out, as accurately as possible, the causes of your problems. This helps identify the therapeutic activities that will be more successful.
Questionnaires will be used many times over the course of the treatment. This will help us determine if the therapeutic treatment is on the right path.
Questionnaires can be handled in different ways. They can be completed in a traditional way (pencil, pen...) or with the help of a PC. Both methods are good. Your therapist will tell you what is best in your situation.
In most cases, questionnaires consist of several statements. For example: “I get along very well with other people”. Mark the answer that best matches your position (absolutely, most of the time, now and then, often, absolutely not). These answers will indicate your strengths and your weaknesses in general functioning.

Here follows Table 2 showing the results of some questionnaires. They will help us complete the definition of the problems and the desired road to solutions.

Table 2. Questionnaires and their results

Questionnaire	Important outcome
(For example: OQ -45	T- score: This means:…… Social roles:…. This means:…….. Risks:…… This means……..

The five steps in more detail

During the course of the treatment the manual or therapists will help you go through the 5 steps: from problems to solutions. Here follows a more detailed description of each step.

- *Step 1. Introduction and preparation*

  If you are a passenger on a train and all of a sudden the train stops in the middle of nowhere, you will face a stressful situation causing anxiety. Everybody should understand this feeling. When the PA system informs about the cause and how long it will take to get it fixed, anxiety vanishes and you go back to a peaceful state of mind. This means that information is a powerful tool to help restore peace.

  People with mental problems have the same feeling. The causes are not always clear and neither the consequences. Explaining what mental problems are, how they arise and how they can be solved (information) brings calm back. That is the main focus of this section. Read it carefully and if you have any question refer to the therapist.

- *Step 2. Regaining overview and establishing connections*

  Everybody who suffers from mental problems has, in a sense, lost the overview over the situation he / she lives in and his / her possibilities to cope with that situation in the appropriate way. In this step, with the support of a simple outline, you will restore the general overview. The outline is called the S, L, C outline (see Tables 3 and 4). This outline will help you identify your problems. This is expressed with the “S” of symptoms. The recent events in your life that might have caused the problems are expressed with the “L” of life events. We also try to find out if the way you cope with events is the best one in that situation. This is expressed by the “C “of coping style.

  All the components of the outline have an effect on each other. For example, most people who have recently passed their driving test feel rather insecure when driving on their own. As long as they drive in an easy, clear and peaceful environment they can handle it although it is stressful. If suddenly they drive on a road with heavy traffic they can panic. Symptoms (in this case panic, sweating, uneasiness) can arise as a coincidence of unforeseen heavy traffic and restricted capacities to cope with the new unexpected situation.

- *Step 3. Definition of targets*

  Once overview has been restored and connections established, the causes of the problem are identified and also what can be done to solve it. In the case of the inexperienced driver, he has to understand that learning to drive a car in different environments takes time. He will have to learn to drive better, coping better, step by step. As far as possible, for the time being, he should try to avoid situations where the traffic is so heavy that makes him lose overview.

This is the way this manual helps you: observing, analysing, putting things together and choosing the best action for every situation.

- *Step 4. Behaviour change*

More often than not, connections show that symptoms are the result of a combination of life events and failing coping. The formula we use to express this is **S = L x C.**

Each of the components can be part of the treatment. Treatment is carried out step by step, slowly but surely. The key approach is a combination between *observing* the shortcomings in my coping repertoire (can I learn from other people by observing how they cope more successfully?) and *exercising* (how can I learn, step by step and first in a safe environment, to change my behaviour slightly in the desired direction?). For example, in the case of the inexperienced driver: what are my shortcomings in my way of driving? Who can help me or teach me to drive better?

- *Step 5. Conclusion and prevention of relapse*

If the steps are carried out properly, your problems will probably be solved. In the course of the treatment you have learnt something important, namely, everybody has his/her strengths and weaknesses. Weaknesses are called pitfalls. They need special attention when bad luck arises or when stressful events happen. The treatment will conclude with the identification of pitfalls and the best ways to cope with them.

STEP 2. Restoring overview and connections

With the help of the S, L, C outline you will restore overview. First we start by explaining the outline and giving an example to understand it better.

The S, L, C outline

Psychological symptoms mostly arise when situations are not favourable. This means there are too many setbacks, losses, too many stressful events simultaneously, loss of support, etc... And at the same time the way of coping with these events fails.

Most of the time we do not realise that our way of coping with what happens in our life is inadequate. We can feel things are not going well. We feel desperate, we panic, we become tired, etc. The first thing that has to be done is to become aware of the stressful events that have happened in our life, how they have affected us and how we cope with them and to what extent our coping is sufficient and when it fails. The S, L, C outline can help us get a clear picture of the situation. Overview is then created by identifying what we are suffering from, the stressful factors in our life and how we can cope with them in a better way.

Table 3. The S, L, C outline

Symptoms	Symptoms from which we suffer such as sleeplessness, no more being able to face normal tasks, sudden panic, feeling empty, feeling extremely tired, etc...
Life events	The most recent life events are described: losses, setbacks, conflicts, frustrations, etc... It is also important to write down the things that are going well (support, successes, etc...)
Coping style / habits	You can write down the way in which you react in your everyday life, especially when setbacks occur. Do you usually react in a negative, neutral or more optimistic way? Do you usually ask for help straight away or are you more independent? Are you a go-getter or the type of person that throws in the towel? Etc...

In the outline below (Table 4) there are some empty boxes to fill in with your first impressions according to S (symptoms), L (life events) or C (coping style).

Table 4. S, L, C, outline

Symptoms	
Life events	

Coping style / habits	

An illustrative example: Mrs. Johnson's outline.

This outline can be a good guide to help you fill in your own outline in greater detail.
Mrs. Johnson is 48 years old. She is divorced. She has two children. They are adult, doing well and living their own life. She has a good relationship with her children. She has a new and difficult personal relationship. She is working part-time (60%) as a secretary for a commercial company. For more than two years she has been overloaded with work: not enough staff to do all the work.
Three main complaints are identified at referral. She is tired. She is tired even after resting the whole weekend. On Monday she is as tired as she was the Friday before. She suffers from heavy stomach aches for which her GP has no explanation. She receives sickness benefit because sometimes she panics at work.
If we list all the actual life events, it is clear that there is overburdening in two important domains of life: the relationship with her boyfriend and her workplace (Table 7 shows the important life domains and how you can assess them).
Half a year before referral Mrs. Johnson's mother passed away. Two months ago her friend's grand-daughter died in a car accident. They are also burdening events. The other side of the coin is that she has a good relationship with her children as well as with some of her work mates.
In the first interview Mrs. Johnson says that she is the type of person who makes high demands on herself. She also mentions that everybody seems to go to her for help and she often forgets herself / neglects her own needs. She is more prone to adapt to other people's requirements than to make her own choices. She is always afraid of other people's reactions and rejections.

Table 5. Mrs. Johnson's S, L, C outline

Symptoms	Tiredness Stomach aches / unexplained Panic at work / cannot handle work anymore
Life events	Troublesome relationship Recent death of mother Not enough staff to do all the work. Overloaded Granddaughter's friend died in car accident
Coping style / habits	Perfectionist / making high demands on herself Adjuster High standards Always ready to adjust herself to other people's demands / neglecting her own interests

Homework: Do try (Table 6 below) to fill in again your own S, L, C outline. Also try to find out the connections between S, L and C.

Table 6. My own S, L, C outline again.

Symptoms	
Life events	
Coping style / habits	

What about my life events?

Problems, complaints or symptoms never come out of the blue. There are always situations or circumstances causing them. These are called provoking factors. In general, they are setbacks (losses, conflicts, stress, etc.) and/or less support from the nearby environment.
In the case of Mrs. Johnson we can see that, on the one hand, she is overloaded at work, she has a troublesome relationship with her new partner and she has lost beloved people. On the other hand, the prolonged understaffed situation at work can be seen as diminishing of support. Fortunately she gets some support from her kids and from some work mates.

Homework: (Refer to table 6). Try to map out the events in your life that could have triggered your problems.
It can be helpful to use table 7 (below) to get an idea on how you function in the most important life domains, for example, health. What is your health like and that of the people you care for? Is it alright, concerning or alarming? How is your relationship with the people you love most like your parents, your partner or your children? Are there problems in this area or is everything going smoothly? What about your financial situation? What do you think about your social relationships (friends, colleagues, clubs, etc)? What is your residential area like (pleasant or unpleasant)?
How about work? What is the relationship with your boss /your colleagues like? Is there a lot of pressure? Do you think problems can come up?
Use table 7 to write down information on important life domains.

Table 7 Important life domains

	Positive	Neutral	Negative
Health			
Close relationships			
Financial situation			
Social relationships			
Work			
Residential area			

In most cases this outline shows that there are problematic areas but fortunately problems do not happen in all areas at the same time. It is good to realise that you are doing well in some life domains.
Unfortunately, setbacks, inconveniences and sometimes disasters cannot always be avoided. Everyone faces setbacks at some point in his/her life. If that happens, it is important to investigate how one copes with those setbacks and if that way of coping is sufficient enough. An important aspect of this treatment method is learning how to improve your coping style.
Sometimes accepting what happens is the best way to cope with a given situation. Accepting does not mean throwing in the towel. It means that one accepts the situation as it is at that moment. This is not easy but it sometimes prevents useless fighting or go-getting (the only final result being getting burnt out). Accepting means that less energy is invested in aspects that cannot be tackled. In the form of questions it would be: why does this happen to me? What has caused it? Why have I gone that far? In such cases it is more sensible and wiser to reformulate the questions: How can I get on with it / cope with it?
We are encountered with the element "C" of the S, L, C outline again. If one considers the different life domains, one understands better the habitual ways of coping or reacting and to what extent they are or not sufficient and what can be done to improve the situation.

Coping style

The "C "of the S, L, C outline represents your habitual reaction patterns. Generally we do not pay much attention to them. They just happen to be like that. We do not stop to think how we are going to react in a given situation. It is something like our personal autopilot. Most people know, more or less, the habits that turn out to be strengths and/or weaknesses.
There are different ways to get an accurate idea about your habits or coping style:

- *Reflection*

Reflection means that one tries to observe oneself when acting in a specific situation. You can reflect while acting although it is easier to reflect afterwards. One realises what has happened (someone has behaved very rudely towards me. I was shocked and did not react). Reflection also means thinking about other possible reactions for the next time. For example, using someone who reacts more assertively in such situations as a model to learn from that person and behave more assertively next time.

- *Inquiring*

People who are close to us usually have a good idea about habits, weaknesses and strengths in our ways of behaving / reacting. Therefore, another way to learn more about the habits, the strengths and the weaknesses in your coping repertoire, is to ask the people close by. You can then make "an analysis of your strengths and weaknesses". In other words, they will give you information on your coping style and you will then be able to think about improvements.

Take note: it is obvious that you should only approach the people you can really trust.

- *Puzzling*

The "scale outline" (see table 8) is a good tool to learn about the strengths and weaknesses of your habitual reaction patterns. Read it carefully and reflect upon it. Fill in the blanks (with crosses) to indicate your positions on the line. Sometimes it can be helpful to do this exercise with a person you can trust. Once completed, the information can be discussed with the therapist. But in fact, you should draw your own conclusions and consider the new potential behaviour.

Table 8. Your position/ coping style on different scales

Below you will find different possibilities in a scale defined as a line between two extreme expressions of a way of reacting. For example, imagine new neighbours have moved next door. You see them unloading a van. Try to imagine what your normal reaction in such a situation would be (approaching them immediately, introducing yourself straight away and offering help, waiting for the right moment to approach them and welcome them, waiting and wondering what kind of people may be, ignoring them, etc...). As you can see, there are many different reactions to one situation, from one end of the scale (approaching them straight away) to the other (ignoring them). Extreme positions are listed below. You should reflect on your own position and indicate where it would be on the line given. This exercise will help you and the therapist identify your strengths and weaknesses in your habitual reaction patterns.

Table 8. Possibilities on the scale

Avoidant. ----------Impulsive

Rigid. ----------Flexible

Driven by own pace.----------Driven by someone else's pace

Doubter. ----------In charge

Trustful.----------Distrustful

Doom mongering. ----------Afraid of nothing

Perfectionist----------Slob

Selfish.----------Altruist

Lone wolf.----------Social

Self-confident.----------Sceptic

Busybody.----------Indifferent

Homework: identify your own position.
Homework: think of the other people's positions (relatives, friends, work colleagues...). You will realise there are many different positions, that is, for each situation there is more than one possible way of reacting. However, we all have our own stereotyped way.

Once that you have learnt that there is more than one possible reaction to a specific situation, it is important to learn to discern different positions or stages on the same scale. See table 9 for examples.

Table 9. Variations on the same scale

Shunning	Avoiding	Cautious	Open minded	Enthusiastic	Impulsive
Underestimating oneself	Doubtful	Careful	Giving the benefit of the doubt	In charge	Overestimating oneself
Arrogant	Self-interested	Neutral	Careful	Generous	Altruistic
Hair-splitter	Meticulous	Careful	Easy	Indolent	Slob

Homework: the S, L, C outline

After doing the exercises you have a better idea of "L "and "C "in your current situation and in your habitual reaction pattern. Now it is possible to fill in your final S, L, C outline below (table 10). This is the starting point for the next activity: establishing the connections between the elements and formulating the diagnosis.

Table 10. My final S L C outline

Symptoms	
Life events	
Coping style / habits	

How do the elements interconnect?

Once S, L and C have been identified and made clear, the next step is to see how they influence each other. First it is important that you read again Mrs. Johnson's S, C, L outline (table 5). Here follows a description of the connections in the case of Mrs.

Johnson. This can serve as an example for you to establish connections in your own situation.

The connections between S, L and C

In the case of the inexperienced driver (pages 33 and 34) it was made clear that symptoms or problems never come out of the blue. There is always a cause or a combination of causes such as being an inexperienced driver who by accident falls into heavy traffic. This combination of events and its consequences result in an easy or a troublesome situation.
In the case of psychological problems, it is important to investigate how life events and coping style or habits influence each other. The **formula: S = L x C** expresses this connection. This means that symptoms are caused or maintained because of the combination of stressful events and the way one reacts (in a non-adaptive way).
If we take Mrs. Johnson's case (page 36, table 5) the connection can be summarised as follows: when *Life events accumulate* (problems in her relationship + overloaded at work + losses of beloved persons), someone who *is inclined to* face /react to problems by adjustments, working even harder to take care of other people neglecting oneself, faces a high risk of getting *symptoms*.

The diagnosis

The diagnosis stems from the formula (in the case of Mrs. Johnson): Tiredness / fatigue and hopelessness are caused by getting overburdened and are amplified by her unilateral way of coping (doom mongering and working even harder).

Homework: My diagnosis
With the help of the S, L, C formula try to formulate the diagnosis that fits with your problems and mail / discuss it with your therapist.

To help you out refer to table 11. Use the blanks to express the elements that best apply to your personal situation.

Table 11. My diagnosis

Since…….. (weeks… months) …….. . I have been suffering from …… (write down your complaints / symptoms) …….. They are caused by …… (write down the setbacks, the losses…) …… and reinforced by the way I cope with them, namely ……. (write down what you have found out about your habits (too much / too less..)) ……

STEP 3. The determination of targets

When the connection between the elements of the S L C outline is clear and when there is a clear diagnosis we can move on to the next step: the determination of targets. The focus is on what has to be changed to solve the problems or alleviate your symptoms. Targets should be as specific as possible (what and to what extent). They should also be manageable (it is better one small step than setting too ambitious targets and failing to reach them).

Back to Mrs. Johnson' example. In her case the connection was determined as follows: *too much burden at the same time* (problems in relationships + work overload + loss of beloved people) for a person that primarily is apt *to adjust, to work harder* when things go wrong *and to ignore oneself*. This made her feel *exhausted and started to have physical problems and put her in a situation of despair.*

Each of the three elements in the connection / diagnosis can become the focus or target of treatment. For example, in the case of Mrs. Johnson this could be:

Symptoms: restoring peace in her life by taking a rest, going on holiday, finding a less demanding job or solving the problems in her relationship. To learn to relax she could do some yoga, mindfulness or breathing and relaxation exercises to get better control over her bodily reactions.
Life events: finding a less demanding job and/or solving the problems in her relationship.
Coping style: bringing efforts and relaxation in balance, finding a better balance between caring for other people and caring for herself, learning to give herself the benefit of the doubt instead of doom mongering.

Homework: Fill in the blanks with the targets you want to reach. Take into account that targets should be small and manageable. Do also consider who in your environment could be a good and trustful assistant to help you reach the targets.

Table 12. My targets

	Targets / What to change	How I will try to reach them
Symptoms		
Life Events		
Habits / Coping style		

Final homework: new measurement

Our experience tells us that when overview is restored and targets are clear we have the tools in place to recover peace. Generally speaking, the patient will feel better and less overburdened by the symptoms. To study objectively the extent to which improvement has been reached, it is important to measure results again. Discuss this aspect with your therapist and how to work it out.

Step 4. Learning new behaviour / habits

Once targets have been defined it is time for ACTION. The focus is on learning by doing. Especially, learning to turn non adaptive habits into more adaptive ones. This is carried out step by step. They key element is "C", but as shown before, it is also important to learn to behave differently in the realm of other elements. Therefore, as well as helping you change your habits, we also teach you breathing and relaxation exercises to help you gain more control over your symptoms.

New Habits: a matter of perspective

In the case of Mrs. Johnson, it became clear that some of her habits contributed (under the pressure of overburdening life events) to her complaints / symptoms: pushing herself too hard, always adjusting herself to other people's demands / expectations, blaming herself if something went wrong and pushing herself even harder than before.
In fact, it is not a bad habit to be aware of other people's needs. However, it can be a wrong habit if it is exaggerated. It will then become "too much of a good quality". In the case of Mrs. Johnson, if she only adjusts herself to other people's demands by pushing herself too far, there is a serious risk that she will never be satisfied. Then, one becomes a victim of his /her own high, but exaggerated qualities. Another aspect of this way of functioning is that there is a risk of getting exhausted and therefore suffering from physical tension.
The same counts for Mrs. Johnson's inclination/habit to adjust herself to other people's demands. This is a positive quality but if this is the only way one can react it makes you exhausted and there is a risk that one ends up with empty hands. She has taken care of other people (which is good) but she has neglected herself (which is not that good).

Too much of a good thing: becoming aware

Often, exaggerated good qualities are at the heart of psychological problems. The first thing one has to do when psychological (or physical) problems arise is to question if there are good qualities that have become exaggerated and have shifted from qualities to pitfalls.
Homework: identify your good qualities and see if they have shifted to pitfalls. Refer to table 11(my diagnosis).
The first step to change overshoot habits is to become aware that one is prone to exaggerate things. Therefore, go back to table 11 and write down the exaggerated habits.
To strengthen your awareness it can be helpful that every day, at the same moment, you take some time to retrospect on how you have behaved in different situations during the day. For example in the case of Mrs Johnson, have I behaved in a responsible way or have I been too responsible? Have I only cared for other people and neglected my own interests or have I reached a balance?
Besides realising that there have been moments when you have reacted in an exaggerated way, it is also important to note if there have been situations in which your reaction was in balance.
Use table 13 to write down your reactions.

Table 13. My habitual reactions and provoking situations

Habit / reaction	In excess / too much	Normal / in balance
Situation in which I reacted		

Relaxation exercises

Psychological complaints are always accompanied by physical tension. That tension can manifest in very different ways: headaches, back pain, fatigue, being nervous, etc. In their turn, those physical complaints reinforce tension, anxiety and agitation.
Relaxation exercises are a good tool to decrease physical tension. There are different methods that can help decrease physical tension, such as mindfulness. But also regular moderate physical activities like daily walks, swimming, biking are excellent means to decrease tension, visit "www.youtube.com" where you will find many easy relaxation and mindfulness exercises.
Our recommendation is to reflect on the mentioned activities and identify the ones that could be helpful in your situation.
Discuss with your therapist and the people in your environment about these possibilities and the one that could be most appropriate for you.

Creating choices

With the support of table 13 you can observe what is happening to you and you will have a better idea about your habitual way of reacting and the different alternatives.
An important tool to learn about alternative ways is to observe how other people react in similar situations. A simple way to learn this is to make a socio-gram. This can be worked out as follows:

1. Choose one of your habits you think is an exaggerated reaction (in the case of Mrs. Johnson this could be: always judging negatively about her achievements/ performances / never being satisfied).
2. Reflect on what the opposite extreme way of reacting to your exaggerated habit is (in the case of Mrs. Johnson this could be: laziness/indolence, being smug, slob).
3. Draw on a piece of paper a line between the extreme opposites (in the case of Mrs. Johnson this could be:
   Perfectionist ----------*Slob.*
4. Do draw the same kind of line between one of your exaggerated habits and its opposite.
5. Indicate with a cross what your habitual position on that line is (for Mrs Johnson, The cross will be on the left side, close to the word: perfectionist).

6. Recall people you know (relative, friends, and work mates) and try to imagine what their position is on the same line. You will observe that there are many different ways of reacting.

Learning by imitating / role models

The earliest way people learn is by imitating others. A young child learns a lot about how to behave and what is allowed and what is not allowed by following the example set by parents, relatives, classmates, friends, etc... Later on in life, the learning process continues by learning from or by imitating idols and role models. Also in adult life learning by imitating is a normal habit. Commercials appeal on our inclination to imitate by "promising" that we will become as famous, beloved, intelligent as a desired role model if we use the same aftershave, night cream, car, clothes, etc the role model uses.

When you want to change your habitual way of reacting it is very sensible to use role models.
This means that when you try to change your habitual way of behaving, you use a "model" whose habits are just a little bit more "in the middle" than your behaviour. To start this exercise you can:

1. Think of when, in what situation, you will try to behave just a little bit differently.
2. Think of a person who reacts just a bit differently from you in that kind of situation.
3. Think of how you will react in a way similar to that person instead of from your habitual position.
4. Start with the experiment.

Some hints:

1. Start with simple situations you think you can handle. Try to change the behaviour you are more or less familiar with. This means rather close to usual or behaviour you showed exceptionally.
2. If possible, do this in cooperation with someone you trust and who is ready to help you.
3. Do realise that when you react in a different way than you used to, people will often react with surprise. Don't be concerned. In fact their surprise is a compliment: you are trying to change your behaviour and they notice it.
4. "Practice makes perfection". The more you try to react in a different way, the more you will succeed in changing your behaviour. This means that it is very important that every day you do exercises to try to react just a little bit differently than you are used to. Do not make things complicated. Start with simple situations. For example when your habitual behaviour is adjusting to other people's demands, like in the case of Mrs Johnson, at least once a day ask other people to do something for you. For example, every day you ask someone to help you out in this or that activity, or you can ask people in the queue at a supermarket whether you can go first... It is always very helpful to think of someone who you think is better skilled in that situation and who could be your "model".

Further methods to change behaviour: Quality Quadrant and Thought Control.

You have probably realised that the term “thinking” has been often used. For example: “……. prone to think quickly: ……”I will never succeed in...”, or “what will other people think about me when ……”
The terms “thinking” or “thinking failures” are used to indicate that good qualities (taking into account other people’s position) can be exaggerated. Symptoms arise when that happens.
The next section outlines two ways to help you recognise your exaggerated ways of thinking and correct them. First part introduces the Quality Quadrant. The second one focuses on the so-called “thinking failures”.

The Quality Quadrant

The Quality quadrant has been designed by Ofman (2006). Ofman suggests that people’s traits or characteristics can manifest in different intensity degrees: in the right proportion, too strong or too weak.
As we saw in the case of Mrs. Johnson, she has excellent traits: doing her best, being ready to obey, helping others whenever possible. But too often she overshoots them and good qualities become pitfalls: one is never satisfied with one’s own performances, there is always room for improvement, and one always judges his/her own actions as a failure or as “not good enough”. Therefore, these people will never stop working and will always keep trying for the better. They will become exhausted and sometimes will panic and feel hopeless.
Table 14 introduces the Quality Quadrant.

Table 14. The Quality Quadrant

Quality	Pitfall
Allergy	Challenge

This table can help you distinguish your good qualities and the exaggerated expression of them. The first one is referred to as *your qualities*. The exaggerated or overshot expression is termed *your pitfalls*. Pitfalls are the foundations of symptoms or problems.
The opposite of the pitfall is also an extreme expression. For example, when “responsibility” is a quality, “”pursuing absolute control” or “being constantly worried so that things do not go wrong” is a pitfall. The opposite is referred to as *the allergy* (for example “irresponsibility” “laziness” or” indolence”).
By filling in the blanks you will identify your own qualities and be proud of them. You will also become aware of potential pitfalls and what to do to avoid them.

In the case of Mrs. Johnson the Quality Quadrant could be as follows:

Table 15. Mrs. Johnson's Quality Quadrant

Quality Open to other people's needs Service provider Aware of the possibility that she can make failures	*Pitfall* Neglects her own interests Working (for others) to death Doom mongering
Allergy Selfishness Laziness	*Challenge* One's interests and other people's interests should be balanced Better balance between tension and relief Giving herself the benefit of the doubt.

Homework: fill in your own quality quadrant (table 16). Do use the statements you mentioned in tables 8, 9 and 11. They focus on the exaggerated aspect for you to identify your pitfalls.
Firstly, fill in the blanks with your pitfalls.
Secondly, reflect on the qualities underlying your pitfalls and write them down under "qualities". It is advisable to ask someone you trust to help you do this exercise.
Thirdly: reflect on your allergies and what you might learn from them.
Finally: think about your challenges for the months to come. Do use again table 12: My targets (transformed to table 17 below) to write down your challenges and how you will reach them.

Table16. My Quality Quadrant

Quality	Pitfall
Allergy	Challenge

Table. 17. Again: my targets

	Targets / what to change	How I will try to reach them
Symptoms		
Life Events		
Habits / coping style		

Thinking Failures

A thinking failure is the expression of a pitfall. Such a failure indicates that one is used to observing daily situations from an exaggerated standpoint. Thinking failures are so much part of our daily way of functioning that we do not pay attention to them. We take them for granted because they belong to our "normal" repertoire. It is only when other people comment on our (exaggerated) way of reacting that we sometimes start to think that we behave differently from the average.
Everyone makes such failures. They become problematic if they become exaggerated and it is impossible or difficult to cope with the situation. The first step to start correcting this "exaggerated" way of thinking is to identify it.
Below there is a list of three common failures: "black and white mindset", "catastrophic thinking" and "taking things too personally".

Black and white mindset
If you pay attention you will notice how people with an "all or nothing"-way of thinking easily fall into extremes and how they tend to exaggerate. In their eyes someone can only be perfect or a complete failure. All-or-nothing thinkers do not take into account that there are a wide range of possibilities. They just think in black and white and ignore any shades of gray in between.
They suffer the so-called tunnel vision. Most of the time they only see the negative aspects and they forget that any event or person may have neutral or positive aspects as well.
In the case of Mrs. Johnson, this problem can be recognized from the fact that she tends to think that whatever she does is not good enough and that it could always be done better or faster. This faulty way of thinking is very exhausting. Mrs. Johnson always works herself to death but gets really exhausted. Moreover, she always has the feeling of being criticized by others and will never admit any compliment. More fuel to do her very best even further.
The same applies to her extreme concern. She is convinced that people need her help and forgets that most people are very capable of solving their problems by themselves. This black and white mentality or wrong way of thinking also triggers her efforts to do her very best. And this may imply that others abuse of her goodness or consider that she is an annoying busybody.

Homework: (table 17) identification and correction of a black and white mindset

1. Think of someone you know well and consider if and to what extent they have a black and white mindset.
2. After that, try to recall if and when you acted this way yourself in the last few days. Did it happen often, just now and then, or not at all?
3. If necessary, ask people who know you well if they have ever noticed that you have shown signs of an all-or-nothing way of reasoning.
4. If you have a black and white mentality, try to see it as your pitfall.
5. Use the core qualities table (table 16) to find out the quality behind this pitfall and try to formulate a challenge.
6. Every day, by means of observation and registration, try to find examples of your exaggerated actions and then try to correct them as a mental exercise ("next time I will do it differently"). *Imagine, as indicated on table 17, that you were invited to a meeting but decided not to go (behaviour) because when you were thinking about the*

meeting, something came to your mind (wrong thinking): other attendees would have a negative attitude towards you. It is important to realise that this habitual way of thinking is overshot. Therefore, try to correct it by, for example, recalling situations in which people reacted in a normal way to you. Do think about this and use those experiences to support a better thinking. Once you have started that "realistic or better thinking", decide what you will do or should do next time you are invited to join a meeting.

7. You could also make a socio-gram (page 44) in order to find examples of behaviour or reaction patterns other people have and that may inspire you to work on your challenge.

Table 17: mental exercise. Correction of a black and white mindset

Behaviour	Erroneous thinking	Correction	Better thinking	How will I change my attitude
"I didn't do, I didn't go, I didn't say…"	Everybody is against me, they all think I am ridiculous	Is that correct? Examples of the opposite	I am sure they do not pay more attention to me than to anyone else	I will...

Catastrophic thinking

Catastrophic thinking is a limited form of all-or-nothing thinking. It means that the thought of a catastrophic result is far beyond reality such as: "If I'm not perfect as a mother, a partner, a colleague, etc... I'll be a failure and will be refused" or "If my child isn't back home within ten minutes after the agreed time I'm sure that something serious has happened".
Obviously, it is reasonable to consider that things can go wrong and to take measures to avoid it. Carelessness is as much a pitfall as overprotection. There should be a balance and the question is if your reasoning is balanced or not.

Taking things personally

It's a natural human tendency to take things personally. When someone looks sad, angry or disappointed most people tend to think that it has something to do with them, that it's their fault.
Some people don't bother and their reaction is that every person is responsible for his/her own problems. If there is anything wrong they think they should try to solve it without help.
Most people, however, will observe, wonder and eventually ask what is wrong and act accordingly. When they finally understand the reason lying behind, many times it differs from what they had originally thought.
Other people take whatever they observe too personally. They think (too frequently) that it has been their fault or that they have done something wrong. They quickly tend to a black-and-white mentality or catastrophic thinking arguing that everything that goes wrong is their fault.

Homework: Recognition and correction.
Go back to table 17.
If you feel that one of these erroneous thoughts is frequent in your reasoning pattern, try to describe it and correct it as indicated above.

Table 17 a. Correction of wrong thoughts

Behaviour	Wrong thinking	Correction	Better thinking	How will I change my attitude
Panic Despair	I always make the wrong decision. I always make mistakes	In my life, I am sure I have done something in a normal way.	I suppose that I am overdoing	I will...

Final Evaluation and measurement
Your therapy is coming to an end. Well done! In order to evaluate your progress and identify your potential pitfalls it is important to go through the questionnaire once again. The results will be discussed in our final evaluation.

Step 5: conclusion and relapse prevention

Prevention is better than cure.

After using this manual, you will be more aware of the weaknesses or the pitfalls in your way of reacting.

To sum it all up, in your case you have a tendency to the following pitfalls (habits / erroneous thoughts):
COMPLETE the sentence: in adverse situations I tend to …… rather than ……..
(Now look back to your answers in table 11)

In the case of Mrs. Johnson this is: a tendency to overdo perfectionism, always thinking that she is not good enough, rather than "I've done my best, it looks good and other people will be happy."

During the therapy you have learnt to identify the tendencies or habits that represent a pitfall for you. You could avoid them as long as you recognize them on time. Therefore, together with your therapist complete table 19 and read it back regularly.

Table 19. Pitfall table
In order to **remain alert** for your **PITFALL(S)**, it is important to follow the next steps:

1. Display your **pitfall** in the blank below. Place an X where you were at the start of the treatment. Place a Y where you stand at this moment, and a Z at the point you want to reach.

2. **Alternatives:** how can I react better in case of setbacks / difficulties?

   Describe alternative behaviour / thoughts.

3. **Recognize signs**: How do I recognize that I am falling back into my old habits?

4. **Reminders:** How can I be alert of my pitfalls? (Think of statements that you can write down. Ask your family or friends to warn you in case you fall back. Once a week, at the same time, think about the way you have reacted)

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