

Summary in English of:

Paul Rijnders & Els Heene (eds). *Kortdurende psychologische interventies voor de eerste lijn*. Amsterdam: Boom Publishers. 2010

(translation: Brief Psychological Interventions for the First line)

See also: www.kortdurendetherapie.nl

This book is divided in 4 parts, each containing several chapters, and an epilogue. Together with the book two manuals are edited, offering a guidance for the therapist how to employ brief psychological interventions. These manuals are named: Kortdurende psychologische interventies voor de eerste lijn: Stappenplan voor volwassenen (brief psychological interventions for the first line: manual for the treatment of adult patients) and: Kortdurende psychologische interventies voor de eerste lijn: Stappenplan voor kinderen en jongeren (brief psychological interventions for the first line: manual for the treatment of young patients). Each manual is accompanied by a “werkboek” (work book). This is a manual for the patient. In this work book, containing 8 chapters, step by step for layman is explained what has been discussed in each step of the treatment. This enables the patient to read at home again what has been discussed, together with advices for homework.

PART I

Part I contains 2 chapters.

Chapter 1 is about epidemiologic issues: Which percentage of the population suffers from mental illness and, how many of them reaches adequate mental health help? According to the ESEMeD research (Alonso and others: *Acta psychiatrica Scandinavica*, 2004) more than 7% in the population in Europe suffers (one year prevalence) from mental illness. This is defined as: the problem fits within the DSM classification; the problem lasts for longer than 6 months; the problem is responsible for the dysfunction on at least one relevant area of life; people express the wish to find professional support.

In each country in Europe no more than 30 - 50% of this group reaches adequate mental help, which is defined as: psychiatrist; psychologist; psychotherapist or counsellor.

It is our hypothesis (among others) that an important reason for this lack is the big gap that exists between mental health services and daily/everyday life (distance, anonymity, ignorance of, stigma, resistance due to anonymity and ignorance). For this reason we (partly) transported our mental health services from the centres / mental hospitals to the offices of GP's, schools and community centres. The result of this action is: many more referrals than before, but also a budget problem. Because together with the growth of referrals the level of the budget kept unchanged. For this reason we worked out a brief psychological treatment (part II and the manuals) to serve more patients within the same budget / time than before.

Chapter 2. describes international outcome research (Lambert , Cuijpers, Wampold, etc) In general this research shows that effective treatment contains: early intervention; conjoint case conceptualisation; problem to be defined in manageable bits, commitment about goals and pathway to reach those goals; learning theory based interventions; relapse prevention. All those ingredients are integrated in our protocol / manual.

The chapter also presents the results of Dutch outcome research (Trimbos Institute; universities) in which the protocol, described in this book is proven to be as effective as CBT

carried out in a classical way, but it reaches the therapeutic goals in less time (on average 25 % less). Follow up after 18 – 24 months confirm this result and the difference. (related to Care as Usual brief interventions were more effective and much more efficient.)

PART II

Part II contains 5 chapters (3, 4, 5, 6, 7). In these the standard way of executing the brief therapy protocol is described.

It starts (chapter 3) with a definition of the characteristics of man / human functioning that underlie our model:

1. Man's way of reacting (emotionally; cognitive and in terms of conduct) is *guided by habits (coping style)*. These are mainly automatic / unconscious. Habits can be adaptive as well as maladaptive. Depending on the situation in which one has to react.
2. Habits are (partly) learned. In other words: man has the *ability to learn*.
3. A special remark of human kind is the possibility to observe (others as well as one self) from a *meta position*. This is to say: man is able to react and at the same time to realize that he reacts in a specific / stereotyped way and that alternative ways of reacting are possible. This also enables man to make choices and, to create out of nothing.
4. All these capacities can be lost, under the pressure of (negative) circumstances / experiences. The result of such a loss is *demoralisation*.

On the basis of these hypothesis, the treatment contains: helping patients to become aware of these possibilities and the reason why he lost some of them; case conceptualisation in terms of adequate and non adequate coping style; treatment plan to restore / ameliorate coping styles.

Chapter 4. (supported by 2 verbatim descriptions of a therapy) describes how treatment has to be carried out. A standard treatment is worked out in 3 phases (conjoint problem definition; behaviour change; relapse prevention). Each phase contains 1 or more steps. In total there are 8 steps.

In phase I (3 steps), supported by a schema (differentiation schema: see for example pages 61, 63, 65) the problem is divided in manageable bits: The symptoms; The circumstances/ life events (stressors that may provoke stress / problems / loss of control) and The coping Style. In step 2, by means of the formula: L (life events) \times C (inadequate way of coping them) = (provokes) S (symptoms). This way we create together with the patient a descriptive diagnosis that can serve as the basis to formulate goals and that is understandable for the patient.

In step 3, on the basis of the formula, goals are defined.

Beside dialogue, we use questionnaires (OQ 45; QOL; Coping lists) to find out, discussing the results of the questionnaire with the patient what the core is of each of the 3 parts of the formula.

In step 4 (The first step in phase II: called behaviour change) we work out how to reach the goals. Basic techniques are social learning; behaviour experiments; exposure; cognitive techniques). These techniques, supported by home work are trained and worked out in the next steps.

In phase III, (= step 8.) we discuss with the patient the results of therapy and what has to be done to prevent relapse.

Chapter 5 is about differential diagnosis.

Brief psychological interventions do serve well in the treatment of patients with moderate severe symptoms (which is, according to ESEMeD, 65 % of the total group of people suffering from psychiatric problems). In this chapter we describe how the group for whom this type of treatment is helpful can be differentiated from the group for whom this kind of therapy is not enough.

Chapter 6. is dedicated to the explanation of the questionnaires we use. It also addresses the different kind of functions questionnaires can have (diagnostic; motivational; explanation and comparison of the results of treatment as well during the course of treatment as at the end of it). This chapter also describes and illustrates the technique of conversation to be used.

Chapter 7. Brief psychological interventions are carried out around two main or basic schemes: The *differentiation schema* (see page 61, 65) which is the core for the descriptive diagnosis en case conceptualisation and the *Balance scheme* (see pages 75,77,80). The balance scheme is the foundation on which therapeutic techniques around social learning, behaviour change /experiments and cognitive restructuring are situated. In this chapter a lot of supportive schemes are presented, together with brief verbatims.

In separate edited books the manual / protocol is described. As mentioned before, there are 8 steps. Each step describes what has to be done this moment in treatment and how. The (also separate edited) work book for the patient contains 8 chapters. Each chapter describes a step. This enables the patient to read at home what has been discussed and worked out in the former session(s). There are also additional exercises and homework described in each chapter.

There are now two manuals and work books available (see: www.kortdurendetherapie.nl). One for the treatment of adult patients and one for the treatment of children and adolescents.

A manual and workbooks for the treatment of patients with medically unexplained symptoms / functional somatic syndromes; another one for patients originally coming from countries / cultures, different than North West Europe and one for the treatment of patients with addict problems are in preparation / under experimental (outcome) research.

Part III

In part III (chapter 8 to 14) each chapter is dedicated to the application of the standard protocol in the treatment of specific target groups. The basic is the same but depending on the remarks or the specificities of the target group, some modifications or some accents must be made different.

Chapter 8. is about the brief treatment of patients with functional somatic syndromes or medically unexplained complaints

Chapter 9. describes how this model helps children and their parents to overcome mental problems. Attention is given to aspects of developmental stages; impact of systems, etc.

Chapter 10. describes the treatment of elderly people.

Chapter 11. is dedicated to answer the question how this model must be executed in the form of a partner relation therapy.

Chapter 12. describes the modifications needed to help people from other than western European cultures to overcome mental problems.

Chapter 13. goes about the treatment of addictions

Chapter 14. is dedicated to the treatment of grief.

Part IV

Part IV (chapter 15, 16,17) is dedicated to important aspects of the professional environment in which brief therapy is carried out.

Chapter 15 is dedicated to medico - legal issues

Chapter 16 describes how to handle crisis situations

Chapter 17 is called: "what a professional who is not trained as a doctor must know about medication".

In The Epilogue we argue that mental health needs 2 fundamental changes:

1. logistic: bring mental health services / psychotherapists to the people. Organise better access by transporting capacity from the too anonymous centres to places better accessible for the patient like GP offices; schools or community centres.
2. with regard to content: more accent on guided self help and better use of didactic principles in the practicing of case conceptualisation and behaviour change.

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