

Specialised Treatment for Severe Bodily Distress Syndromes (STreSS)



Thomas Bewick 1811

Aesop's fable: "The hare and the tortoise"

"Slow but steady wins the race"

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Overview of the treatment programme

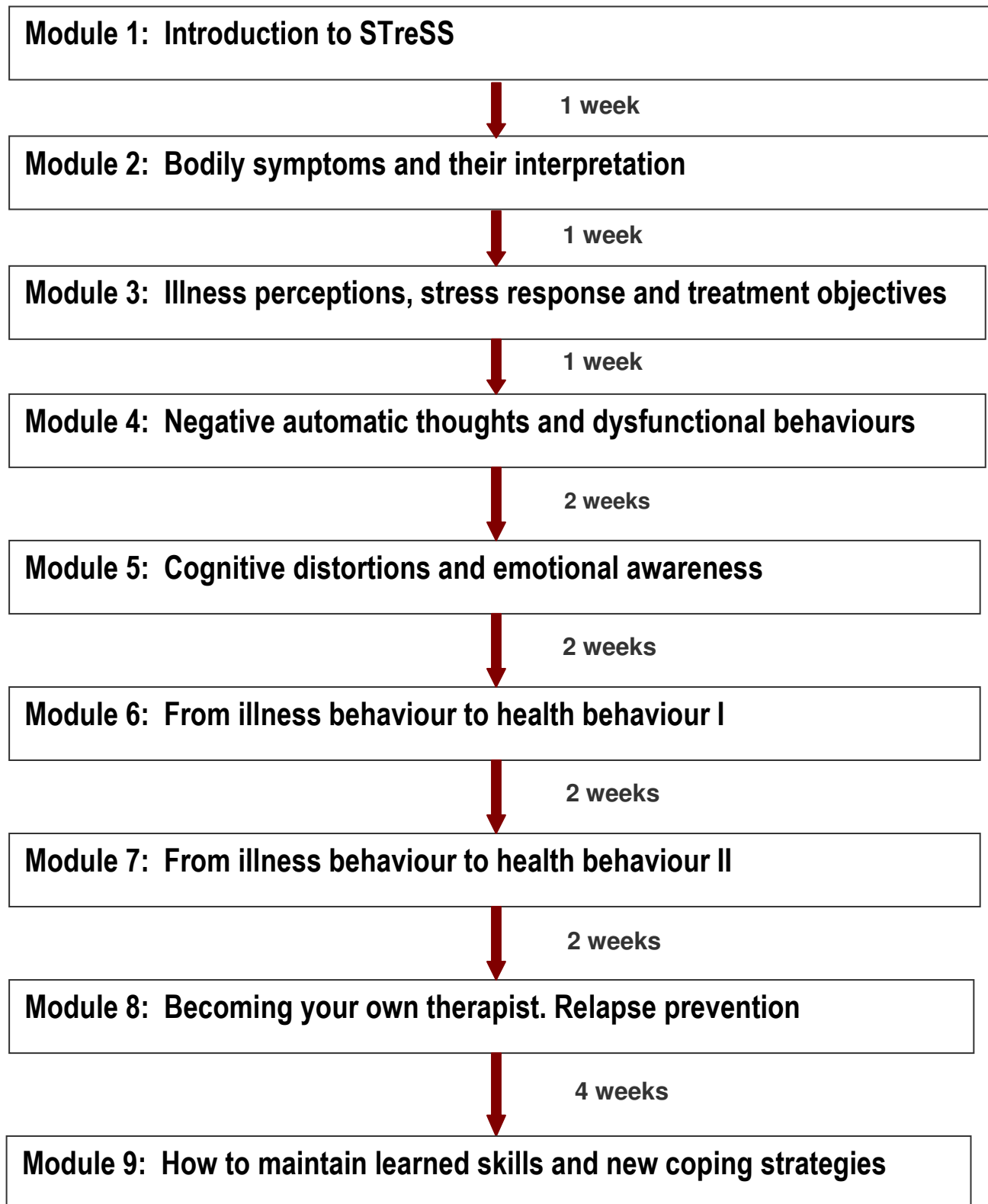


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Introduction

Syndromes of severe and chronic bodily distress, e.g. fibromyalgia, chronic fatigue, irritable bowel, etc., are highly prevalent in all medical settings. They constitute a burden for the sufferers, they are costly for society, and their management and treatment are a major challenge to health care providers. With this treatment manual describing *Specialised Treatment for Severe Bodily Distress Syndromes* (STreSS), we try to provide an evidence-based guide to improved functioning and enhanced quality of life for patients who suffer from severe bodily distress.

Many terms have been introduced to describe physical symptoms and illness that cannot be fully explained by structural bodily pathology. Amongst those terms, designations like *psychosomatic*, *medically unexplained* or *somatoform* are widely used, but nevertheless they are hardly acceptable to many patients and doctors. Based on our clinical experience, we prefer the purely descriptive terms *bodily distress* or *functional*. We regard these terms helpful in providing patients with a positive explanation of the likely origin of their symptoms. *Bodily distress* simply describes patients' basic experience of multiple painful and disabling physical symptoms. *Functional* refers to potentially reversible disturbances of organ function and / or the brain systems underlying symptom experience. Both terms are acceptable to patients and usable by doctors, they do not reinforce unhelpful mind-body dualism, and they are aetiology neutral and hence do not imply a "psychiatric problem" or a "mental disorder".

Nevertheless, the cognitive and behavioural techniques and strategies presented in this treatment manual are developed by psychiatrists and psychologists. What may be even more provoking, STreSS is designed as group treatment to be delivered by two psychiatrists. Does that mean that we do regard bodily distress syndromes to be mental disorders after all? Our patients frequently ask this question, and the answer depends on the understanding of the term "mental disorder". Bodily distress syndromes are *not* mental disorders in the sense that the bodily symptoms are "all in the mind", "not real", or "the result of psychological problems". To our best knowledge, bodily distress syndromes are diseases with a *complex multifactorial aetiology*. Nonetheless, patients suffering from chronic bodily distress are often trapped in a *vicious circle* in which dysfunctional cognitions and behaviours worsen their symptoms and contribute to the maintenance of disability. Moreover, patients' health beliefs or *illness perceptions* are very strongly related to outcome. More important, however, is that cognitive and behavioural treatments have proven effective in various functional somatic syndromes and somatoform disorders. In other words, the techniques used in STreSS are based on gold-standard evidence.

STreSS is not a self-help guide, and we recommend that the manual should only be used by experienced psychiatrists with comprehensive insight in the field of functional disorders and with training in cognitive behavioural therapy, or by other skilled therapists in close collaboration with patients' primary care physicians. A thorough clinical assessment, aimed at (1) excluding relevant physical diseases, (2) initiating treatment for possible comorbid psychiatric disorders, (3) challenging patients' illness perceptions, and (4) explaining the rationale of a behavioural group treatment to the patient, is a basic pre-requisite of STreSS. STreSS may initially trigger or aggravate depression or anxiety, and all effort should be made to prevent premature, patient-initiated termination of treatment. At our clinic, patients who get worse or who are at high risk for dropout are offered individual consultations with their contact therapist.

The efficacy of STreSS has been tested in a randomised controlled trial, and the results showed an immediate, clinically relevant effect on the patients' perceived physical health, their self-rated bodily distress, and their illness worry. This effect was sustained or even augmented at 12-month follow-up. However, before recommending STreSS to be implemented in routine clinical care, large multicenter-trials are needed to explore the (cost-) effectiveness of STreSS or similar complex interventions.

We would be grateful to hear from colleagues and other researchers about their experiences with this treatment manual, and to learn how they adapt STreSS to different clinical settings and to health systems in other countries.

Aarhus, October 2009

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Framework and rules for the group

Framework

1. **Time:** X 1.30-4.00pm. (3.5 hrs.)
2. **Place:** X
3. **Cancellation** of participation in the group as a result of disease, etc. must take place before the start of the meeting and directly to the therapist on: **(no.)**
4. Coffee & tea is served at 1.30-1.45p.m. (Break 1).
5. The hospital is a no-smoking area. **Smoking** is allowed outside.

Rules

1. **Duty of secrecy:** This means that it is not allowed to speak to anyone about who is in the group, and what is said during sessions. If you need to discuss the group with a family member or close friend, it is emphasized that it must be in a manner that makes recognition of the group members impossible.
2. **Everyone has the right to say no** when asked about private matters during exercises, etc., if they don't feel up to it.
3. Each **participant is responsible** for getting the most out of the treatment and thus for giving her or himself a chance to get better.
4. The therapists are responsible for offering the best possible treatment in safe surroundings.

The Hare and the Tortoise

By Jean de la Fontaine

A HARE one day ridiculed the short feet and slow pace of the Tortoise, who replied, laughing: "Though you be swift as the wind, I will beat you in a race." The Hare, believing her assertion to be simply impossible, assented to the proposal; and they agreed that the Fox should choose the course and fix the goal. On the day appointed for the race the two started together. The Tortoise never for a moment stopped, but went on with a slow but steady pace straight to the end of the course. The Hare, lying down by the wayside, fell fast asleep. At last waking up, and moving as fast as he could, he saw the Tortoise had reached the goal, and was comfortably dozing after her fatigue.

Slow but steady wins the race.



Module 1

Introduction to STreSS

Programme

12.30-1.30pm:

- **Welcome**
- **Introduction of therapists**
- **Names of participants**
- **Programme**
- **Box scale registration**
- **Questions regarding box scale registration**
- **Framework and rules**
- **Introduction of participants - 2 & 2. *Exercise 1.1***

1.30-1.45: Break

1.45-2.45:

- **Introduction of group participants**
- **Treatment expectations. *Worksheet 1.1***
- **What is Cognitive Behavioural Therapy (CBT)? Purpose of STreSS. *Teaching 1.1***
- **Regular items at every meeting and educational methods. *Teaching 1.2***
- **Physical exercises. *Exercise 1.2***

2.45-3.00pm: Break

3.00-4.00pm:

- **Dictionary. *Teaching 1.3***
- **Homework for module 2. *First weekly registration form, Worksheet 1.2***
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain										Worst possible pain	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Other symptoms/discomfort:	No other symptoms/discomfort										Worst possible other symptoms/discomfort	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Sadness:	No sadness										Worst possible sadness	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Nervousness:	No nervousness										Worst possible nervousness	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Tiredness:	No tiredness										Worst possible tiredness	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

7. Problems concentrating:	No problems concentrating										Worst possible problems concentrating	
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Teaching 1.1

What is Cognitive Behavioural Therapy (CBT)?

STreSS uses treatment principles and techniques from cognitive behavioural therapy (CBT). But what is CBT?

1. Active cooperation between you and the therapist
2. Together we investigate and explore those aspects of your everyday life that are difficult for you. Together we develop methods that can help you control your symptoms and your discomfort
3. Structured treatment with an agenda for each module
4. Treatment in which we prepare a list of your problems and try to find realistic solutions
5. Treatment which helps you develop short-term objectives, e.g. what do you want to achieve during treatment regarding:
(1) Physical activity, (2) work/occupation, (3) social activity/leisure, (4) other objectives
5. Treatment based on educational methods, e.g. you sit at a table, there is a white board, overheads, you have a work folder, you get written material, exercises, and need to do your homework
6. Exploratory treatment in which you are shown how to ask yourself probing questions. And where you learn that in a given situation you can ask yourself different questions, and that these questions have a variety of different answers, e.g. different ways of thinking and acting in a given situation
7. Treatment where you get the possibility to train new ways of thinking and acting through active participation and exercises
9. Treatment with a time-limit.

The purpose of STreSS

1. In STreSS you learn new ways of managing your symptoms and discomforts
2. In STreSS you learn new ways of thinking when dealing with your symptoms and discomforts
3. In STreSS you learn to explore the relation between your symptoms and discomforts and your thoughts in different situations and social relationships
4. In STreSS you learn how you can maintain your new ways of thinking and acting in order to reduce your symptoms and discomforts.

Teaching 1.2

Regular items at every meeting

STreSS is structured treatment in which the following key points are on the agenda at every meeting:

1. Box scale registration
2. Review of homework
3. Teaching - focused on the topic of the day
4. Exercises
5. Homework
6. Conclusion and round-off
7. Box scale registration

About the teaching methods

For this treatment, we use teaching methods and remedies such as whiteboards, overheads, and flip charts. We sit around a table, where you can work on your exercises. A flip chart will be available, and you will get a work folder with information about the background to the treatment, exercises, and other material.

At each meeting, you get the material that is relevant for this specific module. As you can see, the papers have different colours. We hope this will make it easier to navigate the folder.

Colour codes for the material

😊 **Teaching: Blue**

😊 **Programme for each module: Yellow**

😊 **Exercises: Red**

😊 **Worksheets: White**

😊 **Homework: Green**

😊 **Framework and rules: Orange**

Teaching 1.3

Dictionary

Autonomous nervous system	Areas of the nervous system not controlled by will. Supplying the smooth muscles in the inner organs, blood vessels, and the striated muscles of the heart
Basic model	Schematic model used in Cognitive Behavioural Therapy (CBT), which includes four key elements of (bodily) distress: physical symptoms, thoughts, emotions, actions. The basic model assumes that these four dimensions of distress are closely related to each other
Behaviour	Actions, reactions to certain situations
Box scale	A scale from 0 to 10 for evaluation of strength of e.g. Symptoms, emotions, concentration, where 10 is highest value
Central nervous system	The nervous system that consists of the brain and spinal cord and which controls the entire nervous system
Chronic	Persistent, constant
Cognitions	Thoughts, inner images, interpretations, conceptions, learning ability
Cognitive behavioural treatment (CBT)	Treatment where you investigate thoughts and actions in relation to physical sensations and emotions
Confidential	Private information which must not be passed on
Duty of secrecy	Entrusted confidence
Flip chart	Large board for demonstration with large sheets of paper attached at the top, which are folded back over the edge of the board
Homework	Exercises. New ways of thinking and acting are tested at home
List of objectives	Sheet of paper with a plan of how to reach specific goals
Coping strategy	A method specifically designed to reduce physical and emotional discomfort.
Methods	A systematic plan or technique used for a specific purpose
Peripheral nervous system	The nervous system controlling e.g. skeletal muscles and senses
Questionnaire	A number of printed questions, often part of investigations
Relaxation exercises	Exercises where you learn to relax your muscles
Short term goals	Goals that are composed precisely regarding time, place, duration within a short period.
Summary	A repetition of the subjects we have addressed
Weekly registration form	Schedule for all 24 hours every day for a week
Work folder	Folder with (written) contents used during treatment modules

Worksheet 1.1

Treatment expectations

Evaluation of present condition and confidence in possible change.

The condition

How do you consider your present condition as a whole? (Mark with a cross below)

What do you want to obtain? (Mark with a circle below)

What would you be satisfied with? (Mark with a star below)

Totally disabled 0 _____ 10 Totally healthy

Confidence in an opportunity for change

How profound is your confidence that you will be able to reach an objective with which you will be satisfied? (Mark with a cross below)

What makes you place your cross there and not closer to 10?

How can we help you to get from there to 10?

What could prevent you from reaching your objective?

No confidence 0 _____ 10 Totally sure

Worksheet 1.2

Weekly registration form

Date:							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Night 1-3 hours							
Night 3-5 hours							
Night 5-7 hours							
Morning 7-9 hours							
Morning 9-11 hours							
Noon 11-13 hours							
Afternoon 13-15 hours							
Afternoon 15-17 hours							
Evening 17-19 hours							
Evening 19-21 hours							
Evening 21-23 hours							
Night 23-1 hours							

**No pain/discomfort/
emotions**

**Worst possible pain/
discomfort/emotions**

0 1 2 3 4 5 6 7 8 9 10

Exercise 1.1

Introduction of participants - 2 & 2

Introduce yourself to the person next to you and ask him/her, who he/she is, for example by asking the following questions:

1. What is your name? _____

2. What is your occupation? _____

3. What are you good at? _____

4. What do you like to do? _____

5. What would you like to accomplish from participating in the treatment? _____

After the break we will ask you to introduce the person next to you to the rest of the group.

It may be helpful to write down a few words about your "neighbour" to make it easier to remember after the break.

Exercise 1.2

Physical exercises

You have now been listening for several minutes.

Ask yourself the following questions:

1. How do I feel right now?
2. What do I need right now?
 - ♣ To move around in the chair?
 - ♣ To stand up?
 - ♣ To stretch myself?
 - ♣ To breathe heavily?
 - ♣ To yawn?
 - ♣ To bend down in my knees?
 - ♣ To jog/run on the spot?

Homework for module 2

What is homework?

A very important part of STreSS is to do homework. Since the treatment consists in active cooperation between a therapist and you, where we can only be together for a few hours, and since there are many days between our meetings, time outside the meetings is important for testing the different exercises at home. So, to work together towards your goal – getting better – we all have to make an effort between the meetings, where each of us prepares for the next meeting. We will start the next meeting with a review of your homework.

What does your homework consist of?

Your homework consists of testing some of the exercises at home, exercises that we have gone through and practised here today.

How do I get started with my homework?

First a few words about **habits**. The purpose of having/making habits is to make things easier. When an action or thought has become a habit, we use less energy on performing this action or thinking this thought that has now become a habit (for example when we are learning to ride a bicycle we use a lot of energy to maintain balance etc, but once we know how and it has become a habit, we do not think about it anymore and the body does it automatically, meaning we use less energy).

We all have habits that we consider to be useful/suitable (i.e. riding a bicycle, walking up stairs, driving a car). And other habits that we find inappropriate/unsuitable (i.e. smoking, eating sweets, drinking coffee, lying down for many hours during the day, thinking the same unpleasant thoughts over and over again).

Because it is difficult for us to change ourselves and our habits, we need small steps and persistence to make changes.

As you can see on the front page of your work folder, we have used the picture from Aesop's fable about the hare and the tortoise to emphasise that:

”Slow but steady wins the race”

Continues on next page...

Homework for module 2

What do I need to prepare for next time?

To register the strength of my most bothersome symptom on the weekly registration form

Instructions: Choose the symptom you noted on the box scale form and fill in the first day on the weekly registration form rating the strength of your symptom from 0 to 10. Continue filling in the form at home.

For every time slot, note the number that best describes the strength of your symptom. You can complete the weekly registration form by doing this 2 to 3 times a day.

Getting started with your homework

Here are some questions you may ask yourself, to help you get started and be persistent with regard to your homework.

1. What is most difficult for me, when I need to start doing my homework?

2. Which problems might prevent me from doing my homework?

3. What is the first step I should take to get started with the homework?

Box scale registration

A. Date DD MM YY

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:

No pain											Worst possible pain
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:

No other symptoms/discomfort											Worst possible other symptoms/discomfort
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:

No sadness											Worst possible sadness
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:

No nervousness											Worst possible nervousness
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:

No tiredness											Worst possible tiredness
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:

No problems concentrating											Worst possible problems concentrating
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 2

Bodily symptoms and their interpretation

Programme

12.30-1.30pm:

- **Welcome**
- **Box scale registration**
- **Homework from the previous module.** *Exercise 2.1*
- **Group review of homework**

1.30-1.45pm: Break

1.45-2.45pm:

- **Draw your body and your symptoms.** *Exercise 2.2*
- **Registration of the strength of the symptoms.** *Exercise 2.3*

2.45-3.00pm: Break

3.00-4.00pm:

- **Your understanding of your physical symptoms.** *Exercise 2.4*
- **Homework for module 3.** Weekly registration. *Worksheet 2.1*
Registration of medicine. *Worksheet 2.2*
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	0	1	2	3	4	5	6	7	8	9	Worst possible symptom
	10										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain	0	1	2	3	4	5	6	7	8	9	Worst possible pain
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	Worst possible other symptoms/discomfort
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness	0	1	2	3	4	5	6	7	8	9	Worst possible sadness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness	0	1	2	3	4	5	6	7	8	9	Worst possible nervousness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness	0	1	2	3	4	5	6	7	8	9	Worst possible tiredness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating	0	1	2	3	4	5	6	7	8	9	Worst possible problems concentrating
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Worksheet 2.1

Weekly registration form

Date:							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Night 1-3 hours							
Night 3-5 hours							
Night 5-7 hours							
Morning 7-9 hours							
Morning 9-11 hours							
Noon 11-13 hours							
Afternoon 13-15 hours							
Afternoon 15-17 hours							
Evening 17-19 hours							
Evening 19-21 hours							
Evening 21-23 hours							
Night 23-1 hours							

No pain/discomfort/
emotions

Worst possible pain/
discomfort/emotions

0 1 2 3 4 5 6 7 8 9 10

Worksheet 2.2

Registration of medicine

Date	Name of medicine	Strength (mg)	Frequency

Exercise 2.1

Homework from last time

Review of how your homework has progressed. **Interview each other in groups of two**

How did it go for you?

What was difficult?

What was good?

What did you find out with regard to your most bothersome symptom?

Looking back at the whole week, and the last 24 hours, do you see a pattern concerning the strength of your most bothersome symptom?

Exercise 2.2

Draw your body and your symptoms

1. Draw the contours of your body on your flip chart.
2. Draw or note where in the body you have had symptoms during the past two weeks (e.g. the stomach, joints, head).
3. Note the type of your symptoms (e.g. dizziness, fatigue, pain)
4. Note the strength of your symptoms here and now (from 0-10):

0 = "no pain", "dizziness", "fatigue", etc.

10 = "worst possible pain", "dizziness", "fatigue", etc.'

It is OK to help each other

Exercise 2.3

Registration of the strength of the symptoms

Write down your symptoms in order, stating with the most bothersome symptom first: 1. is the most bothersome symptom, 2. is the second most bothersome symptom etc.

1	
2	
3	
4	
5	

Exercise 2.4

Your understanding of your physical symptoms

How do you explain to yourself that you have these symptoms or discomfort?

Use the list you made in exercise 2.3.

Symptom	Explanation
1	
2	
3	
4	
5	

Homework for module 3

What do I need to prepare for next time?

1. Weekly registration form

Instructions: Choose the most bothersome symptom. Make an estimate of the strength of your symptom in the box scale going from 0 to 10.

Every 2 hours note the number that fits best with the strength of your symptom. You can fill in the weekly registration form by doing this 2 to 3 times a day.

2. Medicine registration

Instructions: Use the form: **Medicine registration**. Write down the name, dosage, and how often you use the medicine on the form.

Help to get started with your homework

1. What is most difficult for me, when I need to start doing my homework?

2. Which problems might stop me from doing homework?

3. What is the first step I should take to get started with the homework?

Box scale registration

A. Date DD MM YY

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B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:											Worst possible pain	
	No pain	0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:											Worst possible other symptoms/discomfort	
	No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:											Worst possible sadness	
	No sadness	0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:											Worst possible nervousness	
	No nervousness	0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:											Worst possible tiredness	
	No tiredness	0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:											Worst possible problems concentrating	
	No problems concentrating	0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 3

Illness perceptions, stress response, treatment objectives

Programme

12.30-1.30:

- **Welcome**
- **Box scale registration**
- **Homework from previous module**
 1. Problems doing it?
 2. Homework from last time. *Exercise 3.1.*
 3. Medicine registration

1.30-1.45: Break, coffee, tea & cookies

1.45-2.45:

- **Bodily distress.** *Teaching 3.1.-3.5.*
- **Physical exercise.** *Exercise 3.2.*
- **Symptom and illness perception.** *Teaching 3.6.-3.7.*

2.45-3.00: Break

3.00-4.00 hours:

- **Objectives you want to achieve during treatment.** *Exercise 3.3.*
- **What is the first step towards the objectives.** *Exercise 3.4.*
- **Staircase of goals.** *Exercise 3.5.*
- **Homework for module 4.** *Weekly registration & Worksheets 3.1, 3.2, 3.3 & 3.4*
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

2. Pain:	No pain											Worst possible pain
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Other symptoms/discomfort:	No other symptoms/discomfort											Worst possible other symptoms/discomfort
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Sadness:	No sadness											Worst possible sadness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Nervousness:	No nervousness											Worst possible nervousness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Tiredness:	No tiredness											Worst possible tiredness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

7. Problems concentrating:	No problems concentrating											Worst possible problems concentrating
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Teaching 3.1

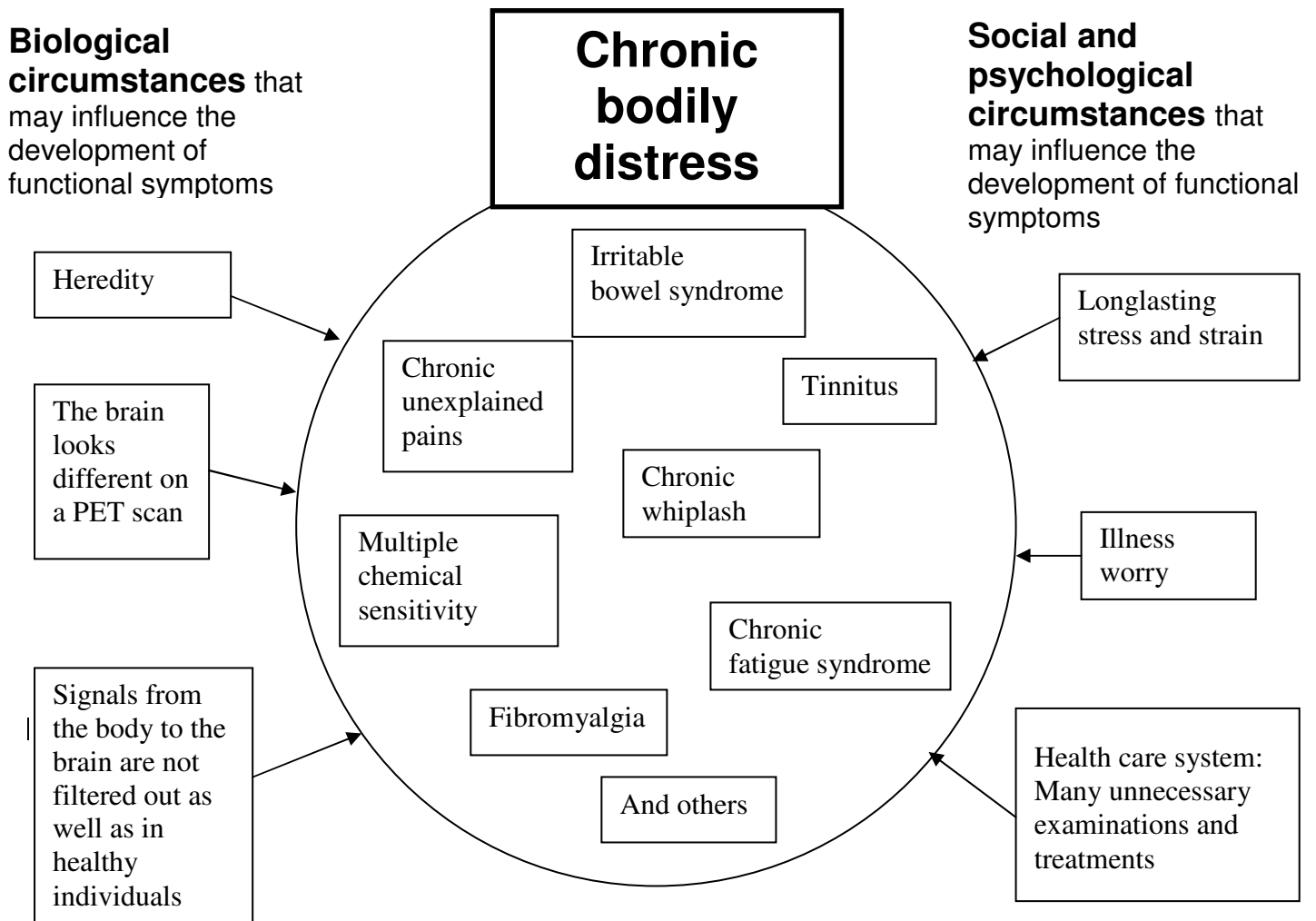
Classification of symptoms and syndromes of bodily distress, also called “medically unexplained symptoms”

- A) **Mild and transient physical symptoms** as a reaction to psychological and social stress.
- B) **Functional disorders:**
 - **Bodily Distress Disorder** = chronic functional somatic symptoms (i.e. so-called »medically unexplained symptoms«), or syndromes like fibromyalgia, chronic fatigue syndrome, irritable bowel syndrome, etc.
 - **Health anxiety** (hypochondriasis).
 - **Dissociative conditions:** spasms, movement- or sensory disturbances, prompted by severe psychological stress.
- C) Physical symptoms accompanying psychological disorders, i.e. **anxiety and depressions**.
- D) Symptom amplification, excessive worrying about disease, and abnormal disease behaviour in connection with **physical disease**.
- E) Self-inflicted disease (Factitious disorder = imaginary disease = Münchhausen’s syndrome). The person is conscious that he or she is self-inflicting the disease, but is not conscious of the reasons behind his or her actions. Rare disease. Such persons are mentally ill.
- F) **Manipulation** (Malingering = simulation). You are conscious of pretending to be ill, and know why you are doing it. Rare condition. Such persons are not mentally ill.

Source: *Fink, Rosendal, Olesen. The Australian and New Zealand Journal of Psychiatry. 2005;39(9):772-81.*

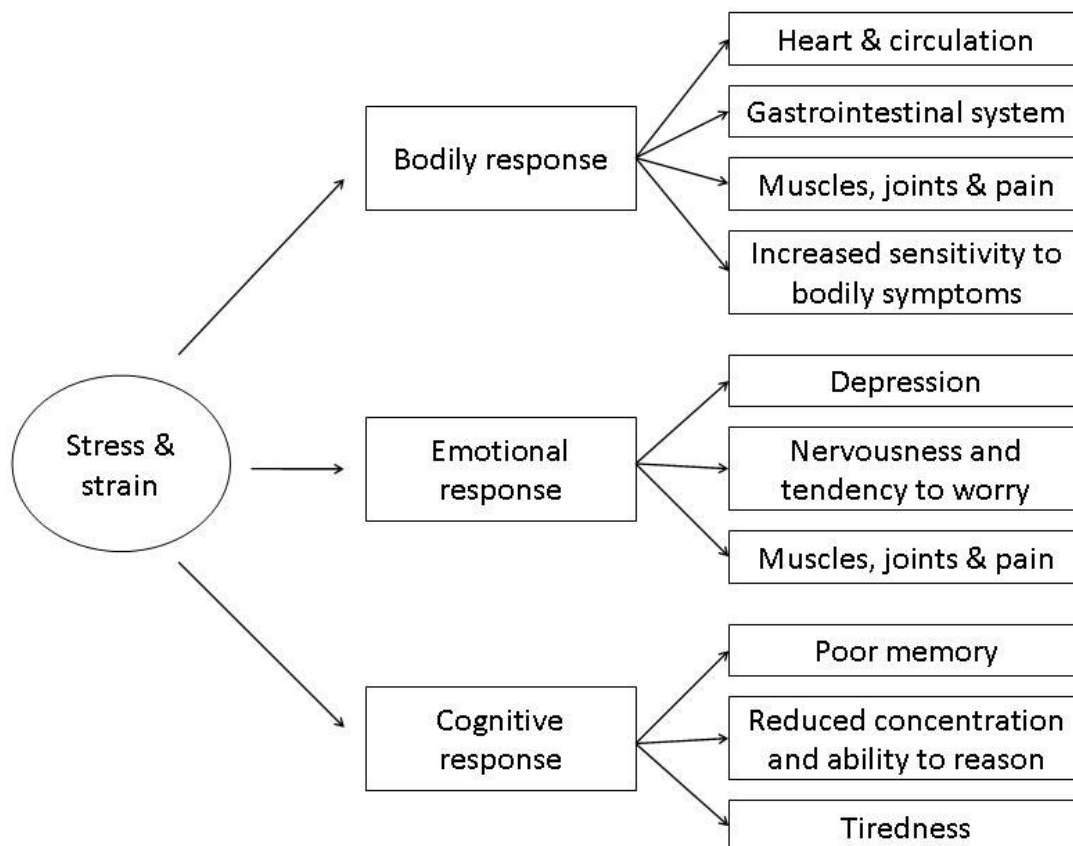
Teaching 3.2

What do we know about chronic bodily distress?



Teaching 3.3

Response to stress



Teaching 3.4

Response to stress & strain 1

Bodily response to stress and strain

Heart and circulation	Hot and cold sweats Shaking or trembling Dry mouth Palpitation (strong heart beats) or "nervous heart" uneasy stomach or »butterflies in the stomach« Reddening or flushing Tightness in the chest Breathlessness without exercise Need to take in further air while breathing quickly and deeply
Gastrointestinal	Loose stools Abdominal pain Bloating, sensation of tightness or heaviness Diarrhoea Stomach upsets or regurgitation Constipation Feeling sick or uncomfortable Vomiting Burning sensation of the chest or upper part of stomach
Muscles and joints (pain)	Pain in the arms or legs Muscle and joint pain Feeling of paralysis or weakness Back pain Pain which migrates from one place to the next Uncomfortable feeling of unresponsiveness or tingling
General symptoms	Memory difficulties Tension headache Dizziness Problems concentrating Tiredness following physical activity Tiredness following mental activity

Teaching 3.5

Response to stress & strain 2

Emotional response to stress and strain

Depressive reaction	Depressed mood Tendency to cry Tendency to keep to oneself Loss of interest in and ability to feel joy/happiness Feeling of guilt Low self-esteem Hopelessness with regard to the future Suicide and death thoughts
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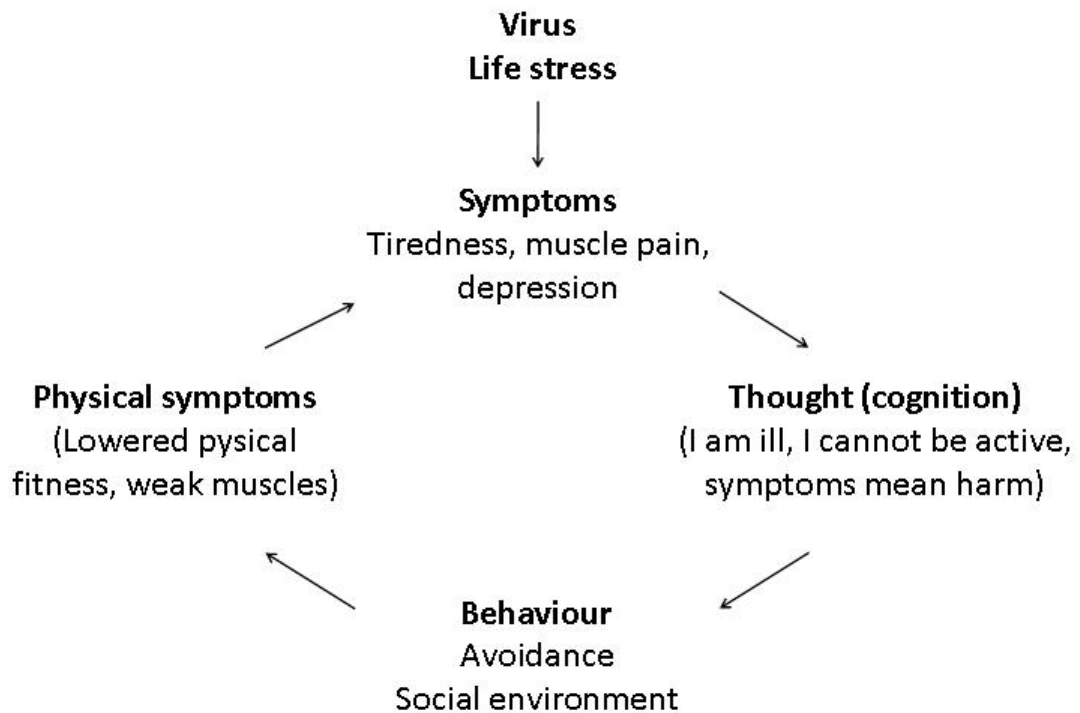
Nervous reaction	Tendency to worry Feeling of restlessness and anxiousness Tiredness Increased sensitivity to noise Irritability Tension and feeling of being under pressure Muscle tension Tension-associated pain (e.g. headache and back pain)
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Cognitive response to stress and strain

Concentration and ability to reason	Problems concentrating Problems thinking clearly and making decisions Loss of interest Loss of energy Tendency to become overwhelmed by everyday tasks
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Teaching 3.6

The vicious circle leading to chronic fatigue and disability

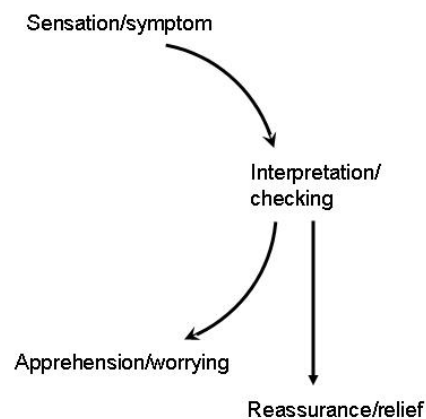


Source: Wessley S, 1995

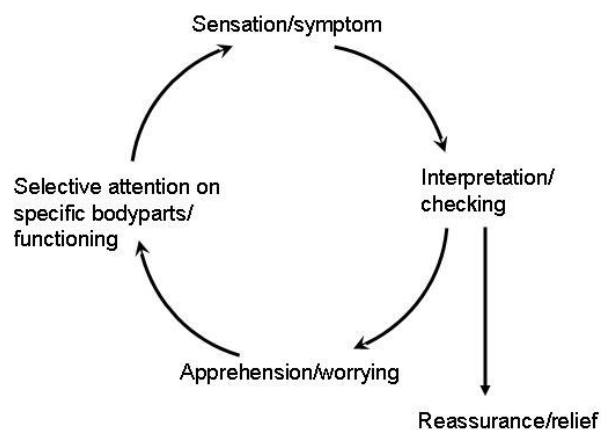
Teaching 3.7

Perception of symptoms and illness

Perception of symptoms and illness 1



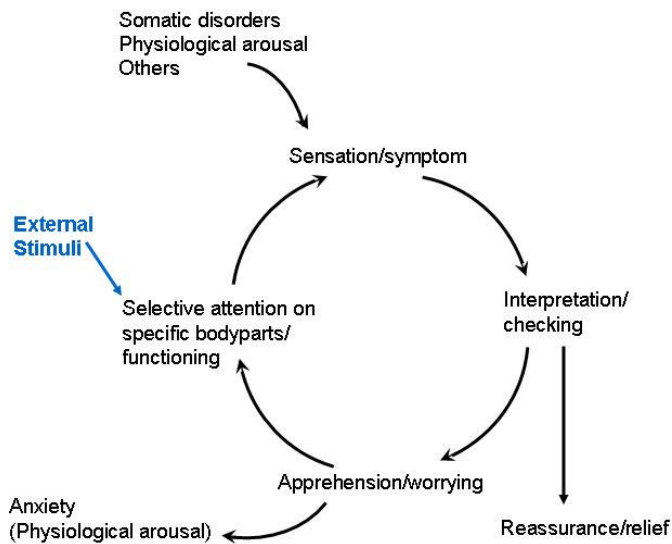
Perception of symptoms and illness 2



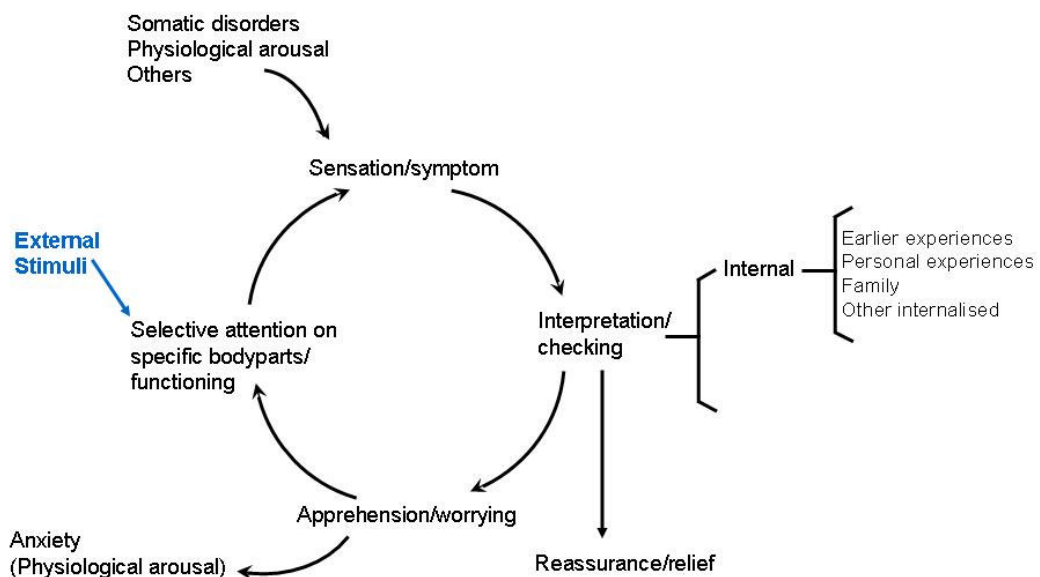
Source: Fink P, Toft T, Rosendal M, Psychosomatics 2002

Teaching 3.7

Perception of symptoms and illness 3



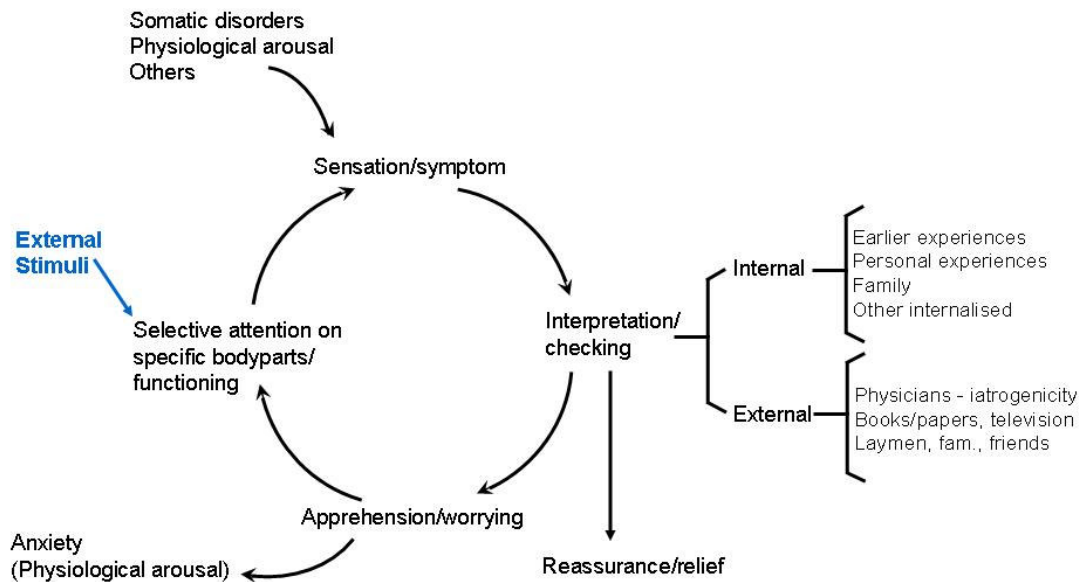
Perception of symptoms and illness 4



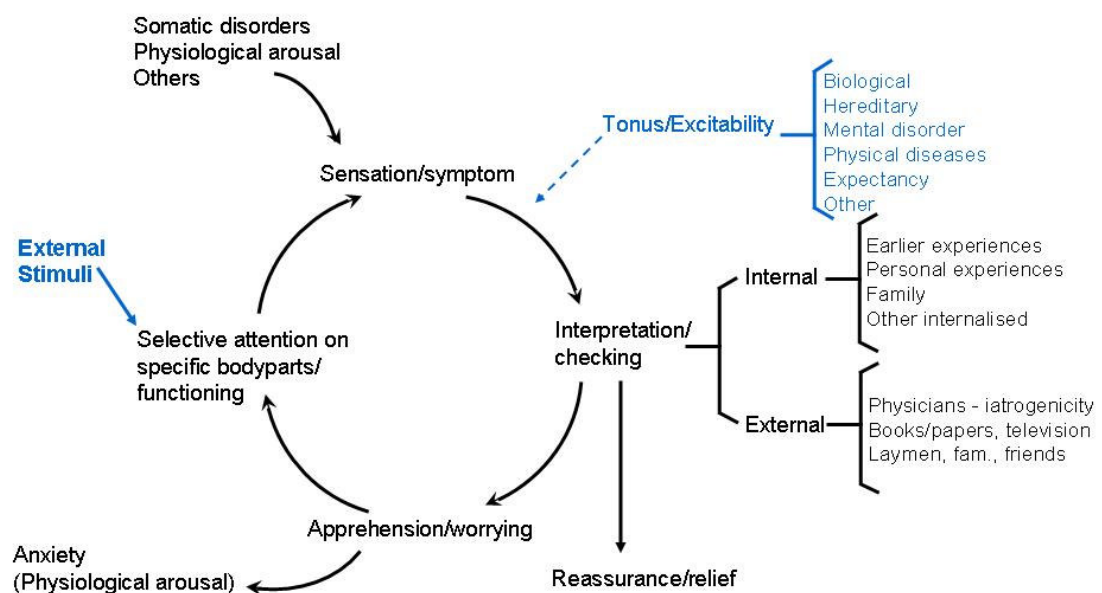
Source: Fink P, Toft T, Rosendal M, Psychosomatics 2002

Teaching 3.7

Perception of symptoms and illness 5



Perception of symptoms and illness 6



Source: Fink P, Toft T, Rosendal M, Psychosomatics 2002

Worksheet 3.1

List of objectives 1

What are your primary treatment objectives? You may have objectives to do with symptoms, behaviour, the relation to other persons, employment or whatever is more important to you.

1.

2.

3.

4.

5.

Worksheet 3.2

List of objectives 2

Slow but steady wins the race

1. Which is your primary objective?

2. How may you reach your objective?

3. Please divide your journey towards the objective into 5 steps, and state the first step here

4. How will you test your first step? (e.g. in the garden, at home in your kitchen, in the woods, at work)

5. How long time will you allow yourself in order to test your first step? (i.e. how many minutes, hours)

6. How often will you test your first step? (number of times daily)

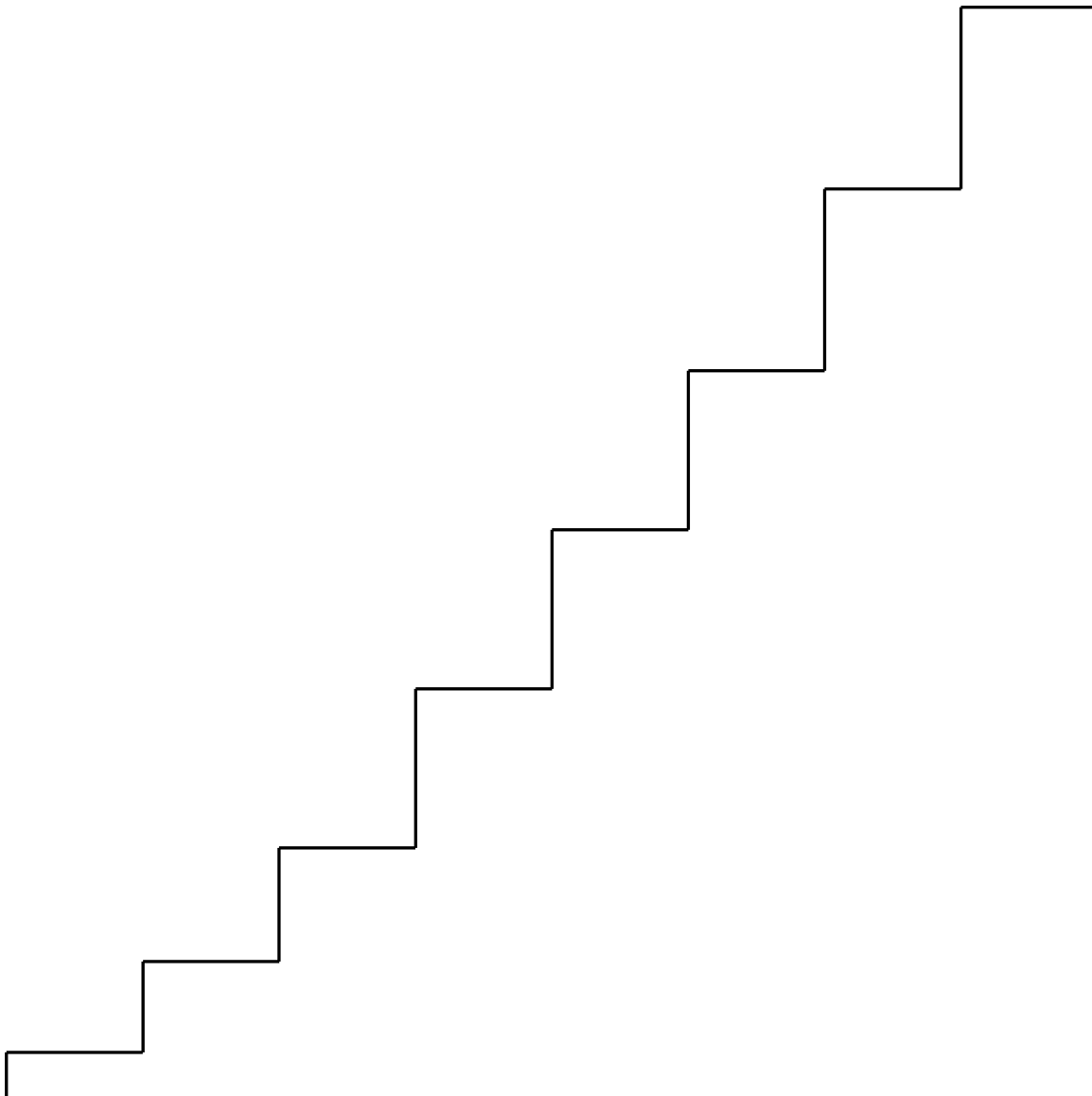
Worksheet 3.3

Staircase of goals

Instruction: Please fill in below.

1. Fill in the final objective of your treatment participation at the uppermost step.
2. At the first (lowest) step, add the partial objective you have decided to achieve by the next session on your way to the final objective.

Note! Objectives should be realistic!



Worksheet 3.4

Weekly registration form

Date:							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Night 1-3 hours							
Night 3-5 hours							
Night 5-7 hours							
Morning 7-9 hours							
Morning 9-11 hours							
Noon 11-13 hours							
Afternoon 13-15 hours							
Afternoon 15-17 hours							
Evening 17-19 hours							
Evening 19-21 hours							
Evening 21-23 hours							
Night 23-1 hours							

No pain/discomfort/
emotions

0 1 2 3 4 5 6 7 8 9 10

Worst possible pain/
discomfort/emotions

Worksheet 3.4

Weekly registration form

Date:							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Night 1-3 hours							
Night 3-5 hours							
Night 5-7 hours							
Morning 7-9 hours							
Morning 9-11 hours							
Noon 11-13 hours							
Afternoon 13-15 hours							
Afternoon 15-17 hours							
Evening 17-19 hours							
Evening 19-21 hours							
Evening 21-23 hours							
Night 23-1 hours							

No pain/discomfort/
emotions

0 1 2 3 4 5 6 7 8 9 10

Worst possible pain/
discomfort/emotions

Exercise 3.1

Homework from last time

Revision of homework: Weekly registration form.

Form groups of two persons and interview each other

Is there a pattern to the strength of the symptoms which bothers you the most - during a 24-hour period and during the week?

Can you identify anything which has helped to relieve your symptoms?

Can you identify anything which has aggravated your symptoms?

Exercise 3.2

Physical exercise

You have now been listening for several minutes.

Ask yourself the following questions:

1. How do I feel right now?
2. What do I need right now?
 - ♣ To move around in the chair?
 - ♣ Get up?
 - ♣ Stretch myself?
 - ♣ Breathe heavily?
 - ♣ Yawn?
 - ♣ Do knee bends?
 - ♣ Jog/run on the spot?
 - ♣ Lay down?

Exercise 3.3

Objectives you want to achieve during treatment

**Form groups of two and interview each other about your objectives.
What are your objectives? (brainstorm together)**

Write down the other group member's treatment objectives. He or she may have objectives to do with symptoms, behaviour, the relation to other persons, employment or whatever is more important to him or her.

For the objectives to be achievable they should be realistic and specific (you have three months to achieve the goals).

Next, write a number by each of your objectives to show which is most and second most important to you, etc.

Exercise 3.4

What is the first step towards the objectives?

Form groups of two and interview each other about the first step or partial objective. Spend approx. 30 minutes on the interview.

1. What is your objective?
2. How may you reach your objective?
3. Divide your journey towards the objective into five steps and describe each step.
4. How will you test your first step? (e.g. in the garden, at home in your kitchen, in the woods, at work)
5. How long time will you give yourself to test your first step? (i.e. how many minutes, hours)
6. How often will you test your first step? (number of times daily)

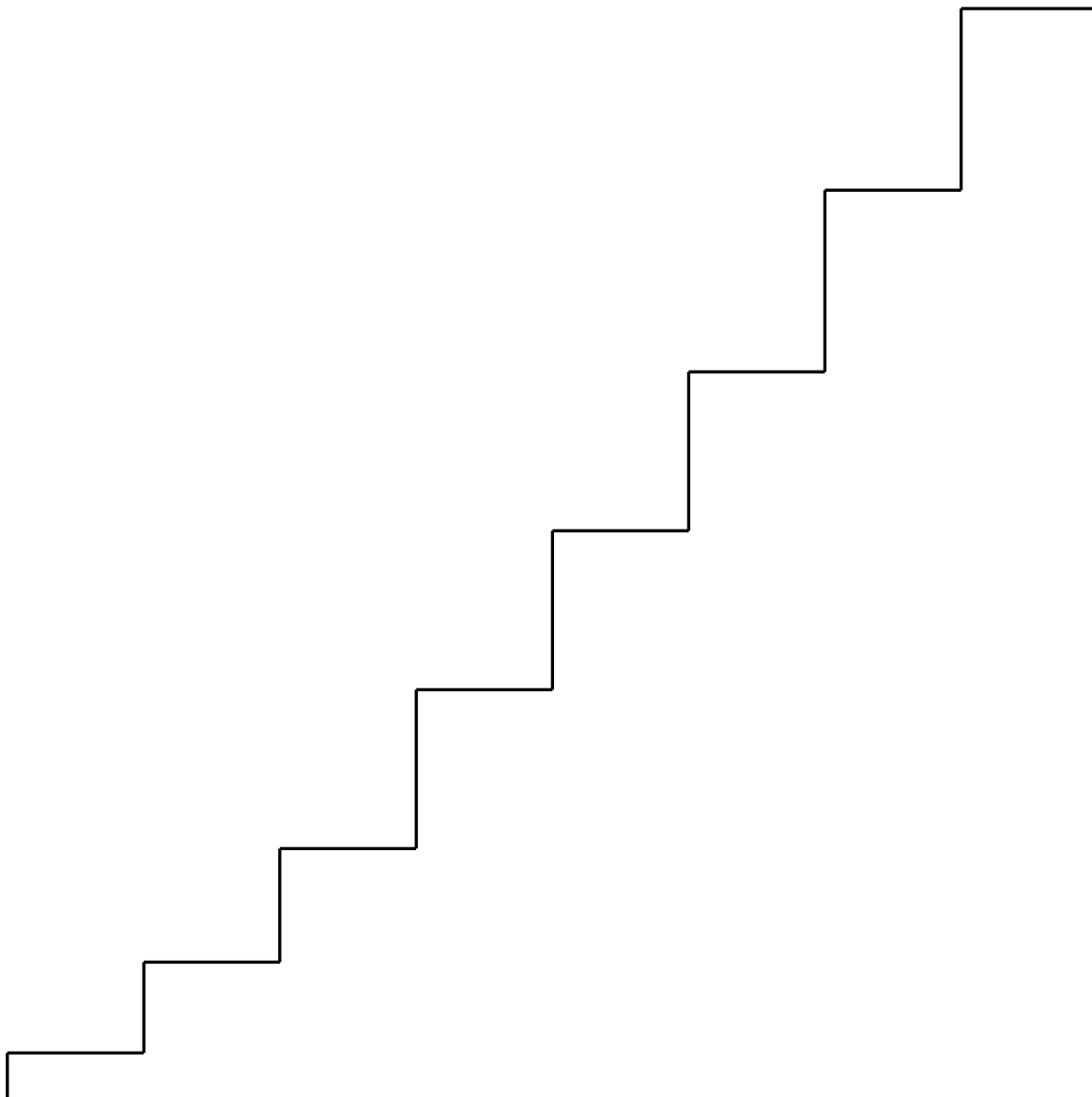
Exercise 3.5

Staircase of goals

Guideline: Please fill in below.

1. Fill in the objective for your treatment participation at the uppermost step.
2. At the first (lowest) step, add the partial objective you are aiming to achieve for the next session on your way to the final objective.

Note! Objectives should be realistic!



Homework for Module 4

What do I need to prepare for next time?

1. Weekly registration form

Instructions: Choose the most bothersome symptom. Make an estimate of the strength of your symptom in the box scale going from 0 to 10.

Every 2 hours note the number that fits best with the strength of your symptom. You can fill in the weekly registration form by doing this 2 to 3 times a day.

2. Testing partial objectives

Instruction: Continue your work to define your treatment objectives and the path which will take you to the objectives. Use *Worksheets 3.1-3.3*

Test the first partial objective you defined during treatment.

Note! Objectives should be realistic and specific and you only have three months to achieve them.

**»Give me the peace of mind to accept that which I cannot change.
The courage to change that which I can.
And the wisdom to know which is which«**

Marcus Aurelius, 150 AD.

Box scale registration

A. Date DD MM YY

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B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	0	1	2	3	4	5	6	7	8	9	Worst possible symptom
	10										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain	0	1	2	3	4	5	6	7	8	9	Worst possible pain
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	Worst possible other symptoms/discomfort
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness	0	1	2	3	4	5	6	7	8	9	Worst possible sadness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness	0	1	2	3	4	5	6	7	8	9	Worst possible nervousness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness	0	1	2	3	4	5	6	7	8	9	Worst possible tiredness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating	0	1	2	3	4	5	6	7	8	9	Worst possible problems concentrating
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 4

Negative automatic thoughts and dysfunctional behaviours

Programme

12.30-1.30pm:

- **Welcome**
- **Box scale registration**
- **Homework from previous module.** *Discussion in two groups*
 1. Weekly registration form
 2. Partial objectives
 3. The Staircase of goals. *Exercise 4.1. Worksheet 4.3*

1.30-1.45pm: Break – coffee & tea

1.45-2.45pm:

- **Physical exercise.** *Exercise 4.2*
- **The basic model.** *Exercise 4.3. Worksheet 4.1*

2.45-3.00pm: Break

3.00 – 4.00pm:

- **Homework for module 5**
 1. Weekly registration form, NEW. *Worksheet 4.2*
 2. Next steps to achieve the objective
 3. The basic model. *Worksheet 4.1*
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

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B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	Worst possible symptom
0 1 2 3 4 5 6 7 8 9 10	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain	Worst possible pain
	0 1 2 3 4 5 6 7 8 9 10	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort	Worst possible other symptoms/discomfort
	0 1 2 3 4 5 6 7 8 9 10	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness	Worst possible sadness
	0 1 2 3 4 5 6 7 8 9 10	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness	Worst possible nervousness
	0 1 2 3 4 5 6 7 8 9 10	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness	Worst possible tiredness
	0 1 2 3 4 5 6 7 8 9 10	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating	Worst possible problems concentrating
	0 1 2 3 4 5 6 7 8 9 10	
	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

Worksheet 4.1

The Basic model

Time:

Situation:

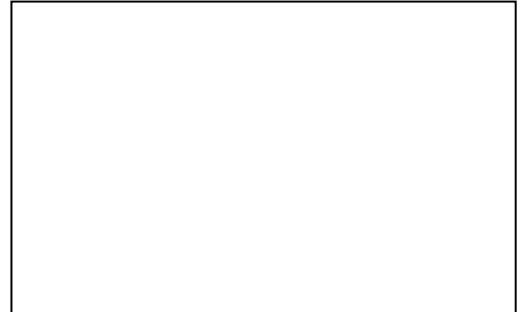
Physical symptom/sensation



Actions



Thoughts

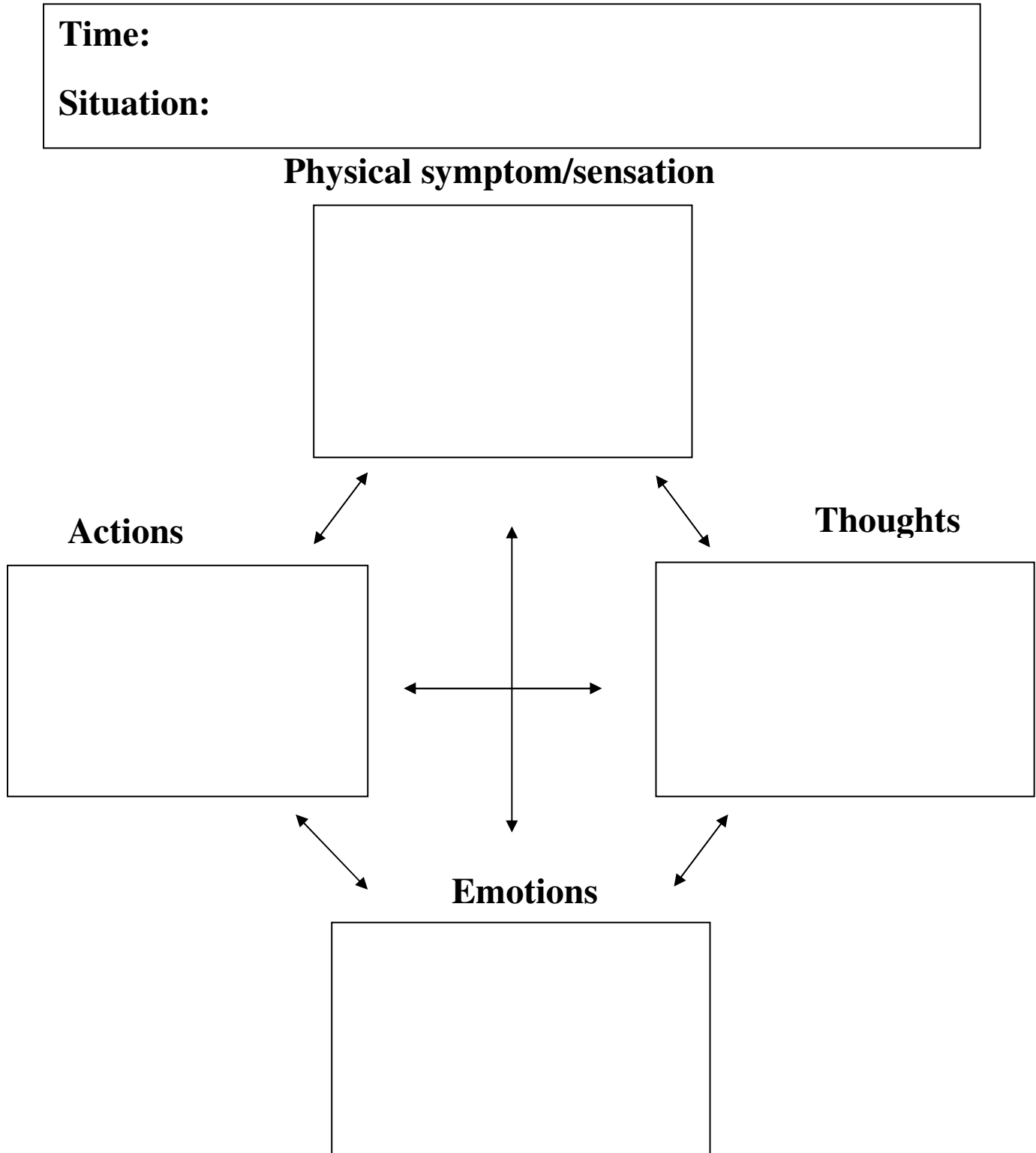


Emotions



Worksheet 4.1

Basic model



Worksheet 4.2

Weekly registration form

Symptom/Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	1	2	3	4	5	6	7	8	9	10	Worst possible pain/discomfort/ emotions
	<hr/>										

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 4.2

Weekly registration form

Symptom/Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/
discomfort/
emotions

1 2 3 4 5 6 7 8 9 10

Worst possible
pain/discomfort/
emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: *on the bus, at work, at mother in law's, etc.*

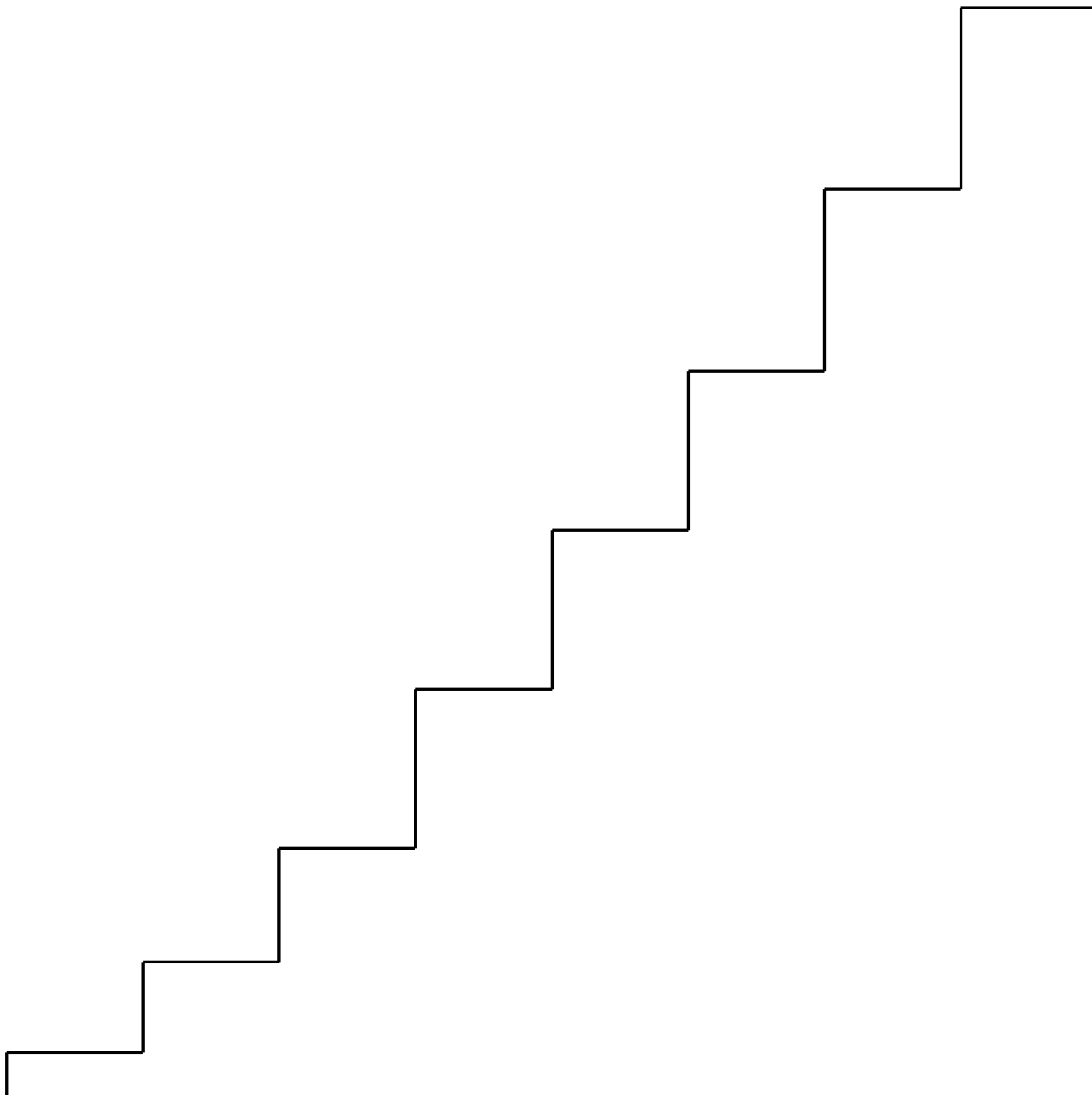
	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 4.3

Staircase of goals

Instruction: Please fill in below.

1. Fill in the objective of your treatment participation at the uppermost step.
2. At the first (lowest) step, add the partial objective you have decided to achieve by the next session on your way to the final objective.
Note! Objectives should be realistic!
3. At the various steps, add the partial objectives there could be on the way to the final objective.



Exercise 4.1

The staircase of goals

1. Use the staircase of goals from your homework assignment (*Worksheet 3.5 from Module 3*). Next, complete this Module's pyramid (*Worksheet 4.3*).
2. State the objective of your participation in the treatment project at the uppermost step.
3. At the first (lowest) step, add the first step, the one you have already completed. Then add the next step which is to take you towards your objective.
Note! Objectives should be realistic!
4. Fill in the partial objectives you believe will be necessary on the various steps up towards the final objective.
5. Finally redraw your entire pyramid on your flip over.

Exercise 4.2

Physical exercises

You have now been listening for several minutes.

Ask yourself the following questions:

3. How do I feel right now?
4. What do I need right now?
 - ♣ To move around in the chair?
 - ♣ To stand up?
 - ♣ To stretch myself?
 - ♣ To breathe heavily?
 - ♣ To yawn?
 - ♣ To bend down in my knees?
 - ♣ To run on the spot?
 - ♣ To lay down?

Exercise 4.3

How to use the basic model of cognitive behavioral therapy (CBT)

1. Choose the **situation in your weekly registration form** (*Worksheet 4.2*) when you felt worst. Add the time and situation to *Worksheet 4.1*.
2. **Physical symptom or sensation** during the situation
What was your bodily experience at the time? Add your description to the basic model on *Worksheet 4.1*
3. Feelings / emotions **during the situation**
What did you feel? Add your description to the basic model on *Worksheet 4.1*.
4. Thoughts **during the situation**
What did you think about? Add your description to the basic model on *Worksheet 4.1*.
5. Actions **during the situation**
How did you act/respond? Add your description to the basic model on *Worksheet 4.1*.

Homework for module 5

What do I need to prepare for next time?

1. Weekly registration form, NEW!

On *Worksheet 4.2* record how many symptoms and what symptoms you have experienced for each day of the week. Feel free to agree with your therapist on leaving some symptoms out, if you have had to deal with many different symptoms

For every entry you make, also add a note to characterize the situation you were in when experiencing the symptoms e.g.: on the bus, at work, at mother in law's, etc.

You can fill in the weekly registration form by adding new entries 2-3 times a day

2. The next steps on your way towards your objective

After talking about your homework for today you now have a better idea about your realistic treatment objectives. Hopefully, you have decided on your next step. For next time, you should test your second step.

Consider any obstacles but also anything else that may increase your chance of success.

Next time we will assess if your partial objective was achieved and whether any adjustments of the objectives and means are needed.

3. The basic model

Pick a situation from this week's weekly registration form. Fill in *Worksheet 4.1* "The basic model" as described in the instruction to *Exercise 4.3*.

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	0	1	2	3	4	5	6	7	8	9	Worst possible symptom
	10										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain	0	1	2	3	4	5	6	7	8	9	Worst possible pain
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	Worst possible other symptoms/discomfort
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness	0	1	2	3	4	5	6	7	8	9	Worst possible sadness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness	0	1	2	3	4	5	6	7	8	9	Worst possible nervousness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness	0	1	2	3	4	5	6	7	8	9	Worst possible tiredness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating	0	1	2	3	4	5	6	7	8	9	Worst possible problems concentrating
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 5

Cognitive distortions, alternative responses and emotional awareness

Programme

12.30-1.30pm:

- **Welcome**
- **Box scale registration**
- **Homework from previous module** *Discussion in two groups*
 1. Problems doing it?
 2. Weekly registration: Symptom/problem registration
 3. Second step towards your objective
 4. The basic model

1.30-1.45pm: Break with coffee and tea

1.45-2.45pm:

- **Cognitive distortions.** *Teaching 5.1. Exercise 5.1 .Worksheet 5.1*
- **Emotions.** *Teaching 5.2*
- **The basic model: Automatic thoughts.** *Exercise 5.2. Worksheet 5.2*

2.45-3.00pm: Break

3.00-4.00pm:

- **The basic model. Alternative thoughts.** *Exercise 5.3. Worksheet 5.3*
- **Homework for module 5.**
 1. Weekly registration form. *Worksheet 5.4*
 2. Your personal path to the your objectives
 3. The basic model
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

2. Pain:	No pain											Worst possible pain
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Other symptoms/discomfort:	No other symptoms/discomfort											Worst possible other symptoms/discomfort
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Sadness:	No sadness											Worst possible sadness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Nervousness:	No nervousness											Worst possible nervousness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Tiredness:	No tiredness											Worst possible tiredness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

7. Problems concentrating:	No problems concentrating											Worst possible problems concentrating
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Teaching 5.1

Cognitive distortions

Name	Explanation	Example	Alternative thought
All or nothing = Black/white thinking	Experiences are categorized as extremes and no middle ground is possible, e.g. evil/good, success/failure. Look for words like always, never, all, none, nothing, everything.	"If I can't do it 100%, I am a failure". "If I can't do it as well as before I fell ill, I can't do it at all".	"If I take one step at a time. I'll reach the level I had before falling ill". "Demanding perfection stops me from getting started in the first place". "Professional athletes who suffer injuries also have to work their way back bit by bit".
Generalisations	Unjustified, sweeping conclusions based on a single event.	"I could not do the things I decided yesterday. I'll never get well".	"Yesterday was a bad day. But the fact is, I have managed to reach my objectives many other days and I am progressing, slowly but steadily".
Focusing on negative aspects	You select the negative events and forget everything else in the situation.	"My son didn't like my food. I'm no good at cooking".	"The others liked the food. I'm an OK cook"
Negative predictions	The possibility that something could happen becomes certainty that it will.	"If I have to practice now, I will definitely fall ill".	I can't see into the future and therefore don't know if I'll fall ill. This worries me. But that's not the same as knowing for certain".
Catastrophic thinking	Trivial events are perceived as catastrophes.	"I can feel my heart beating. I'll probably die in a moment".	"My heart is beating. I've experienced that many times before, and nothing happened then".
Excessive bodily focus	Bodily sensations are experienced as signs of serious physical disease.	"My stomach aches. I believe I was nauseous yesterday. It's probably cancer".	"I've had my stomach checked. They found no signs of disease".

Teaching 5.2

Four fundamental emotions

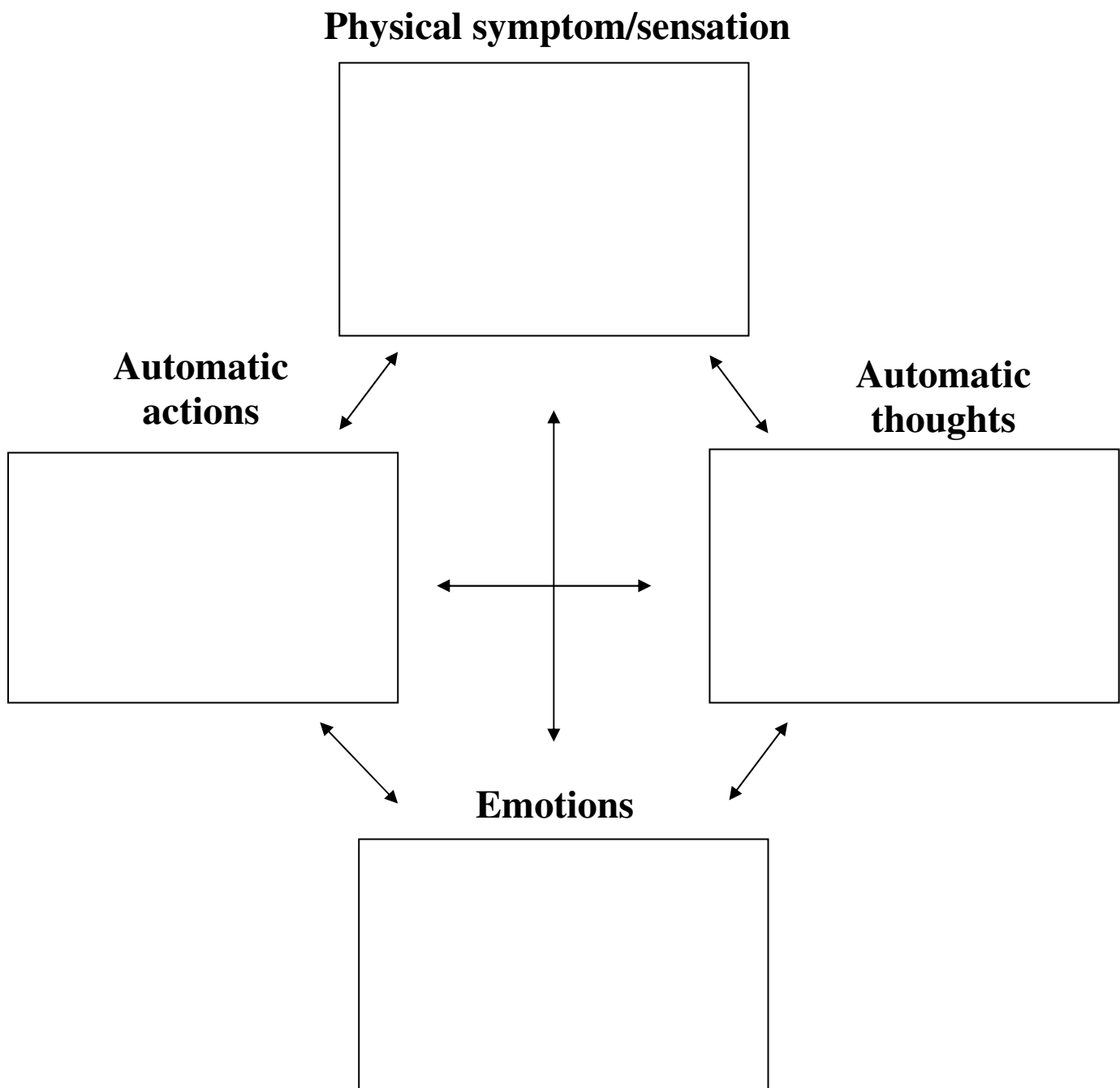
Fear	Anger	Sadness	Desire
worried	angry	careless	happy
concerned	frustrated	sad	cheerful
anxious	annoyed	embarrassed	joyfull
frightned	grumpy	quilty	unconcerned
impatient	ill-tempered	incompetent	blisfull
restless	furious	useless	excited
confused	vicious	hopeless	harmonic
cormented	bad-tempered	depressed	
upset	revolted	dejected	
	aggressive		

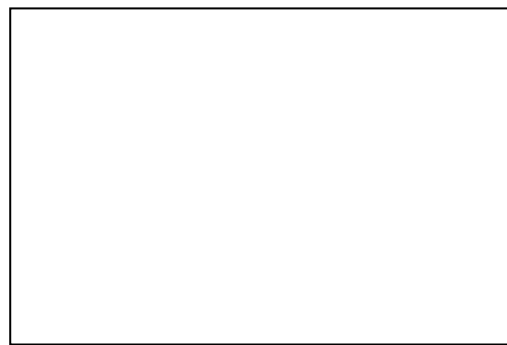
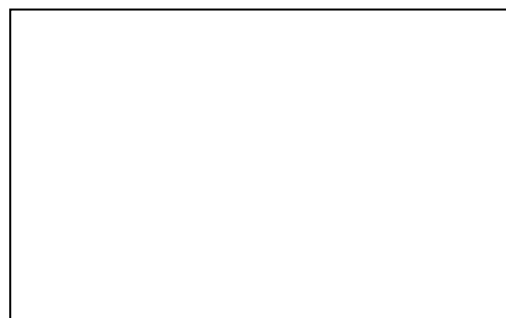
Worksheet 5.1

Cognitive distortions

Mark the **cognitive distortions** you know from yourself. Add an example in the **Example** column. Then try to find a more realistic **Alternative thought**.

Name	Explanation	Example	Alternative thought
All or nothing = Black/white thinking	Experiences are categorized as extremes and no middle ground is possible, e.g. evil/good, success/failure.		
Generalisations	Unjustified, sweeping conclusions based on a single event.		
Focusing on negative aspects	You select the negative events and forget everything else in the situation.		
Negative predictions	The possibility that something could happen becomes certainty that it will.		
Catastrophic thinking	Trivial events are perceived as catastrophes.		
Excessive bodily focus	Bodily sensations are experienced as signs of serious physical disease.		

Worksheet 5.2**Basic model with automatic thoughts or actions****Time:****Situation:**

Worksheet 5.3**Basic model with alternative thoughts or actions****Time:****Situation:****Physical symptom/sensation****Alternative
actions****Alternative
thoughts****Emotions**

Worksheet 5.4

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	1	2	3	4	5	6	7	8	9	10	Worst possible pain/discomfort/ emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 5.4

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/
discomfort/
emotions

1 2 3 4 5 6 7 8 9 10

Worst possible
pain/discomfort/
emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Exercises 5.1-5.3

Cognitive distortions and the basic model

Exercise 1: Cognitive distortions

Use *Worksheet 5.1*. Mark the **cognitive distortions** you know from yourself. Add an example in the **Example** column. Then try to find a more realistic **Alternative thought**.

Next, consider the distortions you have not marked and try to find an example for each.

Exercise 2: The basic model with automatic thoughts or actions

Complete *Worksheet 5.2: The basic model with automatic thoughts or actions* for yourself. Base your work on a situation in which you experienced bodily symptoms which occurred during the last week.

Exercise 3: The basic model with alternative thoughts or actions

Complete *Worksheet 5.3: The basic model with alternative thoughts or actions* for yourself. Take your alternative thoughts as a starting point and then write down what the alternative thoughts will lead to in terms of feelings, actions and symptoms.

Homework for module 6

What do I need to prepare for next time?

1. Weekly registration form

Instruction:

In this sheet you record how many and which symptoms you have experienced for every day of the week. If you have many symptoms, talk to your therapist about leaving out some of them. For each entry add a few words to describe the situation you were in when experiencing the symptoms, e.g. “on the bus”, “at work”, etc. Complete the weekly registration form by filling in parts of the form 2-3 times a day.

2. The next steps on your way towards your objective

After talking about your homework for today you now have a better idea about your realistic treatment objectives. Hopefully, you have decided on your next step. For next time, you should test your next step.

Consider any obstacles but also anything else that may increase your chance of success.

Next time we will assess if your partial objective was achieved and whether any adjustments of the objectives and means are needed.

3. The basic model

Instruction:

1. Select one or more situations from the last two weekly registration forms. You should look for the situations when you felt really bad. Next, fill in *Worksheet 5.2*, “The Basic model with **automatic thoughts or actions**”.
2. Now think of some **alternative thoughts** and add them to *Worksheet 5.3*, “The basic model with alternative thoughts or actions”. On the basis of the alternative **thoughts**, imagine what these would lead to in terms of emotions, and how the alternative **thoughts** might change your symptoms and actions.
3. Finally, think of some **alternative actions** and add them to *Worksheet 5.3*, “The basic model with alternative thoughts or actions”. On the basis of the alternative **actions**, imagine what these would lead to in terms of emotions, and how the alternative **actions** might change your symptoms and thoughts.

Box scale registration

A. Date

DD	MM	YY
<input type="text"/>	<input type="text"/>	<input type="text"/>

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	0	1	2	3	4	5	6	7	8	9	Worst possible symptom
	10										
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain	0	1	2	3	4	5	6	7	8	9	Worst possible pain
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	Worst possible other symptoms/discomfort
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness	0	1	2	3	4	5	6	7	8	9	Worst possible sadness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness	0	1	2	3	4	5	6	7	8	9	Worst possible nervousness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness	0	1	2	3	4	5	6	7	8	9	Worst possible tiredness
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating	0	1	2	3	4	5	6	7	8	9	Worst possible problems concentrating
		10										
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 6

From illness behaviour to health behaviour I: Pleasant activities. Life chart

Programme

12.30-1.30pm:

- **Welcome**
- **Box scale registration**
- **Homework from last time.** *Discussion in 2 groups*
 1. Weekly registration form
 2. Test of partial objectives
 3. The basic model

1.30-1.45pm: Break, coffee & tea

1.45-2.45pm:

- **Pleasant activities.** *Teaching 6.1. Exercise 6.1*
- **Draw your life chart.** *Exercise 6.2*

2.45-3.00pm: Break

3.00-4.00pm:

- **The basic model.** *Worksheets 6.1 & 6.2. Exercises 6.3 & 6.4*
- **Homework for module 7.**
 1. Weekly registration form. *Worksheet 6.3*
 2. Test of partial objectives. *Worksheet 4.3 from Module 4*
 3. The basic model. *Worksheets 6.1 & 6.2*
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No pain											Worst possible pain
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No other symptoms/discomfort											Worst possible other symptoms/discomfort
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No sadness											Worst possible sadness
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No nervousness											Worst possible nervousness
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No tiredness											Worst possible tiredness
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No problems concentrating											Worst possible problems concentrating
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Teaching 6.1

List of ideas for pleasant activities

1. Reading fiction
2. Writing a diary entry
3. Doing aerobic
4. Horseback riding
5. Buying flowers for yourself
6. Buying books
7. Going to the movies
8. Going for a run
9. Tell yourself that you have done a good job
10. Think of positive situations that you have enjoyed with friends

11. Listen to music
12. Relax in the sun
13. Laugh
14. Refresh positive travel memories
15. Listen to others
16. Read a newspaper or magazine
17. Spend time on a hobby (model airplanes/collecting stamps)
18. Spend time with friends
19. Plan a holiday or other activities which make you happy
20. Meet new people

21. Eat something delicious/special
22. Do karate/judo
23. Attend Yoga
24. Do household activities
25. Repair your bike or car
26. Dress up in sexy or stylish clothes
27. Enjoy a quiet evening
28. Look after your plants
29. Go swimming
30. Exercise

31. Start collecting something
32. Go to a party
33. Consider buying something
34. Play golf
35. Play football
36. Fly a kite
37. Discuss politics, movies, books philosophy, etc. with friends
38. Attend a family celebration
39. Ride a motorbike
40. Have sex

41. Go for a run in the woods
42. Go camping
43. Sing in the shower or while doing household activities
44. Buy/pick and arrange flowers
45. Go to church/mosque/synagogue
46. Loose weight
47. Think of the things you're good at
48. Take a day off
49. Arrange a class reunion
50. Go skating

51. Go sailing
52. Travel abroad
53. Paint og draw
54. Do some needlework
55. Sleep
56. Go for a ride in a car
57. Participate in association work/meetings
58. Go hunting
59. Join a choir
60. Flirt

61. Start playing an instrument
62. Be creative (pearls, ceramics, etc.)
63. Make a gift for someone you love
64. Buy a good CD
65. Watch boxing
66. Plan a party
67. Cooking
68. Go climb a mountain
69. Write poetry, short stories, books, articles, etc
70. Go shopping

71. Have dinner out
72. Work
73. Go sightseeing
74. Do some gardening
75. Go to a beauty parlour/hairdresser's
76. Play tennis
77. Spend time with your own other children
78. Go to the theatre
79. Go to a concert
80. Daydreaming

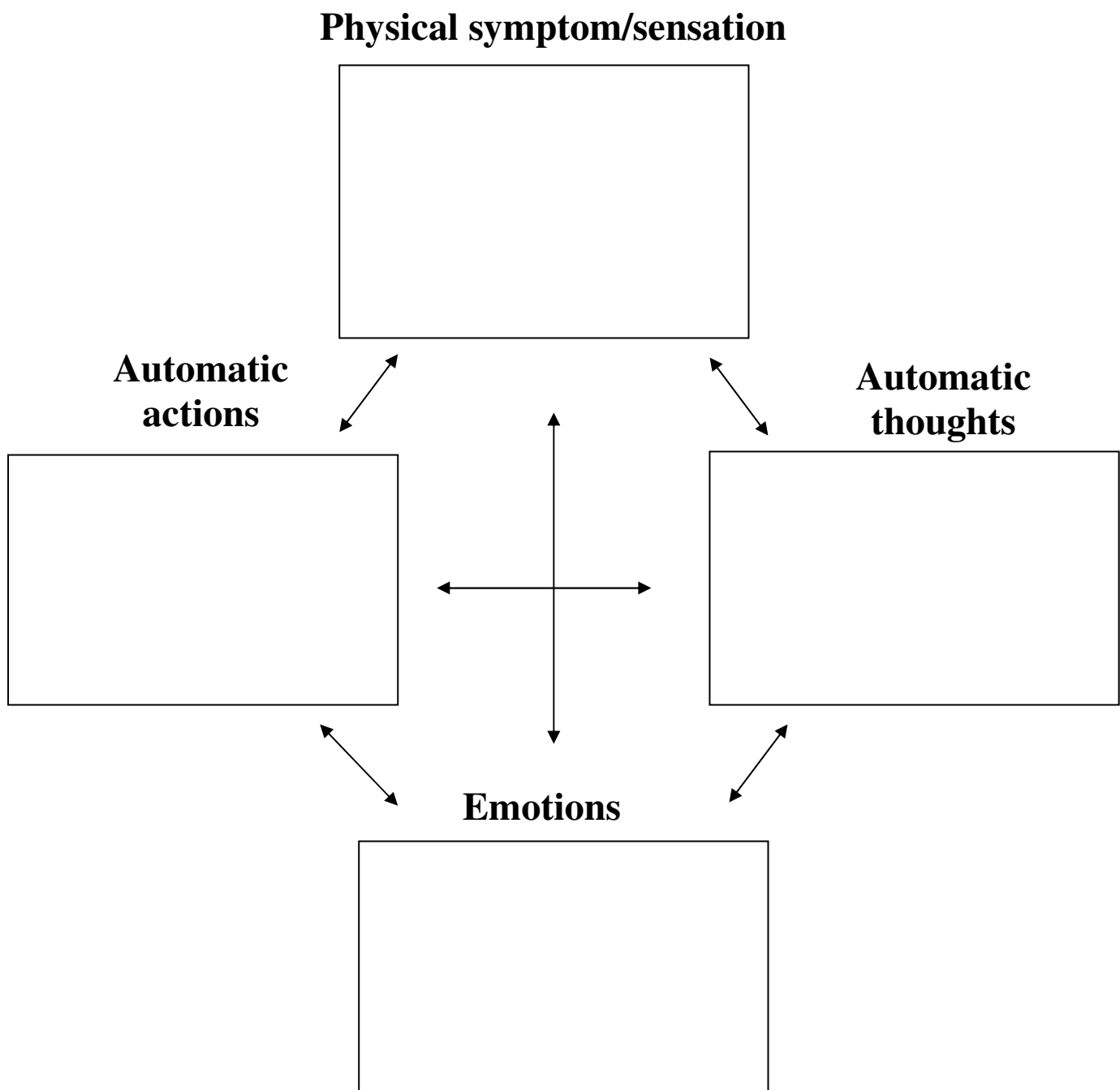
81. Go for a ride
82. Listen to the radio
83. Watch TV
84. Make a to do list
85. Go bike-riding

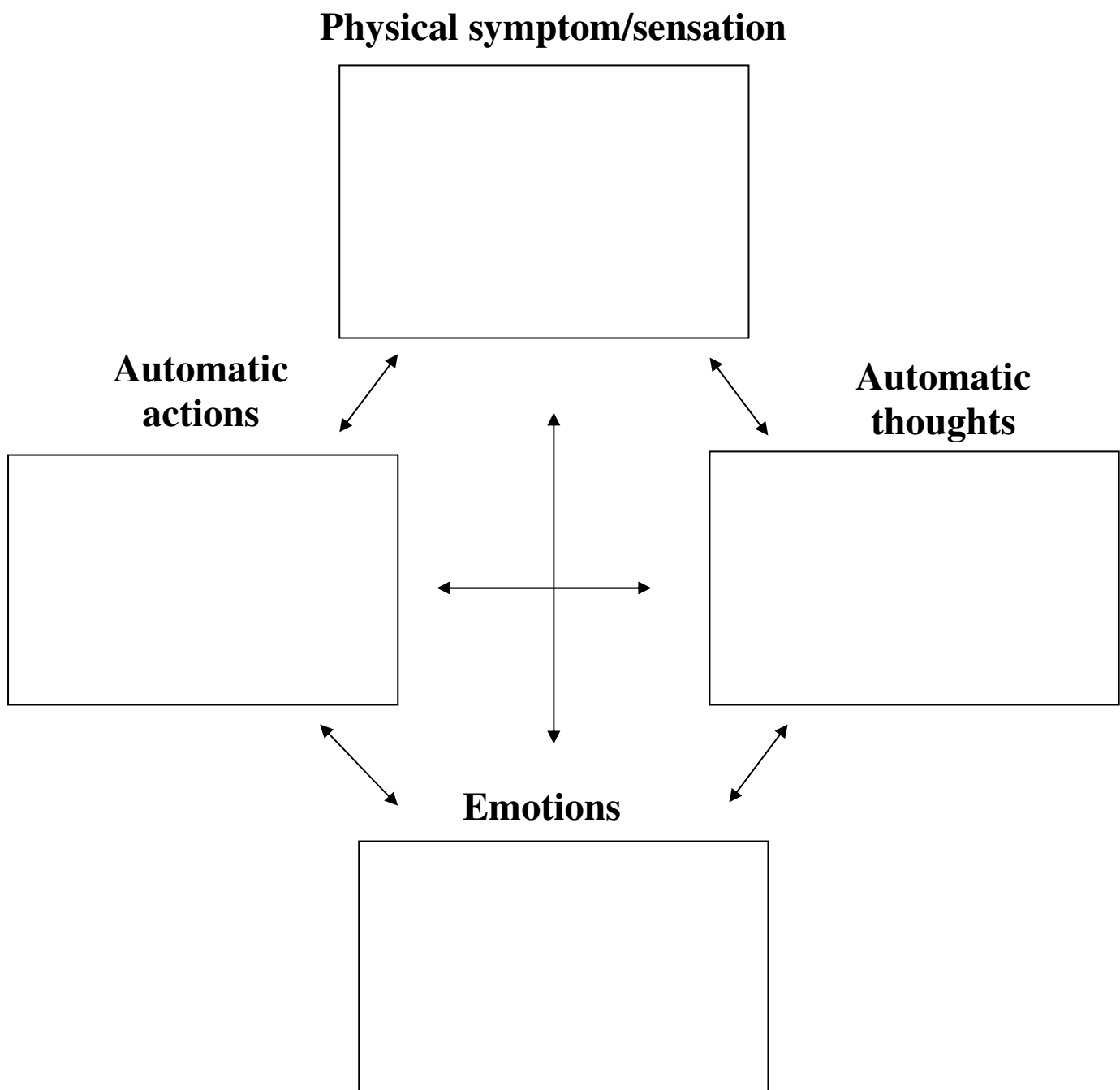
86. Go for a walk by the sea
87. Go shopping or buy someone a present
88. Go to the zoo, parks, botanical gardens, etc.
89. Complete an assignment
90. Go to the races (horseback/motor)
91. Eat candy, cakes and crisps
92. Teach someone something you're good at
93. Take pictures with a digital or normal camera
94. Go fishing
95. Follow a diet
96. Spend time with animals
97. Fly an aeroplane
98. Read specialised literature
99. Join an amateur theater group
100. Spend time on your own
101. Play badminton
102. Take a long bath in the tub
103. Take a vacation
104. Pay off some old debts
105. Collect things (coins, stones, etc.)
106. Set up a date
107. Relax
108. Write letters
109. Take your children to an amusement park
110. GO dancing
111. Go for a picnic
112. Meditate
113. Play volleyball
114. Have lunch with a friend at a café
115. Play cards/games (backgammon, chess, etc.)
116. Do some crosswords
117. Play rounders
118. Watch and show someone photographs
119. Play the guitar
120. Play pool
121. Buy yourself something nice (perfume, shoes, clothes, etc.)
122. Talk with friends on the phone
123. Visit a museum
124. Light a candle
125. Receive or give a massage
126. Go to a sauna or Turkish bath
127. Go skiing
128. Go canoeing
129. Go bowling
130. Do some carpenting

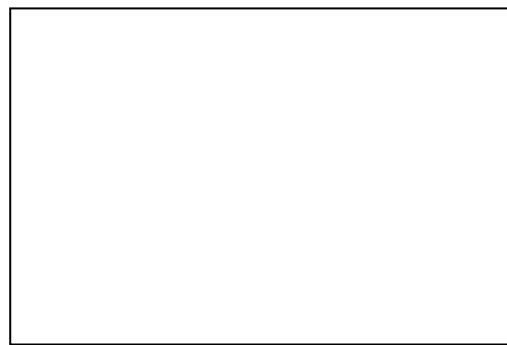
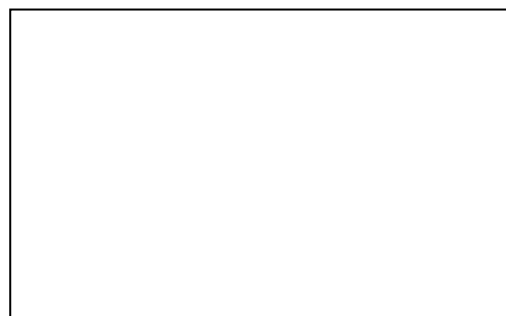
- 131. Fantasise about the future
- 132. Go to the ballet, tap-dancing, salsa, etc.
- 133. Take care of fishes in an aquarium
- 134. Get into politics
- 135. Do some volunteer work
- 136. Do a puzzle
- 137. Go to the beach
- 138. Redecorate or touch up your home
- 139. Attend a sports event
- 140. Go to a disco or bar

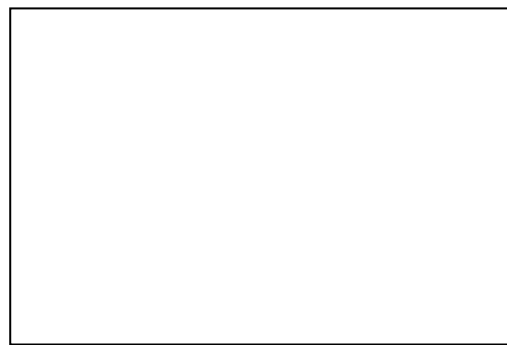
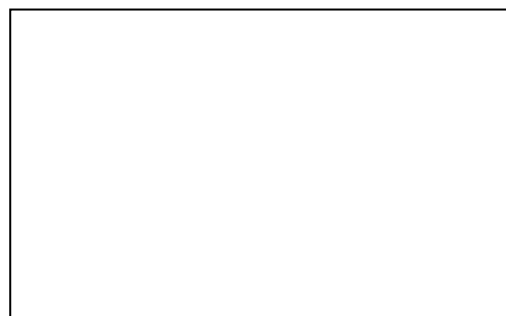
- 141. Attend a lecture
- 142. Invite friends over for dinner
- 143. Wash your hair and put on moisturizer
- 144. Go waterskiing
- 145. Go window shopping
- 146. Go to the circus, an amusement park, etc.
- 147. Go to flea markets
- 148. Surf the internet
- 149. Use your playstation
- 150. Chat on the internet

- 151. Look at the stars
- 152. Bake a cake
- 153. Have a footbath
- 154. Spend time with your partner, children and/or friends

Worksheet 6.1**Basic model with automatic thoughts or actions****Time:****Situation:**

Worksheet 6.1**Basic model with automatic thoughts or actions****Time:****Situation:**

Worksheet 6.2**Basic model with alternative thoughts or actions****Time:****Situation:****Physical symptom/sensation****Alternative
actions****Alternative
thoughts****Emotions**

Worksheet 6.2**Basic model with alternative thoughts or actions****Time:****Situation:****Physical symptom/sensation****Alternative
actions****Alternative
thoughts****Emotions**

Worksheet 6.3

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/
discomfort/
emotions

1 2 3 4 5 6 7 8 9 10

Worst possible
pain/discomfort/
emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 6.3

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/
discomfort/
emotions

1 2 3 4 5 6 7 8 9 10

Worst possible
pain/discomfort/
emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Exercise 6.1

Pleasant activities

Add 10 pleasant and realistic activities

You may choose activities which you now find positive, or activities which were positive to you before your symptoms restricted your activities.

To produce 10 symptoms, you can brainstorm, consult the list of pleasant activities and think back on the activities you took part in during a typical week before your symptoms set in.

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Exercise 6.2

Life chart

Instruction:

Add the following to the figure below:

At the top, write the year you were born.

On the left side of the line, add your symptoms in the order they appeared. The most important data is when the symptoms started.

Once you have added your symptoms and the year they occurred or your age at the time beside the symptoms, please add a few words to describe any current or previous social events which you believe may be linked to your symptoms.

Finally, transfer your life chart to your flip over.

19

Symptoms	Age	Year	Social events

Exercise 6.3 & 6.4

The basic model

Exercise 3: The basic model with automatic thoughts or actions

Fill in *Worksheet 6.1: The basic model with automatic thoughts or actions* for yourself, departing from a situation during the last week in which you experienced symptoms.

Exercise 4: The basic model with alternative thoughts or actions

- Now think of some **alternative thoughts** and add them to *Worksheet 6.2, "The basic model with alternative thoughts or actions"*. On the basis of the alternative **thoughts**, imagine what these would lead to in terms of emotions, and how the alternative **thoughts** might change your symptoms and actions.
- Finally, think of some **alternative actions** and add them to *Worksheet 6.2, "The basic model with alternative thoughts or actions"*. On the basis of the alternative **actions**, imagine what these would lead to in terms of emotions, and how the alternative **actions** might change your symptoms and thoughts.

Homework for module 7

What do I need to prepare for next time?

1. Weekly registration form

Instruction:

In this sheet you record how many and which symptoms you have experienced for every day of the week. If you have many symptoms, talk to your therapist about leaving out some of them. For each entry add a few words to describe the situation you were in when experiencing the symptoms, e.g. “on the bus”, “at work”, etc. Complete the weekly registration form by filling in parts of the form 2-3 times a day.

2. The next steps on your way towards your objective

After talking about your homework for today you now have a better idea about your realistic treatment objectives. Hopefully, you have decided on your next step. For next time, you should test your next step.

Consider any obstacles but also anything else that may increase your chance of success.

Next time we will assess if your partial objective was achieved and whether any adjustments of the objectives and means are needed.

3. The basic model

Instruction:

4. Select one or more situations from the last two weekly registration forms. You should look for the situations when you felt really bad. Next, fill in *Worksheet 6.1*, “Basic model with **automatic thoughts**”.
5. Now think of some **alternative thoughts** and add them to *Worksheet 6.2*, “The basic model with alternative thoughts or actions”. On the basis of the alternative **thoughts**, imagine what these would lead to in terms of emotions, and how the alternative **thoughts** might change your symptoms and actions.
6. Finally, think of some **alternative actions** and add them to *Worksheet 6.2*, “The basic model with alternative thoughts or actions”. On the basis of the alternative **actions**, imagine what these would lead to in terms of emotions, and how the alternative **actions** might change your symptoms and thoughts.

Box scale registration

A. Date

DD		MM		YY	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom												Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:

No pain												Worst possible pain
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:

No other symptoms/discomfort												Worst possible other symptoms/discomfort
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:

No sadness												Worst possible sadness
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:

No nervousness												Worst possible nervousness
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:

No tiredness												Worst possible tiredness
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:

No problems concentrating												Worst possible problems concentrating
0	1	2	3	4	5	6	7	8	9	10		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Module 7

From illness behaviour to health behaviour II: Sleep, diet, exercise, relations to others

Programme

12.30-13.30:

- **Welcome**
- **Box scale registration**
- **Homework from last time.** *Discussion in 2 groups*
Test of partial objectives.
The basic model.

13.30-13.45: Break, coffee & tea

13.45-14.45:

- **Sleep.** *Teaching 7.1-7.4. Exercise 7.1-7.2. Worksheet 7.1*
- **Diet.** *Exercise 7.3*
- **Physical exercise.** *Exercise 7.4*
- **Relations to others.** *Exercise 7.5*

14.45-15.00: Break

15.00-16.00:

- **The basic model.** *Worksheets 7.2 & 7.3*
- **Preparation of meeting with social worker**
- **Homework for module 8.**

Weekly registration form. *Worksheet 7.4*

Test of partial objectives

What will I achieve during therapy and what will I need to work on afterwards?

The basic model. *Worksheets 7.2 & 7.3*

(if relevant) Sleep table. *Worksheet 7.1*

- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

2. Pain:	No pain											Worst possible pain
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Other symptoms/discomfort:	No other symptoms/discomfort											Worst possible other symptoms/discomfort
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Sadness:	No sadness											Worst possible sadness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

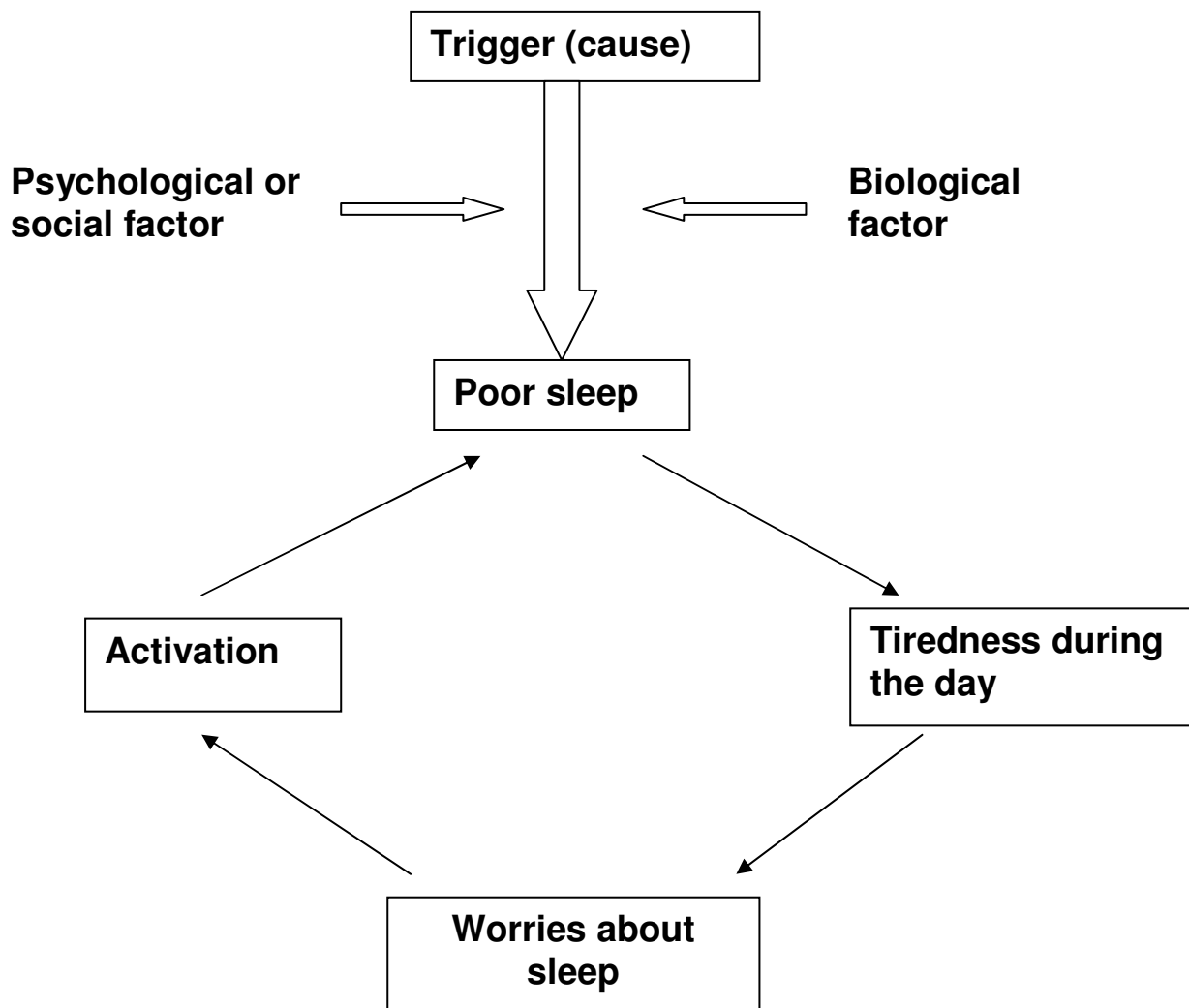
5. Nervousness:	No nervousness											Worst possible nervousness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

6. Tiredness:	No tiredness											Worst possible tiredness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

7. Problems concentrating:	No problems concentrating											Worst possible problems concentrating
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Teaching 7.1

Sleeplessness



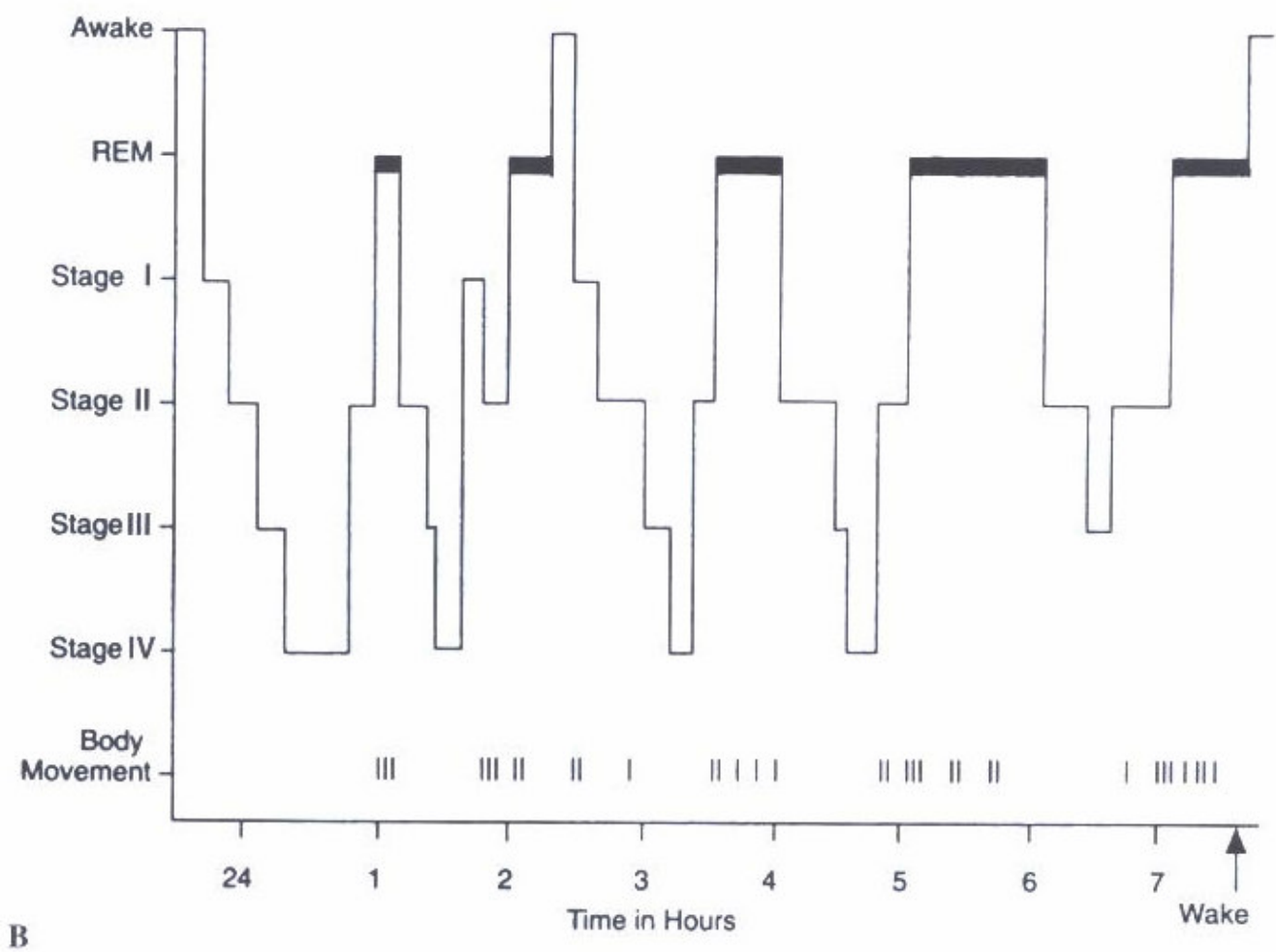
Teaching 7.2

Causes for sleeplessness

- **Poor sleep hygiene**
 1. Stimulants (coffee, tobacco)
 2. Light
 3. Sound
 4. Food
 5. Exercise
- **Taught sleeplessness**
 1. Poor sleeping habits
 2. Unrealistic expectations
 3. Lacking knowledge
- **Psychological conditions**
 1. Stress
 2. Fear
 3. Depression
- **Medicines and alcohol**
- **Biological and medical conditions**
 1. Urination during the night
 2. Pain
 3. Chronic bronchitis
 4. Reduced heart function
- **Circadian rhythm disturbances**
 1. Shift working
 2. Jet lag
 3. Chronic bed rest
 4. Senility
- **Unexplained sleeplessness**

Teaching 7.3

Sleep chart



Teaching 7.4

Sleep hygiene

1. Get up at the same time every day, no matter how many hours you have slept
2. Only try to sleep if you feel tired
3. Only use your bed for sleeping and having sex
4. Get up and go to another room if you haven't fallen asleep within 15 minutes. Go back to bed when you feel tired (the aim is to fall asleep quickly)
5. If you can't fall asleep – repeat step 4 (several times if needed)
6. Avoid sleeping during the day
7. Avoid tobacco, coffee and alcohol
8. Make sure you engage in physical exercise daily, during the daytime
9. Avoid sleeping medicine for long periods of time.

Worksheet 7.1**Sleep table****Week:**

Time	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	1	2	3	4	5	6	7
Monday																									
Tuesday																									
Wednesday																									
Thursday																									
Friday																									
Saturday																									
Sunday																									

Signs:

↓ Went to bed

↑ Got up

[----] Sleep

M Medicines and stimulants

D Disturbances

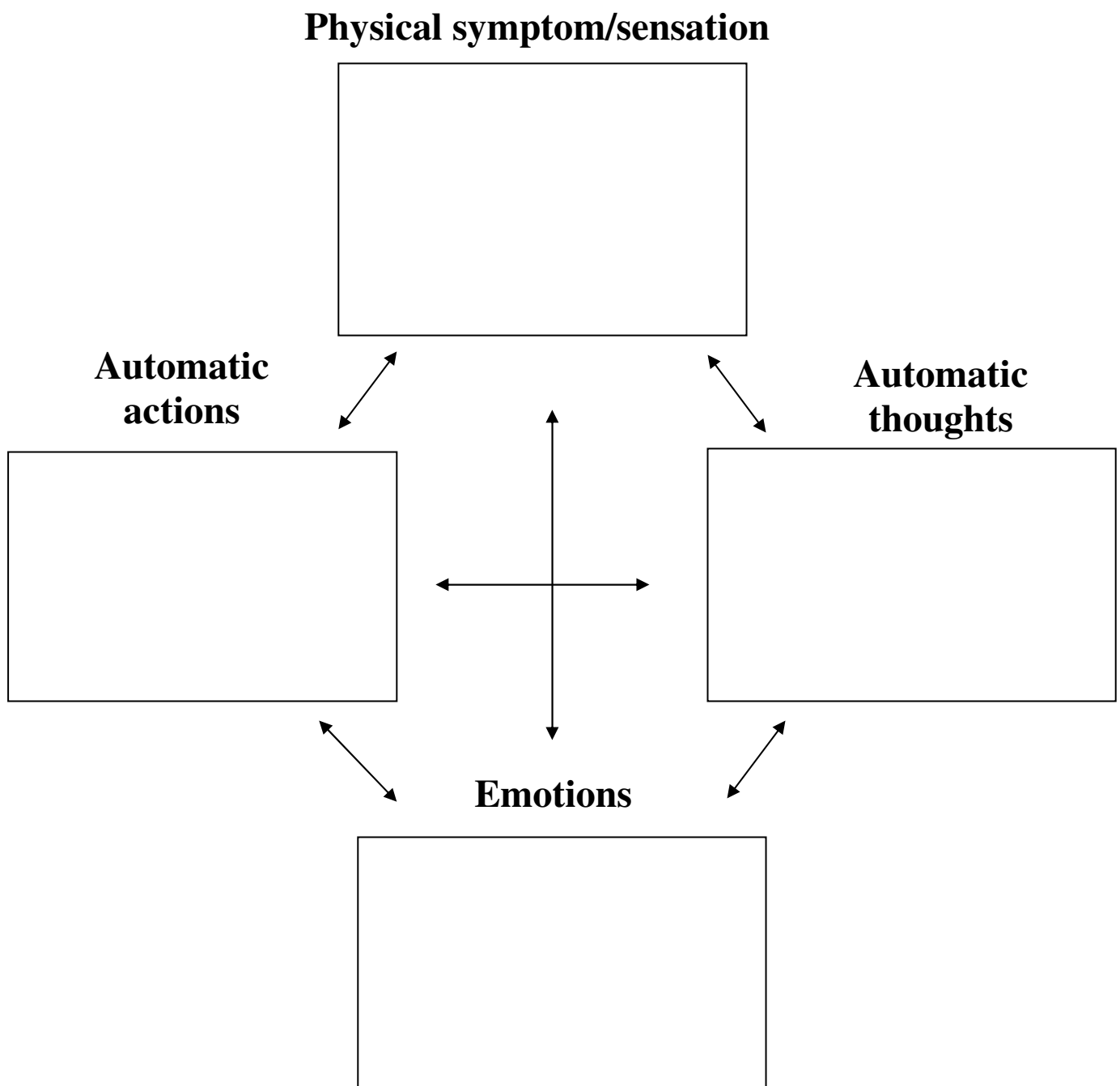
Comments:

Worksheet 7.2

Basic model with automatic thoughts or actions

Time:

Situation:

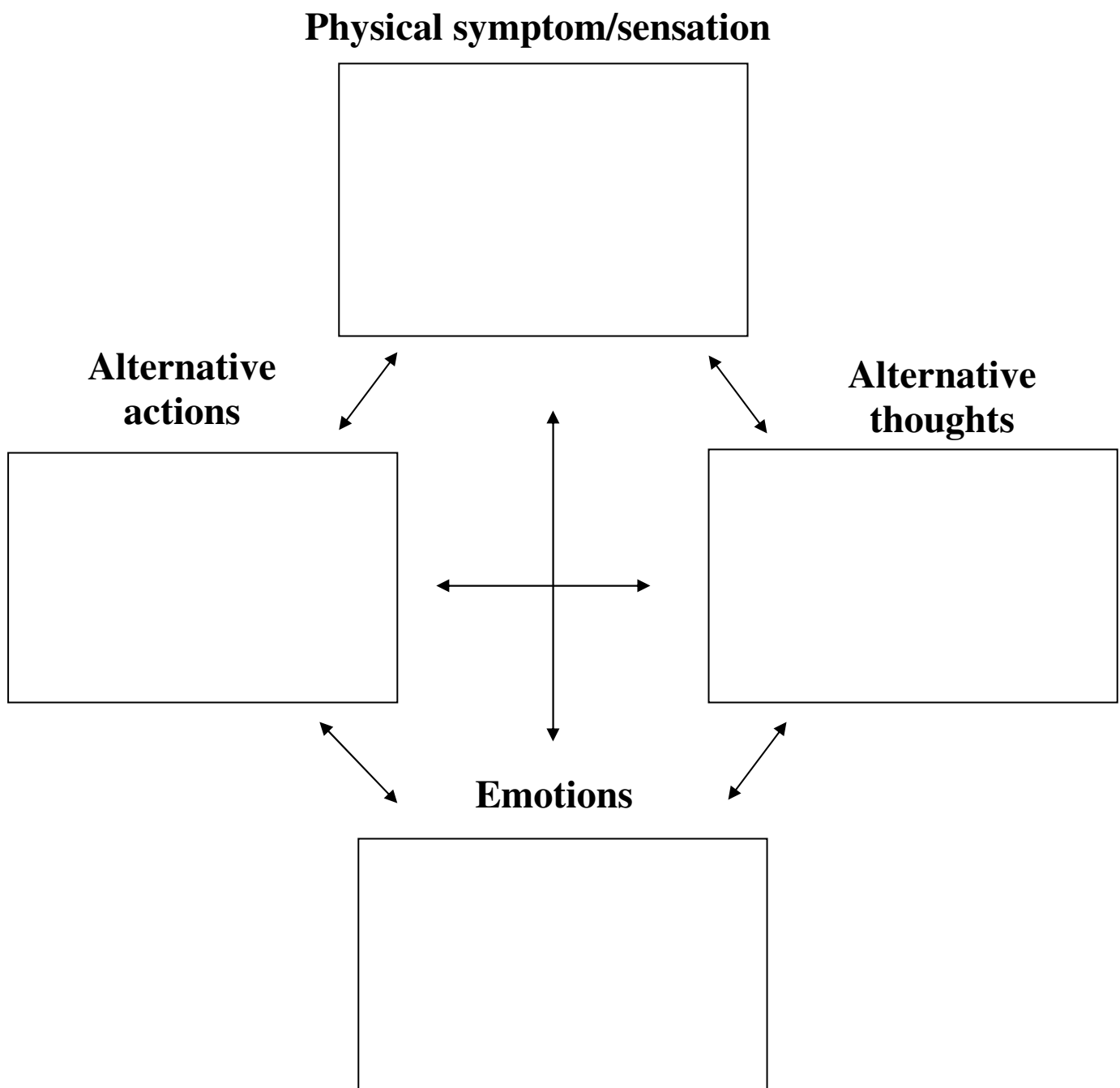


Worksheet 7.3

Basic model with alternative thoughts or actions

Time:

Situation:



Worksheet 7.4

Weekly registration form

Symptom/Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	1	2	3	4	5	6	7	8	9	10	Worst possible pain/discomfort/ emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, *e.g.: on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 7.4

Weekly registration form

Symptom/Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	1	2	3	4	5	6	7	8	9	10	Worst possible pain/discomfort/ emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, e.g.: on the bus, at work, at mother in law's, etc.

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Exercise 7.1

Sleep table

Fill in the Sleep table (Worksheet 7.1) for the night leading up to today. 5 min.

- ↓ The time you went to bed
- ↑ The time you got up
- [----] Use this to indicate when you fell asleep and woke up
- M Medicines and stimulants
- D Disturbances

Notes: Any other important events, thoughts, emotions or bodily symptoms.

Exercise 7.2

Sleep

Fill in on your own. 5 min.

When do you go to bed?
When do you wake up in the morning?
How many hours do you sleep during the day?
How long are you awake during the night?
How many hours do you sleep during a 24-hour period?
Do you sleep too little or too much?

Exercise 7.3

Diet

Fill in on your own. 5 min.

What do you have for breakfast?
What do you have for lunch?
What do you have for supper?
Do you eat in-between meals? What do you eat?
Do you eat too much or not enough?
Is your diet sufficiently healthy?

Exercise 7.4

Physical exercise

Fill in on your own. 5 min.

Which forms of exercise do you like?
Which form(s) of exercise do you do as part of your daily activities?
On average, how much time do you spend on exercise daily?
Do you exercise too much or not enough?
What can you do about it?

Exercise 7.5

Relations to others

Fill in on your own. 15 min.

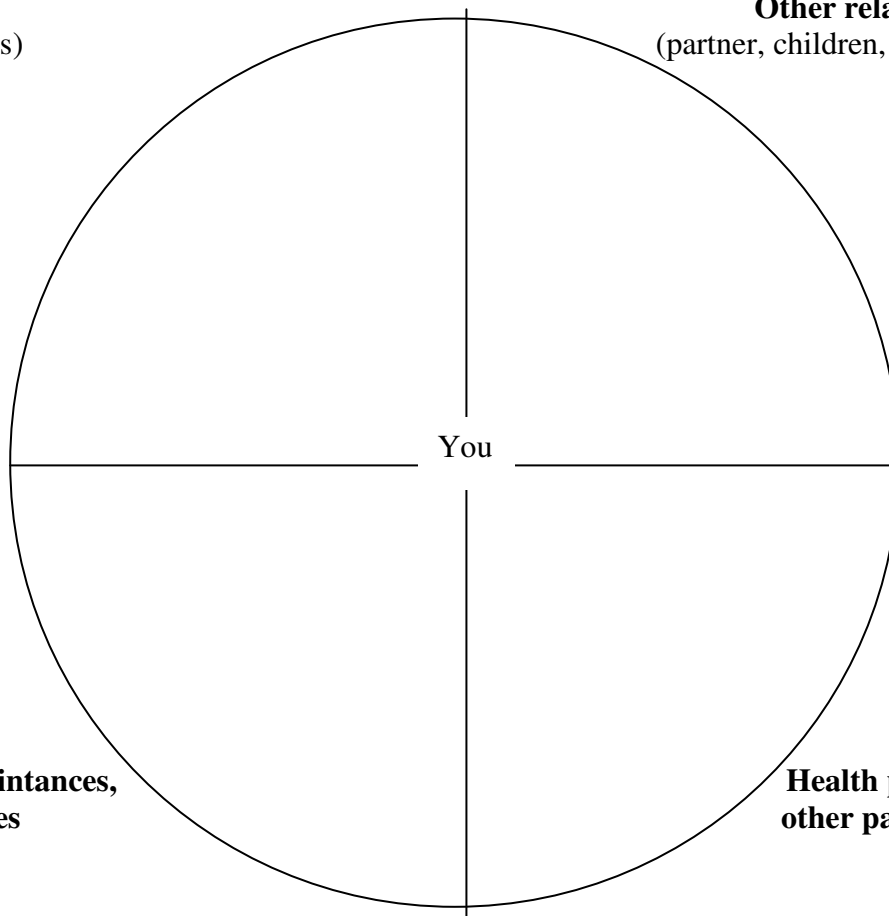
Instruction:

Add your social network to the below map. You are the centre. Draw a small circle for every person you see regularly and feel attached to. Write a letter in each circle to identify the person. Next, write the letter and then the name somewhere outside the circle. The circle allows you to place these persons in one of four distinct fields. *Close relatives* are your parents and siblings, if you have any. *Other relatives* are your partner, your children and the rest of your family. The closer a person is attached to you, the closer this person should be placed to the centre (to you).

When you have finished, look at the figure and decide if you are satisfied with your network or if you want to work strengthen or tone down your relation to other persons.

Close family
(parents, siblings)

Other relatives
(partner, children, rest of family)



**Friends, acquaintances,
Work colleagues**

**Health professionals,
other patients**

Homework for module 8

What do I need to prepare for next time?

1. Weekly registration form

Instruction:

In this sheet you record how many and which symptoms you have experienced for every day of the week. If you have many symptoms, talk to your therapist about leaving out some of them. For each entry add a few words to describe the situation you were in when experiencing the symptoms, e.g. “on the bus”, “at work”, etc. Complete the weekly registration form by filling in parts of the form 2-3 times a day.

2. The next steps on your way towards your objective

After talking about your homework for today you now have a better idea about your realistic treatment objectives. Hopefully, you have decided on your next step. For next time, you should test your next step.

Consider any obstacles but also anything else that may increase your chance of success.

Next time we will assess if your partial objective was achieved and whether any adjustments of the objectives and means are needed.

3. What will I achieve during therapy and what will I need to work on afterwards?

Instruction: Consider what you have already achieved and what still needs to be done. You should now decide what you will be working on during the next three months. See the previous list of objectives (*Worksheet 3.1 and Exercise 3.3*) from *Module 3*.

4. The basic model

Instruction:

1. Select one or more situations from the last two weekly registration forms. You should look for the situations when you felt really bad. Next, fill in *Worksheet 7.2*, “Basic model with **automatic thoughts or actions**”.
2. Now think of some **alternative thoughts** and add them to *Worksheet 7.3*, “Basic model with alternative thoughts or actions”. On the basis of the alternative **thoughts**, imagine what these would lead to in terms of emotions, and how the alternative **thoughts** might change your symptoms and actions.
3. Finally, think of some **alternative actions** and add them to *Worksheet 7.3*, “Basic model with alternative thoughts or actions”. On the basis of the alternative **actions**, imagine what these would lead to in terms of emotions, and how the alternative **actions** might change your symptoms and thoughts.

5. Sleep table (if relevant)

Instruction: Fill in the sleep table (*Worksheet 7.1*) by following the instructions provided on the sheet.

Box scale registration

A. Date DD MM YY

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B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	0	1	2	3	4	5	6	7	8	9	Worst possible symptom
	□	□	□	□	□	□	□	□	□	□	

2. Pain:	No pain	0	1	2	3	4	5	6	7	8	9	Worst possible pain
		□	□	□	□	□	□	□	□	□	□	

3. Other symptoms/discomfort:	No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	Worst possible other symptoms/discomfort
		□	□	□	□	□	□	□	□	□	□	

4. Sadness:	No sadness	0	1	2	3	4	5	6	7	8	9	Worst possible sadness
		□	□	□	□	□	□	□	□	□	□	

5. Nervousness:	No nervousness	0	1	2	3	4	5	6	7	8	9	Worst possible nervousness
		□	□	□	□	□	□	□	□	□	□	

6. Tiredness:	No tiredness	0	1	2	3	4	5	6	7	8	9	Worst possible tiredness
		□	□	□	□	□	□	□	□	□	□	

7. Problems concentrating:	No problems concentrating	0	1	2	3	4	5	6	7	8	9	Worst possible problems concentrating
		□	□	□	□	□	□	□	□	□	□	

Module 8

Becoming your own therapist. Relapse prevention

Programme

12.30-1.30pm:

- **Welcome**
- **Box scale registration**
- **Homework from last time.** What will I achieve during therapy and what will I need to work on afterwards? *Exercise 8.1*
Staircase of goals. Test of partial objectives. *Exercise 8.2*

1.30-1.45pm: Break with coffee & tea

1.45-2.45pm:

- **Fill in the basic model with automatic thoughts and actions, and then with alternative thoughts and actions.** *Exercise 8.3 & 8.4.*
- **Problem solving technique.** *Exercise 8.5.*

2.45-3.00pm: Break

3.00-4.00pm:

- **Homework for module 9** Weekly registration form. *Worksheet 8.5*
Test of partial objectives. *See Exercise 8.2*
The basic model. *Worksheet 8.1 & 8.2*
Problem solving technique. *Worksheet 8.3*
Relapse prevention. *Worksheet 8.4*
- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom												Worst possible symptom
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No pain												Worst possible pain
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No other symptoms/discomfort												Worst possible other symptoms/discomfort
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No sadness												Worst possible sadness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No nervousness												Worst possible nervousness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No tiredness												Worst possible tiredness
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

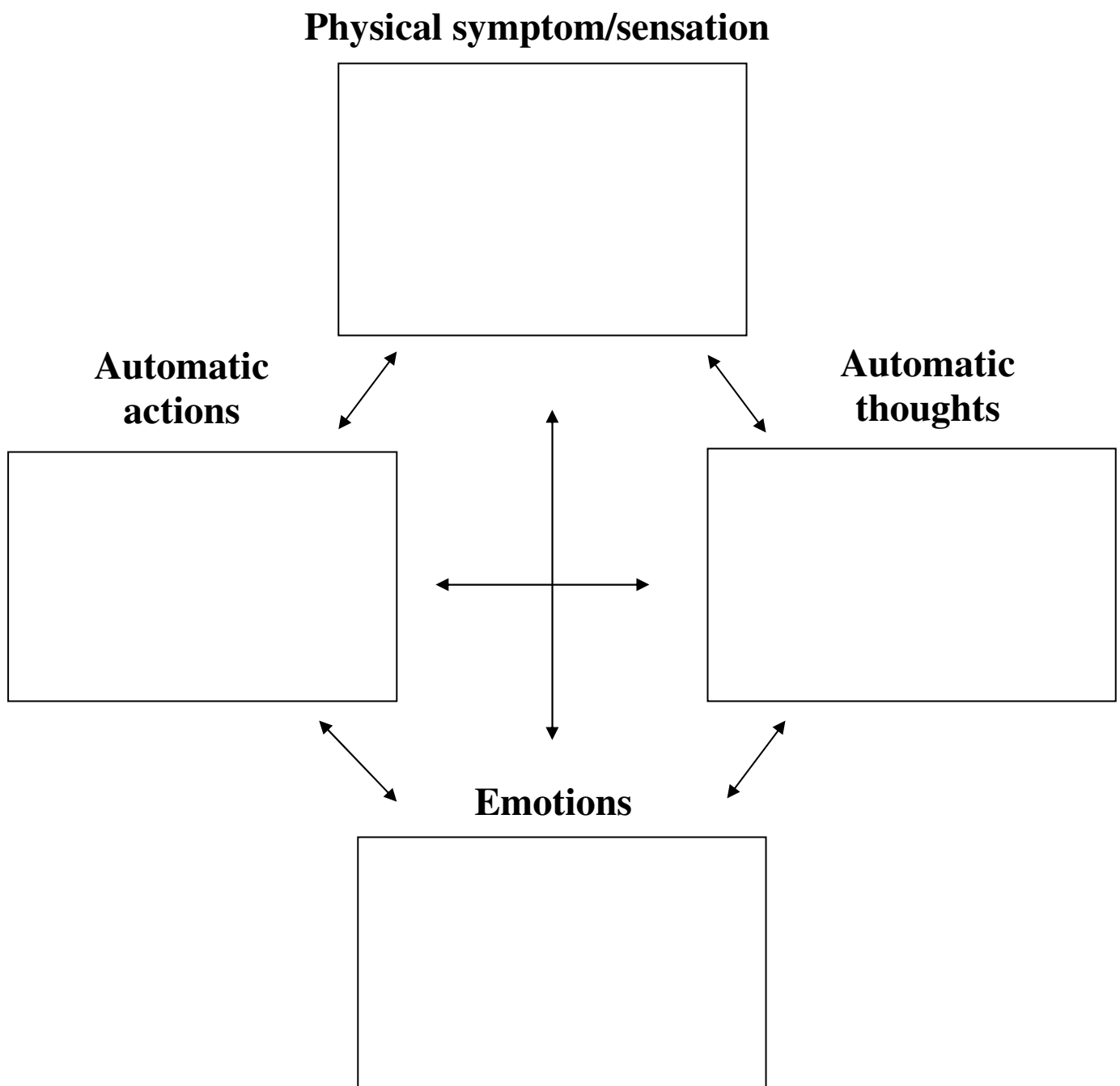
No problems concentrating												Worst possible problems concentrating
	0	1	2	3	4	5	6	7	8	9	10	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Worksheet 8.1

Basic model with automatic thoughts or actions

Time:

Situation:

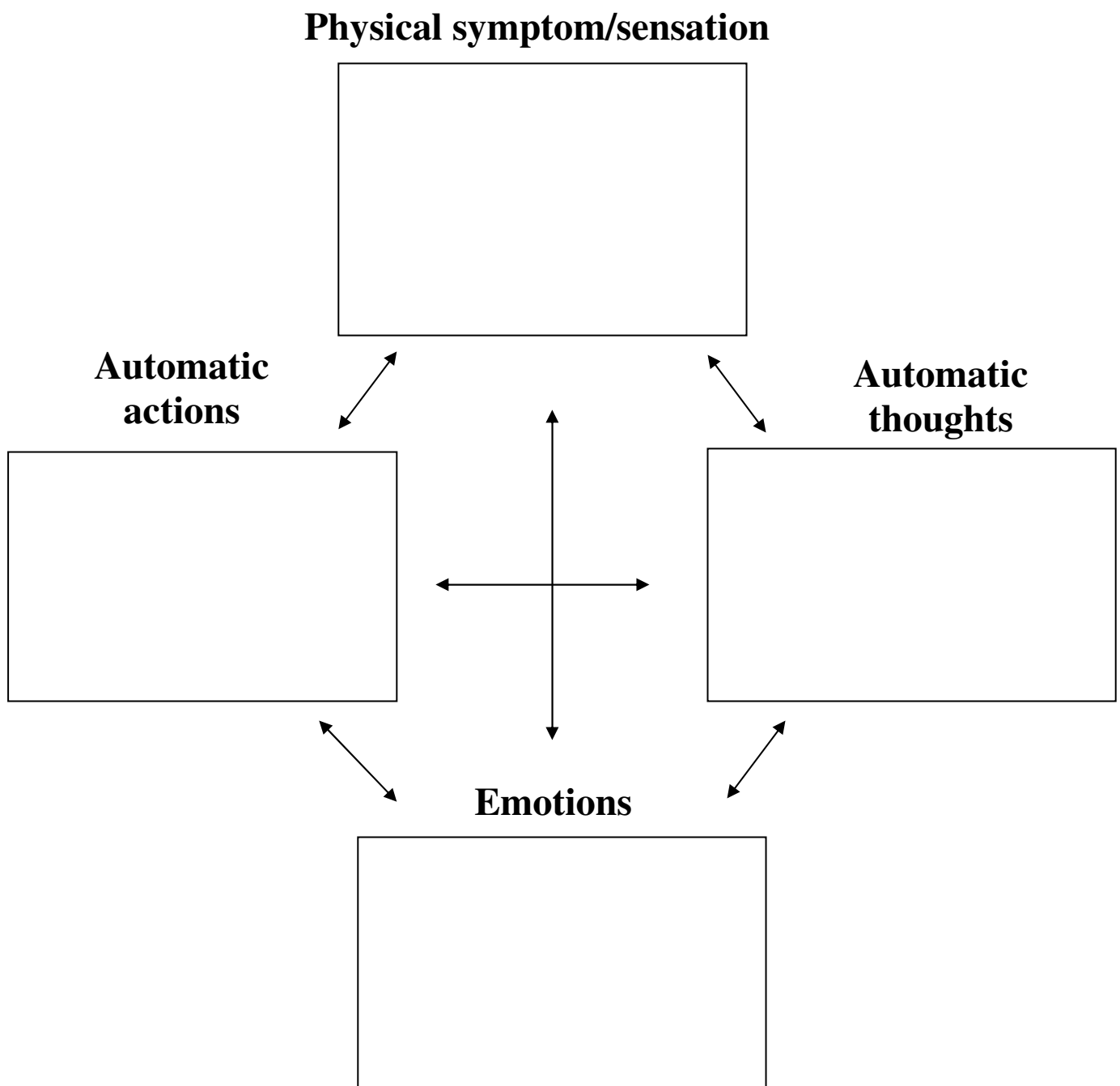


Worksheet 8.1

Basic model with automatic thoughts or actions

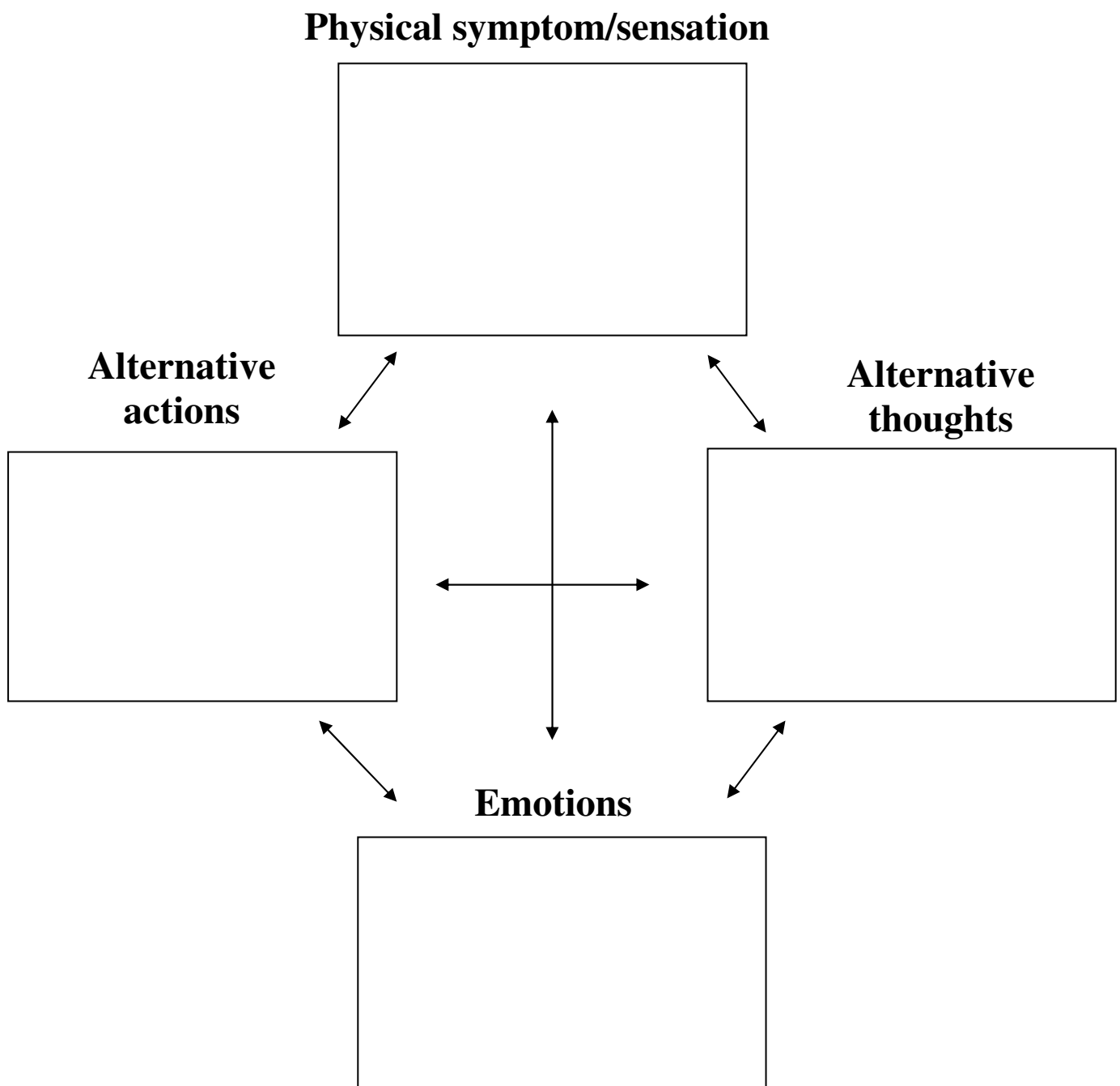
Time:

Situation:



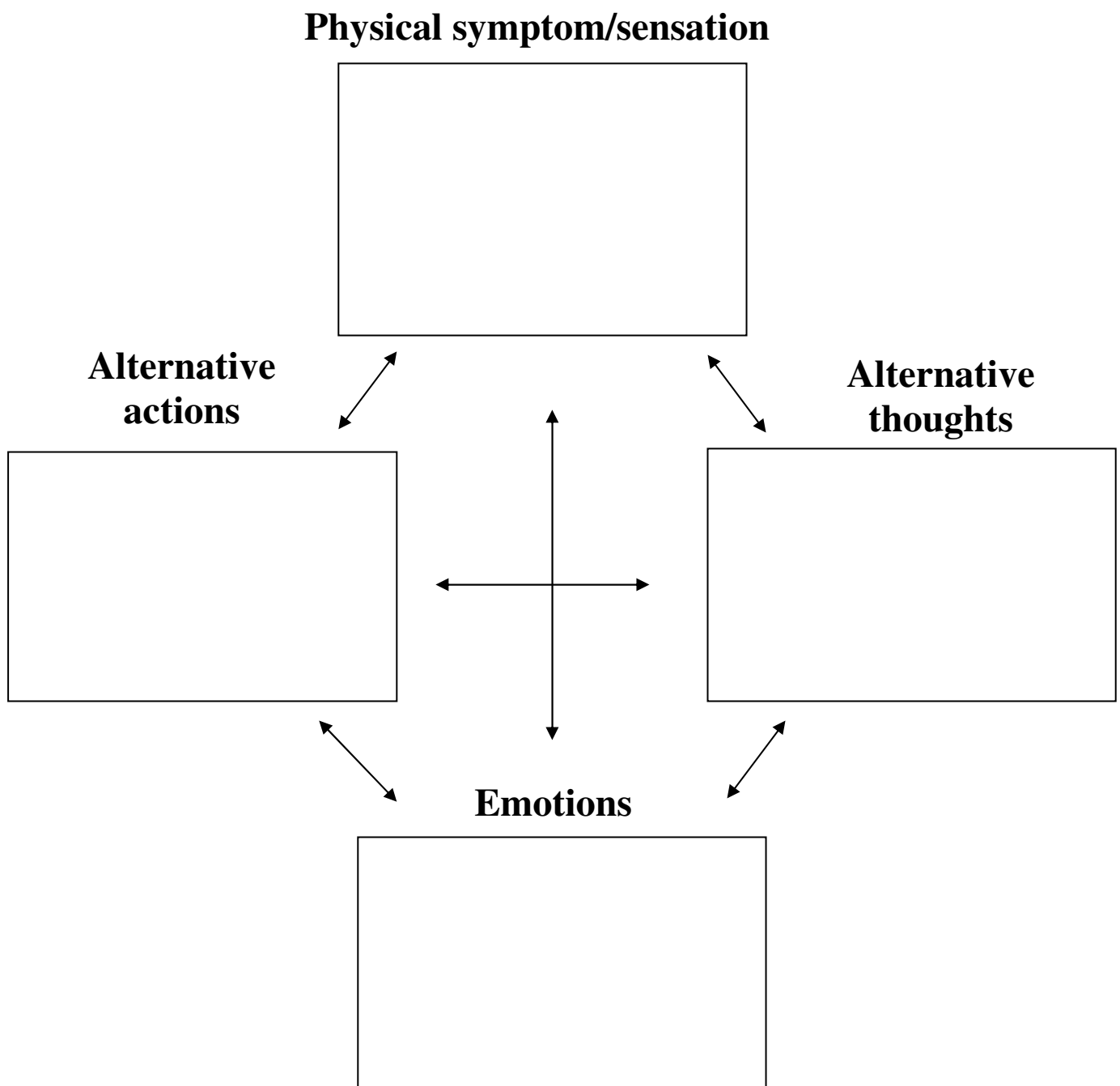
Worksheet 8.2

Basic model with alternative thoughts or actions

Time:**Situation:**

Worksheet 8.2

Basic model with alternative thoughts or actions

Time:**Situation:**

Worksheet 8.3

Problem solving technique

1) What is your problem?
2) What will you have achieved once you have solved the problem?
3) Describe various ways in which the problem may be solved (this may require a lot of imagination)
4) For each way in which the problem may be solved, consider pros and cons Finally, choose the best or more realistic solution to your problem.
5) The way you have decided to solve your problem should be divided into steps or partial objectives. Make sure these are realistic and that you are capable of executing every single step (Staircase of goals). Describe how you will perform each step, when you will start, and when you aim to have achieved your objective.
6) Decide how and when you will execute each single step - on your own or with someone else?
7) What could stop you from taking the steps you have planned? What can you do to secure your success?
8) Next time consider if you executed the planned step, and if the next steps need to be adjusted.

Worksheet 8.4

Relapse prevention

Instruction: Fill in each of the fields below to the best of your ability. Take your time!

How do you understand your bodily distress / functional symptoms?

What is the most important thing or point you have learned?

What has changed since you started in therapy?

Worksheet 8.4, cont.

What have you done to achieve such change?

Which techniques have you found to be most effective and how do they help you?

Which techniques would benefit from further training?

Worksheet 8.4, cont.

What effect will it have for you, if you continue doing the things you have found helpful?

How can you make sure that you will continue using these techniques/strategies in the future?

Which future situations could make you vulnerable for relapse?
What can you do to avoid or handle such situations?

Worksheet 8.4, cont.

Does anything need to be changed in the list of objectives you made in *Module 3, Exercises 2 and 3*?
What are your objectives for the near future?
How will you achieve the objectives?

Which would be the early signs of relapse?
What may you do, if you become aware that some of these signs are present?
What is particularly important to remember stop doing or continue doing?
How could that help you to reduce your number of symptoms?

Which obstacles might stop you from using the techniques and how can these obstacles be overcome?

Worksheet 8.5

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	1	2	3	4	5	6	7	8	9	10	Worst possible pain/discomfort/ emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 8.5

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/
discomfort/
emotions

1 2 3 4 5 6 7 8 9 10

Worst possible
pain/discomfort/
emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 8.5

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/
discomfort/
emotions

1 2 3 4 5 6 7 8 9 10

Worst possible
pain/discomfort/
emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Worksheet 8.5

Weekly registration form

Symptom / Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	<div style="display: flex; justify-content: space-around; align-items: center;"> 12345678910 </div> <hr style="width: 100%;"/>	Worst possible pain/discomfort/ emotions
-------------------------------------	--	--

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms e.g.: *on the bus, at work, at mother in law's, etc.*

	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Exercise 8.1

What will I achieve during therapy? What will I need to work on afterwards?

Instruction: Fill in the below fields on your own.

What will I achieve during therapy?

What will I need to work on afterwards?

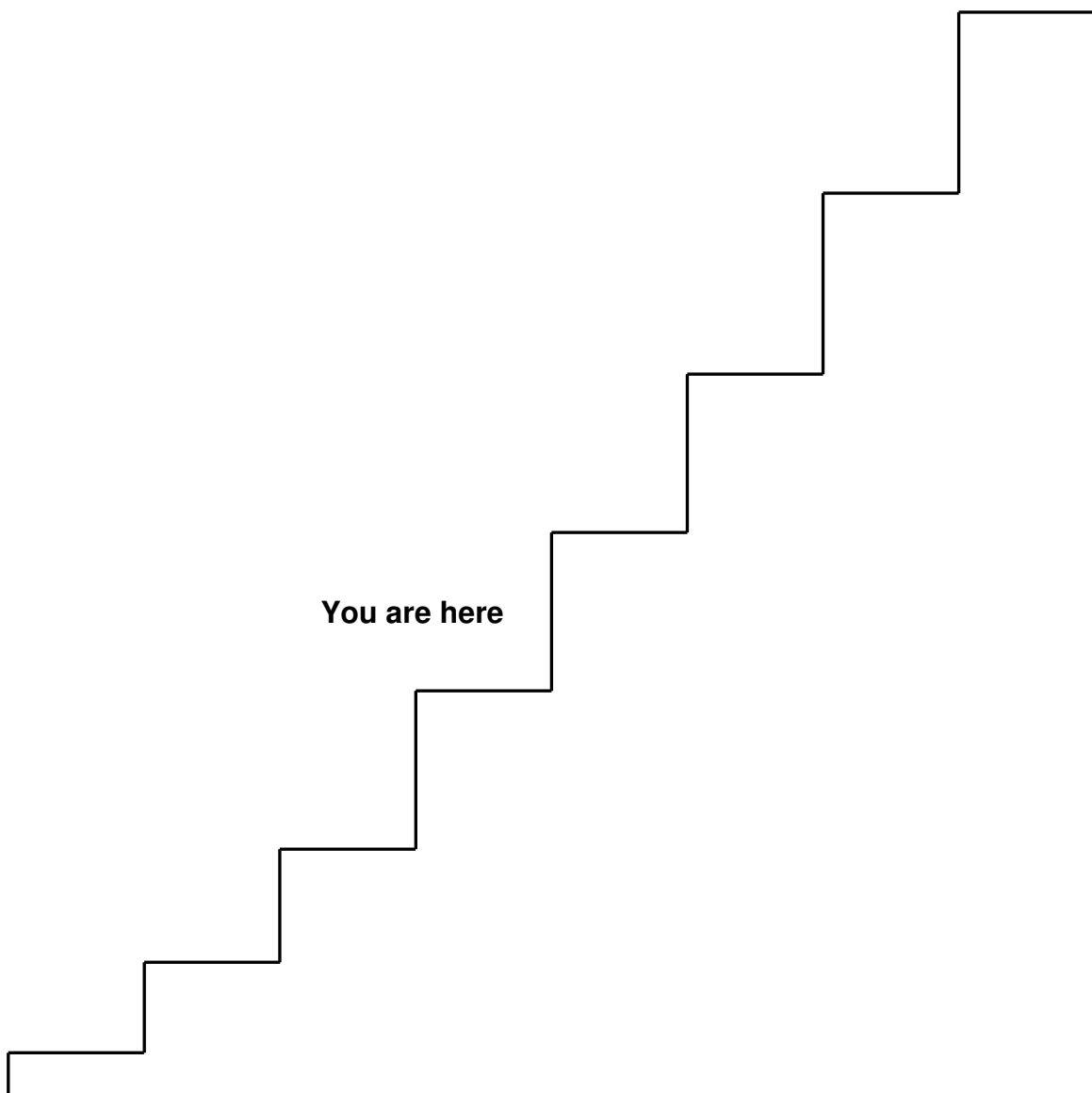
Exercise 8.2

Staircase of goals

Instruction: Please fill in below.

1. Fill in the objective of your treatment participation at the uppermost step.
2. At the various steps, add the partial objectives you have already achieved and the next partial objectives on your way to the final objective

Note! Objectives should be realistic!



Exercise 8.3 & 8.4

The basic model

Exercise 3: The basic model with automatic thoughts or actions

Fill in *Worksheet 6.1: The basic model with automatic thoughts or actions* for yourself, departing from a situation during the last week in which you experienced symptoms.

Exercise 4: The basic model with alternative thoughts or actions

- Now think of some **alternative thoughts** and add them to *Worksheet 8.2, "The basic model with alternative thoughts or actions"*. On the basis of the alternative **thoughts**, imagine what these would lead to in terms of emotions, and how the alternative **thoughts** might change your symptoms and actions.
- Finally, think of some **alternative actions** and add them to *Worksheet 8.2, "The basic model with alternative thoughts or actions"*. On the basis of the alternative **actions**, imagine what these would lead to in terms of emotions, and how the alternative **actions** might change your symptoms and thoughts.

Exercise 8.5

Problem solving technique

1) What is your problem?
2) What will you have achieved once you have solved the problem?
3) Describe various ways in which the problem may be solved (this may require a lot of imagination)
4) For each way in which the problem may be solved, consider pros and cons Finally, choose the best or more realistic solution to your problem.
5) The way you have decided to solve your problem should be divided into steps or partial objectives. Make sure these are realistic and that you are capable of executing every single step. (Staircase of goals) Describe how you will perform each step, when you will start, and when you aim to have achieved your objective.
6) Decide how and when you will execute each single step - on your own or with someone else?
7) What could stop you from taking the steps you have planned? What can you do to secure your success?
8) Next time, consider if you executed the planned step, and if the next steps need to be adjusted.

Homework for module 9

What do I need to prepare for next time?

1. Weekly registration form

Instruction:

In this sheet you record how many and which symptoms you have experienced for every day of the week. If you have many symptoms, talk to your therapist about leaving out some of them. For each entry add a few words to describe the situation you were in when experiencing the symptoms, e.g. “on the bus”, “at work”, etc. Complete the weekly registration form by filling in parts of the form 2-3 times a day.

2. The next steps on your way towards your objective

After talking about your homework for today you now have a better idea about your realistic treatment objectives. Hopefully, you have decided on your next step. For next time, you should test your next step.

Consider any obstacles but also anything else that may increase your chance of success.

Next time we will assess if your partial objective was achieved and whether any adjustments of the objectives and means are needed.

3. Preventing relapse

Use *Worksheet 8.4*. Relapse prevention. Take a good look at the sheet. Go through one point at a time and answer it thoroughly. Take your time. Feel free to take breaks and return to a point once you have had a chance to consider pros and cons. We recommend that you use a pencil to make it easier to change the text as you progress.

4. The basic model

Instruction:

1. Select one or more situations from the last two weekly registration forms. You should look for the situations when you felt really bad. Next, fill in *Worksheet 8.1*, “Basic model with automatic thoughts or actions”.
2. Now think of some **alternative thoughts** and add them to *Worksheet 8.2*, “Basic model with alternative thoughts or actions”. On the basis of the alternative **thoughts**, imagine what these would lead to in terms of emotions, and how the alternative **thoughts** might change your symptoms and actions.
3. Finally, think of some **alternative actions** and add them to *Worksheet 8.2*, “Basic model with alternative thoughts or actions”. On the basis of the alternative **actions**, imagine what these would lead to in terms of emotions, and how the alternative **actions** might change your symptoms and thoughts.

5. Problem solving technique

Use *Worksheet 8.3*: Problem solving technique. Choose one of your problems and go through the sheet to solve it.

Box scale registration

A. Date DD MM YY

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B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel **right now** with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom		Worst possible symptom
0	1 2 3 4 5 6 7 8 9	10
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain		Worst possible pain
	0	1 2 3 4 5 6 7 8 9	10
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort		Worst possible other symptoms/discomfort
	0	1 2 3 4 5 6 7 8 9	10
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness		Worst possible sadness
	0	1 2 3 4 5 6 7 8 9	10
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness		Worst possible nervousness
	0	1 2 3 4 5 6 7 8 9	10
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness		Worst possible tiredness
	0	1 2 3 4 5 6 7 8 9	10
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating		Worst possible problems concentrating
	0	1 2 3 4 5 6 7 8 9	10
	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>

Module 9

How to maintain learned skills and coping strategies

Programme

12.30-1.30pm:

- **Welcome**
- **Box scale registration**
- **Homework from last time.**
Preventing relapse/coping
Group discussion.
- **Collection of the Box scale registrations**

1.30-1.45pm: Break with coffee & tea

1.45-2.45pm:

- **Group discussion continued**
- **What happens when you get better? *Teaching***

2.45-3.00: Break

3.00-4.00:

- **Round-off**
- **Box scale registration**

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom											Worst possible symptom
	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Pain:	No pain											Worst possible pain
		0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Other symptoms/discomfort:	No other symptoms/discomfort											Worst possible other symptoms/discomfort
		0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Sadness:	No sadness											Worst possible sadness
		0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Nervousness:	No nervousness											Worst possible nervousness
		0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Tiredness:	No tiredness											Worst possible tiredness
		0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Problems concentrating:	No problems concentrating											Worst possible problems concentrating
		0	1	2	3	4	5	6	7	8	9	10
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Copy sheet

Weekly registration form

Symptom/Problem registration

Please use the below scale to record how bothersome your symptoms are for every part of each day:

No pain/ discomfort/ emotions	1	2	3	4	5	6	7	8	9	10	Worst possible pain/discomfort/ emotions

For every entry you make, also add a note to characterise the situation you were in when experiencing the symptoms, *e.g.: on the bus, at work, at mother in law's, etc.*

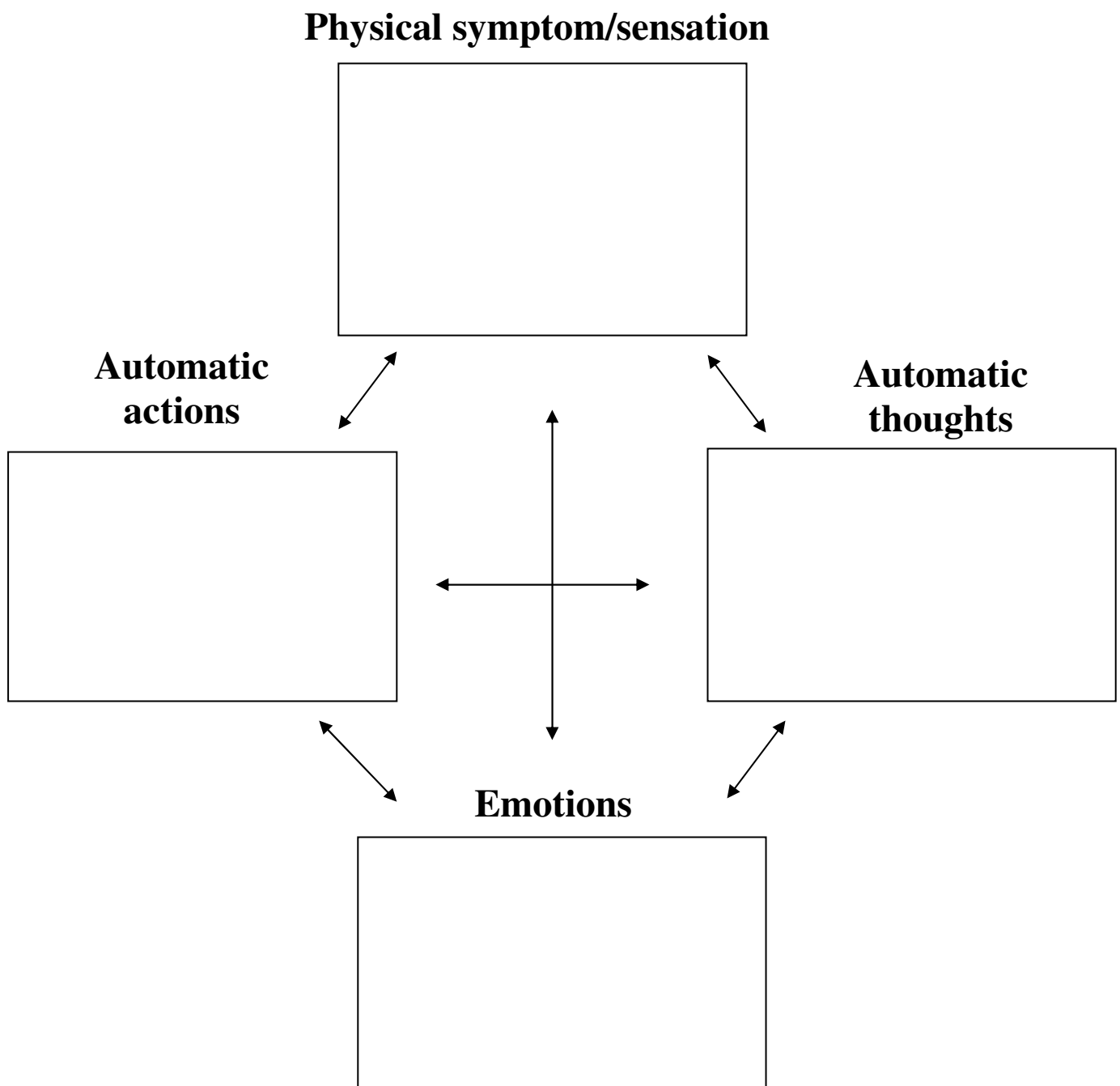
	day date:	day date:	day date:	day date:	day date:	day date:	day date:
Morning							
After- noon							
Evening							
Night							

Copy sheet

Basic model with automatic thoughts or actions

Time:

Situation:

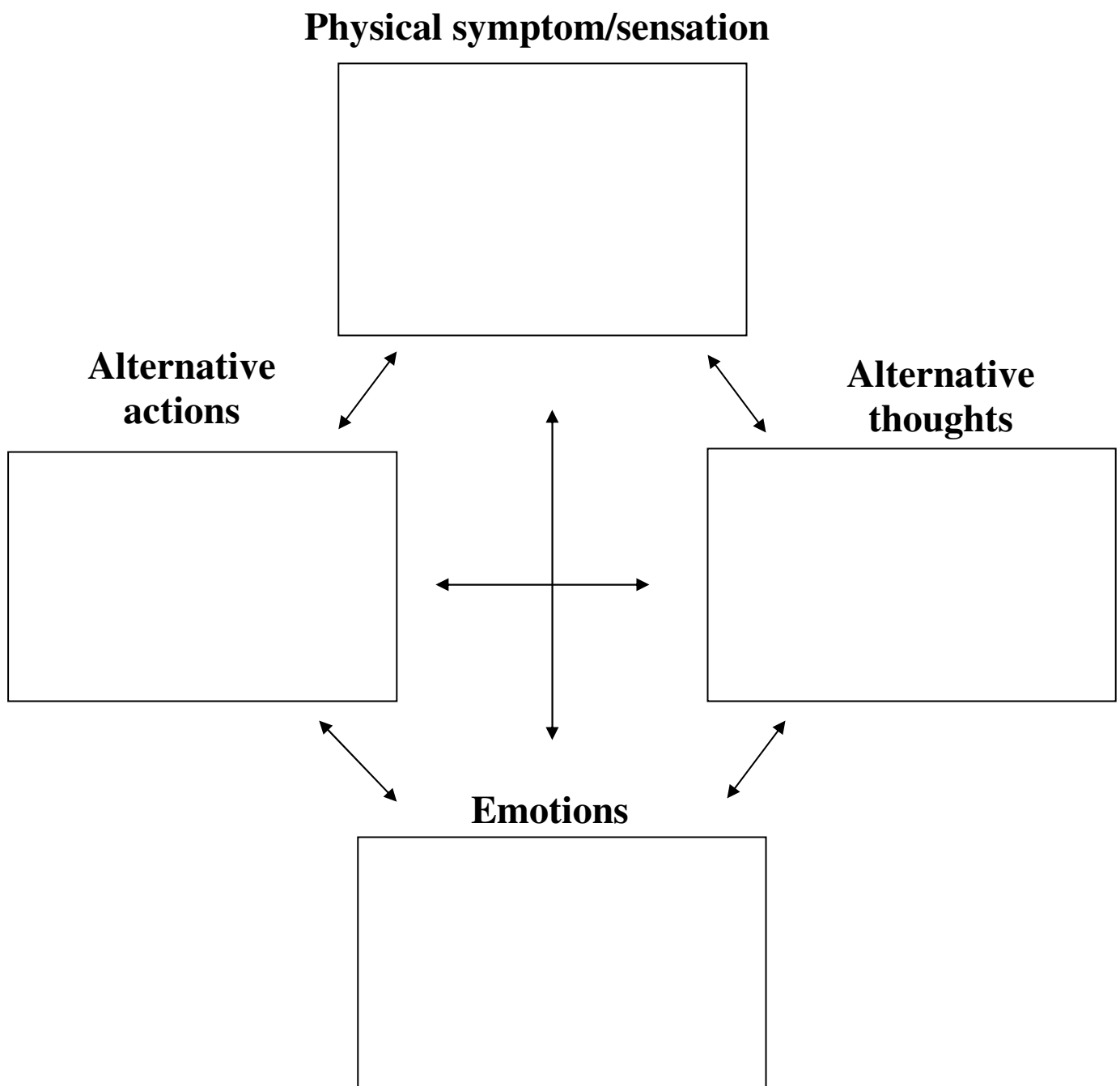


Copy sheet

Basic model with alternative thoughts or actions

Time:

Situation:



Copy sheet**Symptom interpretation**

Symptoms	Causes	What supports your explanation	What contradicts your explanation

Rank causes by adding a '1' by the most important cause, a '2' by the second important cause etc.

Copy sheet

Solving problems

1) What is your problem?
2) What will you have achieved once you have solved the problem?
3) Describe various ways in which the problem may be solved (this may require a lot of imagination)
4) For each way in which the problem may be solved, consider pros and cons Finally, choose the best or more realistic solution to your problem.
5) The way you have decided to solve your problem should be divided into steps or partial objectives. Make sure these are realistic and that you are capable of executing every single step. (Staircase of goals) Describe how you will perform each step, when you will start, and when you aim to have achieved your objective.
6) Decide how and when you will execute each single step - on your own or with someone else?
7) What could stop you from taking the steps you have planned? What can you do to secure your success?

Copy sheet

Slow but steady wins the race

1. What are your objectives?
2. How may you reach your objective?
3. If you needed to divide your journey towards the objective into five steps, what would those five steps be?
4. How will you test your first step? (e.g. in the garden, at home in your kitchen, in the woods, at work)
5. How long time will you give yourself to test your first step? (i.e. how many minutes, hours)
6. How often will you test your first step? (number of times a week)

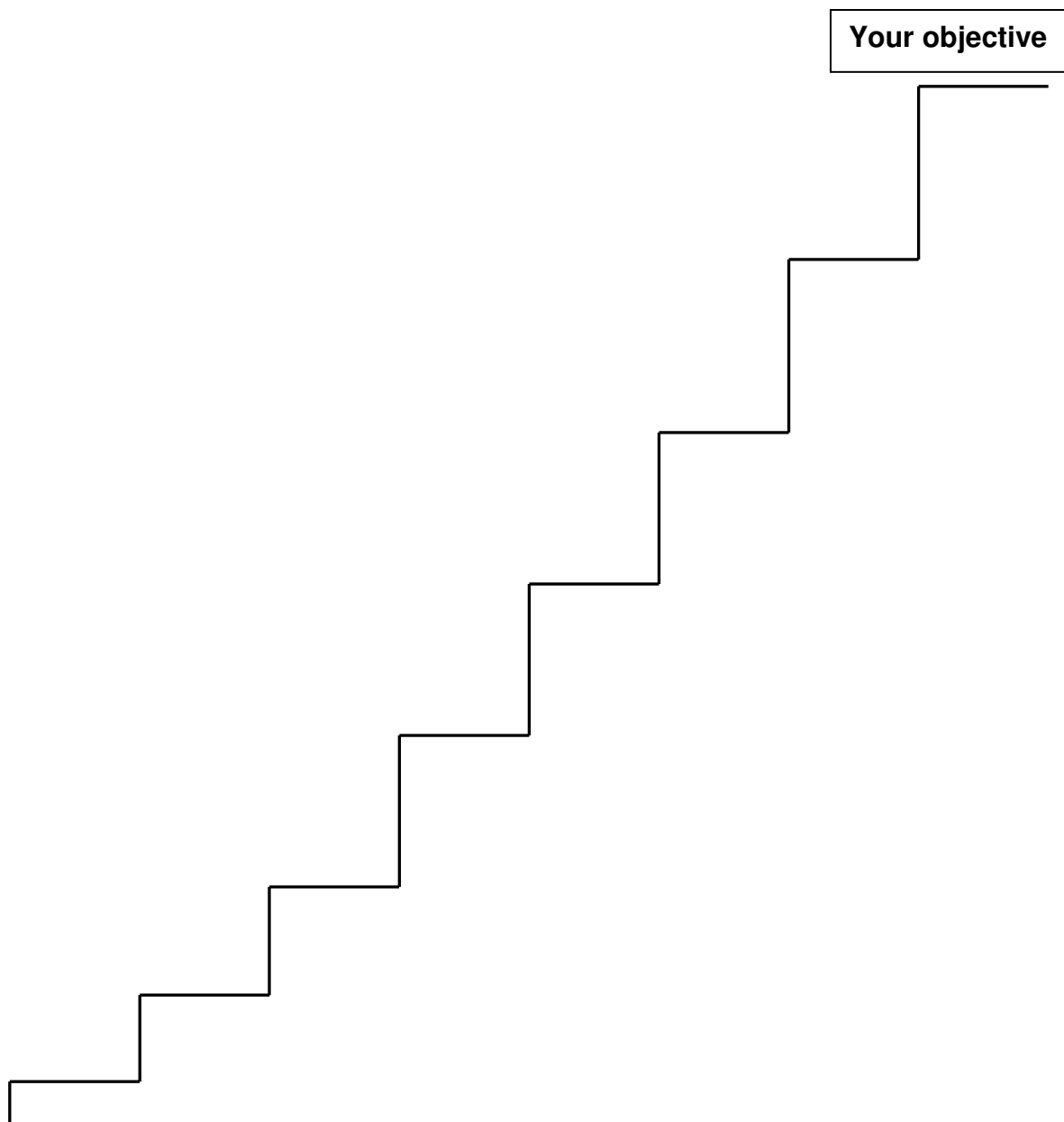
Copy sheet

Staircase of goals

Instruction: Fill in the below steps.

1. Fill in the objective of your treatment participation at the uppermost step.
2. At the various steps, add the partial objectives you have already achieved and the next partial objectives on your way to the final objective

Note! Objectives should be realistic!



Copy sheet

List of objectives

For each of the main areas below (Physical, Social, Work related, Other), add at least one objective you would like to be able to achieve during therapy (i.e. you have 3.5 months to achieve the objectives).

To ensure that you may achieve the objectives, they should be realistic and specific.

The following are examples of objectives from the Physical objectives category:

1. "To go for a 15 minute walk every morning from 10.00 to 10.15"
2. "To do relaxation exercises for ten minutes every morning from 9.00 to 9.10"

Please do not write anything about your pains, discomforts and symptoms in your objectives.

A. Physical objectives

1. Keeping fit _____
2. Keeping strong _____
3. Relaxation exercises _____

B. Social and leisure time objectives

1. Socially _____
2. Family _____
3. Leisure time _____

C. Work and employment related objectives

1. _____
2. _____
3. _____

D. Other objectives

1. _____
2. _____

Box scale registration

A. Date DD MM YY

--	--	--	--	--	--

B. Time of day ☐ First registration ☐ Second registration

We would like to know how you feel right now with regard to the following:

1. Your most bothersome symptom. Fill in the symptom here: _____

No symptom	0	1	2	3	4	5	6	7	8	9	Worst possible symptom
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No pain	0	1	2	3	4	5	6	7	8	9	Worst possible pain
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No other symptoms/discomfort	0	1	2	3	4	5	6	7	8	9	Worst possible other symptoms/discomfort
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No sadness	0	1	2	3	4	5	6	7	8	9	Worst possible sadness
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No nervousness	0	1	2	3	4	5	6	7	8	9	Worst possible nervousness
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No tiredness	0	1	2	3	4	5	6	7	8	9	Worst possible tiredness
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

No problems concentrating	0	1	2	3	4	5	6	7	8	9	Worst possible problems concentrating
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	