The World Psychiatric Association

WPA Educational Programme on Depressive Disorders

Training

volume four

METHODS OF TRAINING AND EDUCATION ABOUT DEPRESSION

Revision of 2008

EDITORS OF THE EDUCATIONAL PROGRAMME

Mario Maj, Norman Sartorius, Allan Tasman and Oye Gureje

TASK FORCE ENTRUSTED WITH REVIEW AND UPDATE OF THE MATERIALS

N. Sartorius (Co-chairman)
A. Tasman (Co-chairman)

M. Benyakar
E. Chiu
H. Chiu
S. Douki
L. Gask
D. Goldberg
O. Gureje
S.V. Ivanov
S. Kanba
M. Kastrup
M. Maj
M. Riba
S. Tyano
D. Wasserman

ADVISERS TO THE TASK FORCE

J.J. Lopez-Ibor
F. Lieh Mak
A. Okasha
E. Paykel
C. Stefanis

AUTHORS OF THIS VOLUME

L. Gask and D. Goldberg

CONTRIBUTORS TO THE PREVIOUS EDITION

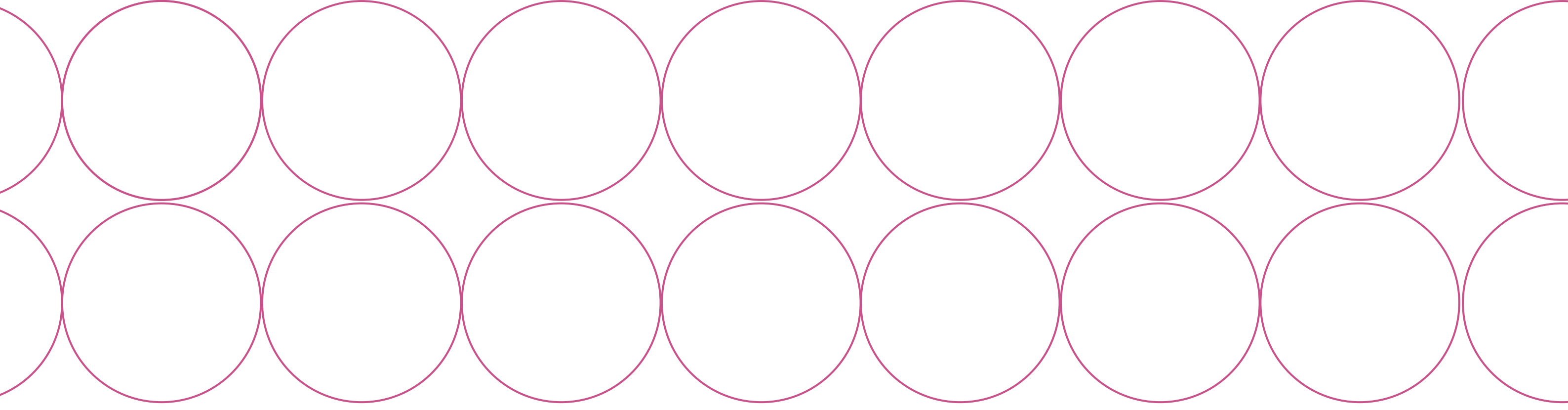
Editors

L. Gask
D. Goldberg
N. Sartorius

Authors

T. Chalder
L. Gask
S. Standart
G. Thornicroft
A. Tylee

The authors would like to gratefully acknowledge the editing done by Ruth Ross as well as the typesetting and layout design by c|change inc. www.cchangeinc.com



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WHY IS TRAINING NECESSARY?

Primary care workers vary in their ability both to detect and manage mental disorders. The purpose of this volume is to provide a model that psychiatrists and other teachers can use in working with primary care workers, including doctors and other allied staff, to improve their colleagues' knowledge of depression, to provide them with new skills, and, in some cases, to modify attitudes that may not be helpful to those who are emotionally distressed. The methods described here will *always need to be adapted to the particular cultural and clinical setting in which the participating workers are based.* For this reason, a preliminary planning session should always be held to gain a better understanding of the needs of the participants and plan the training accordingly. Specific advice is provided concerning how long a good training course should be and what preliminary work needs to be done before the course starts. Helpful activities for remedying skill deficits are also suggested. In this volume, each topic is considered separately, with special attention to an area that is often neglected in undergraduate medical education—improving mental health skills. Three appendices are also included: Appendix I presents the Depression Attitude Questionnaire, which can be used to assess a general practitioner's views on depression and its treatment; Appendix 2 presents a role playing example concerning negotiating treatment for depression; and Appendix 3 lists a number of educational videotapes that are available and gives information on how to obtain copies.

WHAT TO TEACH

Knowledge Deficits

In some areas, undergraduate medical education did not include training in psychiatry and there is a knowledge gap to close. However, many doctors have simply not been exposed to much mental health training since their undergraduate days and their knowledge may be out of date. There may be knowledge deficits about the number of abnormal symptoms and signs that need to be present to justify a diagnosis and an intervention, as well as about the efficacy of different pharmacological and psychosocial interventions for specific disorders. The material presented in the first four volumes of this World Psychiatric Association (WPA) educational programme includes helpful information in these areas, but the selection of educational slides must be tailored to the specific needs of the audience. This educational package can also be used in conjunction with the World Health Organization's (WHO) Classification of Mental Disorders for Primary Health Care (ICD10-PHC) (English version available on line at www.mentalneurologicalprimarycare.org), which gives detailed advice on the management of the 24 mental disorders that are most commonly encountered in primary care settings. In its original form, this Classification consisted of a set of 24 cards, which was subjected to a field trial in 15 countries. The British field trial showed that use of the depression cards caused doctors to require more depressive symptoms before prescribing antidepressants and expanded their management strategies for dealing with a depressive episode (Goldberg et al. 1995). This system now forms part of a training pack that can be obtained from WHO which includes a range of materials that may be useful in teaching mental health skills. However, it should not be automatically assumed that a knowledge deficit is the main problem: it is far more common for doctors to have skill deficits of which they are unaware.

Teaching can also be provided about specific psychosocial interventions—what they are and for which disorders they have been found effective: for example, problem-solving for depression (Mynors Wallis 2005), simple behavioural interventions (e.g., motivational interviewing) for alcohol problems (Miller and Rollnick 1992), graded exercise combined with cognitive-behavioural strategies for fatigue (Tylee and Chalder training video—see Appendix 3), and reattribution for medically unexplained symptoms (Gask et al. 2000—see Appendix 3). All of these problems may complicate the assessment and treatment of depression in primary care. Lectures designed to convey knowledge should be brief and tailored to the needs of the audience (too often psychiatrists present information that only psychiatrists need or want to know and do not address the needs of family doctors), with plenty of opportunities for questions and discussion, and provision of handouts with key references and Internet links.

Case Discussions

Case discussions should be focussed in order to challenge members of a group to think through problems for themselves in a systematic fashion. One approach, preferably facilitated by a primary care physician with a specific interest in mental health problems, aided by a psychiatrist as a 'resource' person, is to take the group through a series of consultations that the presenting doctor has had with a patient, asking them specific questions each time a new piece of information is provided.

For example:

This 45 male patient first came to see me 2 years ago….

[from the case notes] Patient presented complaining of back pain—much worse. Problems at home. Cannot see anything positive in the future. Wife threatening to leave.

Possible questions for the group might be:

- What else do you need to know?
- What would you like to ask?
- How might you ask that?
- What would you do?

At each stage (usually structured around each time the patient has consulted the physician), the presenting doctor provides the information from the patient's case in response to the questions he prompts the audience to ask and takes them through the case chronologically, using the patient's case history as a learning tool.

A Problem-Solving Approach

Another way of using case discussions is to structure the session around a case study provided by a group member as a focus for problem-solving. The key point here is that the problem to be solved is *not the patient's problem* but rather it is *the problem the patient poses for the doctor* who is presenting the case. The group assists the person presenting the case to work through the questions shown in Table 4.1.

TABLE 4.1

Problem-solving approach to case discussion

- What is the problem with this patient?
- What do I want to achieve?
- What are the key sources of support that I have?
  - Can I make use of them?
  - If not, why not?
- What sources of relevant training do I have access to?
  - Can I make use of them?
  - If not, why not?
- Am I guilty of undervaluing what I have achieved so far?
- What are my options?
  - Advantages and disadvantages
  - Preferred option
- What is my plan of action now?

Unhelpful Attitudes

Doctors who are insensitive to mental health problems are often found to have unhelpful attitudes towards patients with such problems. A useful way of measuring attitudes is the "Depression Attitude Questionnaire" (DAQ) (Botega et al. 1992), which is presented in Appendix 1. These unhelpful attitudes have often developed because the physician has no management strategies to help such patients; such doctors may benefit greatly from skills teaching. To the extent that skill deficits are remedied, it has been found that attitudes to patients with mentally illness also improve. Group discussions can also be useful in challenging unhelpful attitudes. Such discussions may be triggered by case presentations, videotaped interviews, or, most powerfully, participation of real patients telling their own stories.

Lack of specific skills

General interview skills

In general terms, the skills needed to conduct good clinical interviews are those needed by any good communicator—to allow the patient to tell the story in his or her own way and to be curious about recent events in the patient's life that may be subjecting him or her to stress. This sounds very simple, but it is not. Patients typically present with somatic symptoms and often have combinations of real physical disorders and other symptoms for which no obvious cause has been found. The doctor is under time pressure to bring the interview to a satisfactory resolution and needs to exclude possible organic causes for the patient's various symptoms. Small wonder that the temptation is to interrupt the patient with an agenda of the doctor's own in order to systematically exclude possible physical causes before the patient has been given a chance to describe the symptoms in his or her own way.

This early stage of the interview can last anywhere from 20 seconds to several minutes. During this portion of the interview, the doctor encourages the patient to talk and asks open-ended questions that allow the patient the freedom to describe symptoms in his or her own way. Provided that patients are encouraged to do this, the moment will soon arise when the doctor becomes more directive and exerts more control over the interview. When symptoms are described that sound atypical, or for which there are no obvious physical causes, the doctor may need to supplement his of her knowledge of the patient's home and family background or discover whether the person has experienced stressful life events. When cues arise that suggest psychological distress, the doctor should be alert for them and follow up with directive questions.

Interviews in primary care tend not to follow the rigid schemas taught in medical school, but may oscillate between personal questions about the family and allowing more description of somatic symptoms to emerge. From time to time, it may be necessary to make some supportive comment to the patient. Skills found to be particularly important in the detection of psychological problems in primary care are summarised in Table 4.2.

TABLE 4.2

Characteristics of a general practitioner's interview style that increase ability to accurately assess patients' emotional problems

Early in the interview	Interview style
• Makes good eye contact	• Makes empathic comments
• Clarifies presenting complaint	• Picks up verbal cues
• Uses directive questions for physical complaints	• Picks up non-verbal cues
• Begins with open-ended questions and moves to closed questions later	• Does not read notes while taking the history
	• Can deal with over-talkativeness
	• Asks fewer questions about past history

It is a mistake to suppose that conducting such interviews requires some special ability that is quite different from other skills in clinical medicine, and that those who are good physical diagnosticians are likely to have little psychological acumen. In fact, the reverse is the case—doctors with high psychological sensitivity do better than insensitive doctors on tests of factual knowledge of medicine, and are more likely to possess postgraduate qualifications.

The observations presented above are based on an analysis of many hundreds of interviews between general practitioners and their patients, in the course of which it became clear that doctors who are good at detecting emotional disorders have patients who make it easy for them by exhibiting more cues relating to distress than similarly distressed patients being interviewed by less sensitive doctors (Davenport et al. 1987; Marks et al. 1979). What is happening is that less sensitive doctors discourage free communication and patients become aware of this very early on (Goldberg et al. 1993). Some of the behaviours that discourage patients are not making eye contact, having a more avoidant posture at the beginning of the interview, interrupting the patient before he or she has finished speaking, and asking many "closed" questions, to which the patient must reply "yes" or "no". Patients who pick up these cues from the doctor speak with less distress in their voices, keep their hands and arms still, and are much less likely to mention psychological symptoms. By contrast, patients interviewed by doctors who are good at picking up distress are encouraged by the doctor's attentive posture and tendency to make eye contact; these doctors make more facilitations while listening and ask questions with a psychological content, using a directive rather than a closed style. Some behaviours act as cues when performed by sensitive doctors but not by insensitive doctors; these include questions about the patient's social life, having an empathic manner, and the total number of questions that are asked about the patient's psychological adjustment.

Related work (Millar and Goldberg 1991) has demonstrated that sensitive doctors generally have superior communication skills and are better able to prescribe medication, communicate information about treatment more effectively, and give advice more clearly than less sensitive doctors. Thus, doctors with superior communication skills make detection of distress easy for themselves, by behaving in a way that makes it easy for their patients to display the distress they feel. Doctors whose communications skills are less good can manage to make patients suppress all evidence of their distress, so that it may not even be manifest to a psychiatrist viewing a videotape of the consultation.

Specific skills for depression

In addition to improving communication skills, there are a number of other specific skills that may need improvement. These skills correspond to specific tasks that must be carried out in the process of assessing for and managing depression effectively (Table 4.3). Doctors also need to learn how to negotiate antidepressant medication treatment with patients. It is also important for primary care workers to learn about available local resources and form links to specialist services and non-governmental organisations who can provide necessary expertise and support. These agencies may be invited to participate in the training, but it is essential to ensure that they fully understand the purpose of the training and do not see this as an opportunity to simply ensure referrals to their own organisations. However large such agencies or institutions may be, they cannot perform the essential role of front-line workers in assessing and managing depression. However, these agencies may feel unnecessarily threatened by attempts to develop the role of primary care workers and such concerns, if present, should be addressed.

TABLE 4.3

Assessment and management of depression

Assessment during the consultation	Management during the consultation	
Psychological Assesses severity of illness (preferably using a standardised measure such as the Patient Health Questionnaire-9 [PHQ-9]) • Asks about • suicide risk, deliberate self-harm • presence or absence of anxiety symptoms • duration, chronicity • pattern of illness • history • associated alcohol and drug use • psychotic features	• Listen, empathise • Explain diagnosis • Explain somatic symptoms • Address patient's ideas and concerns • Agree on a problem list • Negotiate management plan • Self-help literature • Antidepressants • Build trust • Arrange to follow-up and monitor progress	Brief psychological strategies that may be employed during consultation include: • Behavioural activation • Self-help • Problem-solving approach • Anxiety management • Simple motivational strategies
Social Asks about • nature of social difficulties • social support or lack of • confidants or lack of • background vulnerability factors • family history		
Physical • examination/investigation of causes of physical problems • comorbidity- (e.g., diabetes, cardiovascular disease)		

METHODS OF TEACHING

Modelling Skills

Video-feedback has been used for at least 20 years in efforts to change professional behaviours. The first systematic studies involving the use of this technique to teach skills were done in several different settings. It is important that the required skills be modelled by actual primary care workers rather than by mental health professionals. Over the years, we have produced a series of videotapes that demonstrate skills necessary for dealing with patients who are somatising their psychological distress, are depressed, have chronic fatigue, have drinking problems, have dementia, are psychotic, or have anxiety. All of these tapes contain examples of role-plays in which one can stop the tape to practice specific skills. A list of available instructional videotapes is provided in Appendix 3. In some countries, it may be more appropriate to use these tapes as 'templates' for producing more culturally appropriate local materials. However, they can also be 'overdubbed' in the local language at relatively low cost (much less expensive than subtitling) and this approach has been used successfully in Europe. Many of the tapes contain "discussion points", and most of the tapes also have notes reminding the teacher of items to elicit from the group at specific points. The teacher plays the role of a facilitator during these discussions, encouraging those who have not spoken to contribute and agreeing with suggestions that seem helpful. If someone suggests something that the teacher considers unhelpful, the teacher asks how others in the group handle such situations rather than disagreeing with the speaker. The teacher is generally supportive to the group and only suggests his or her own solutions if they do not emerge in the general discussion. Opportunities for practising micro-skills using role-play are also provided in some of the material.

At times it may be helpful to let a participant try an immediate role play of a new behaviour—but in general it is best to avoid doing this in a larger group, since it is mortifying to make obvious mistakes in front of colleagues. However, the doctor describing a problem can be invited to become the patient he or she is describing. Most doctors find it very easy to do this and enjoy having the teacher deal with the problem they have described. The teacher plays the role of "doctor", explaining that this is how a mental health professional might handle such a moment, and that the participants must decide whether it is a suitable strategy for general practitioners.

Use of Role Playing to Practice Skills

Unless the doctor practices the new skills that have been demonstrated nothing will be gained—it will be as though he or she tried to learn to ride a bicycle by listening to a lecture and watching a demonstration by a skilled rider. Doctors are unlikely to try out their new skills with real patients until they have practised them in less demanding circumstances, and this is where role playing comes in. For each role play, it is necessary to prepare three documents, one for the person who will play the doctor, one for the "patient", and one for the observer. These three individuals constitute the role play *trio*.

The "**doctor**" is told what the practice knows about the patient who is about to be seen—not the actual medical notes, but the relevant information about the patient that would normally have been available.

The "**patient**" is told to play someone of his or her own age and gender, but is typically given another occupation. "Patients" are told about their presenting symptoms and any recent life events that they may or may not wish to tell the doctor about. If asked questions by the doctor that have not been covered, they are advised to answer them from their personal experience.

The **observer** is given the most information—i.e., all the information on the patient and doctor forms as well as a list of behaviours they are to look out for. After the enactment, the observer is asked to do the following:

1. To ask the "*doctor*" how he or she felt the interview went. What was he or she pleased with about it? Was there anything that could have been improved?

2. To ask the "*patient*" how he or she felt about the interview, and how the problem was handled. What did he or she like about the interview? Could anything have been improved?

3. To give the "*doctor*" feedback, based on the observer's own observations.

The teachers (as indicated above, the ideal ratio would be 1 teacher to six doctors) move around the room from one set of doctors to another, offering advice and help as appropriate. The enactments should be quite short—lasting no more than about 4 minutes; with feedback and discussion typically taking another 10–15 minutes. The trio should then proceed to the next role play, changing roles so that each doctor gets a chance to play the "doctor" role. An example of a role play is provided in Appendix 2. It is important that such role plays are adapted to the conditions of the culture in which the teaching is occurring, and that sufficient copies are made for several trios of doctors to use the same role-play.

Using Videotapes of the Trainees' Own Consultations

Feedback on video- and audiotapes has been used in the acquisition of skills for many years. Lesser (1981), who called the method of audiotape teaching he developed in Canada in the early 1980s "problem based interviewing", came to England and helped to turn his method into a group teaching course using video feedback, which was evaluated with positive results. This method is be discussed in more detail below.

PLANNING YOUR OWN COURSE

Preliminary activities

Managerial

Collaboration: There is no substitute for a collaborative relationship with a local teacher of general practitioners, with the teacher-doctor preferably working closely within the usual training arrangements for medical practitioners. The length of the training will, to some extent, depend on the availability of local doctors for training. A course of 10 sessions, each lasting 2–3 hours is ideal; however, sometimes it is only possible to recruit doctors for a single session. However, a single session may arouse enough interest that the doctor decides to come back for other sessions. In such cases, one of the prepared videotapes, accompanied by role playing, may be used in a session that focuses on a particular topic that has been identified as being important in the local area (e.g., management of somatised emotional distress, talking to people with alcohol problems, or identification of depression).

Timing: It is important to discover which times of day are convenient for local doctors to attend training, remembering that training may need to be held on weekends or evenings. It is also advisable to invite more doctors to attend than you have places, because many doctors will be unavailable on the chosen day for one reason or another. Only trial and error can decide how many "extra" doctors to invite to a given location. If the doctors are going to be invited to role play, you should plan for at least one teacher for every 6 doctors—more is an advantage, fewer will create difficulties if doctors are to obtain maximum benefit from the training.

How long should a session last? You should plan for at least an hour to comfortably include some slide presentations, discussion, and a couple of turns at role-play—an hour and a half would be preferable, if possible. In planning the session, allow 10 minutes for each brief paired role play to acquire micro-skills (see below) and 15–20 minutes for longer role-plays carried out in trios. If you want to include some video feedback, it is wise to allow for two of these sections, with a short break in the middle. Allow a minimum of half an hour (and preferably three quarters of an hour) for each session of video-feedback.

Course content: Preparing teaching materials, and adapting them to local needs

Setting the local agenda: Time should be spent establishing the knowledge base of the particular group of doctors who will be attending and selecting only those knowledge-deficit topics that the group asks for. There is nothing more alienating than to give up valuable time to attend a learning session only to be told things that you already know. It is often helpful to elicit advice from a local teacher of general practitioners concerning topics that need to be included for a given group of doctors. This teacher can be invited to look through the WPA package and select material that he or she thinks will be important for this particular group. The teacher can also give an opinion about whether or not to include the extra slides that accompany this article. The general practitioner teacher can also be shown a list of possible role plays and asked to identify behaviours that would not generally be familiar to his or her colleagues; the teacher may also suggest other scenarios that cause difficulties locally and work with you to prepare special role plays before the course starts.

Motivation: It can sometimes be helpful to improve the motivation of doctors to come to the training. Methods for doing so will, of course, depend upon the particular location and its available resources. For example, methods used in England include paying for a locum to cover the doctor's absence, arranging for the general practitioner training organisation to award postgraduate credits for attending the course, and providing sandwiches and light refreshments during breaks for tea or coffee. When doctors are coming for training in the evening directly after work, it may be important provide a light meal so that they can work later without loss of concentration.

Real material: If it is possible to obtain videotapes of real consultations that occurred between doctors who will be attending the training and their patients, this provides the *best* teaching material of all: however, such materials are often quite difficult to obtain. Alternatively, the general practitioner teacher may be able to provide a videotape of his or her interviews with patients: such tapes should provide examples of good medical behaviours—one should one never uses such recordings to point out mistakes. If videotapes are available, time should be spent viewing them beforehand and selecting brief excerpts that illustrate particular points. If any videotapes from doctors who will be attending are available, it is important to explain that the doctor can choose which videotapes to show the larger group and that there is no question of other doctors seeing a tape about which the maker of the tape is unhappy. The skills required by the teacher to provide feedback on videotapes are discussed in more detail below.

Training teachers to assist you

In addition to the general practitioner teacher, who will be chairing the session(s), and the mental health resource person, it is essential to have at least one other mental health professional or general practitioner teacher with some mental health training experience be involved in the teaching. You should have a meeting with the lead general practitioner teacher who will be chairing the session, during which the teachers can mutually agree on how the session is to be organised and whether role playing is to be included; all additional teachers should be invited to this planning meeting. Teachers who do not have the opportunity to participate in such planning sessions are often very anxious about their participation and may feel that their task is to teach the general practitioners how they personally handle such patients in the mental health setting. However, general practitioners need to learn a rather different set of skills, because their time is short and they must often exclude possible physical causes for the patient's symptoms. You should tell them the additional teachers to observe the experienced teachers until they are familiar with the situation, but you should also encourage them to listen to and supervise any role plays beginning with their first attendance. They invariably enjoy doing so, and this process serves to break the ice. From that point on, they will be able to organise their own courses for general practitioners.

The Course Itself

In terms of the content of the course, the ability to deal with emotionally distressed patients can be considered in terms of attitude, knowledge, and skills.

Increasing motivation to learn: Assessing attitudes.

If the general practitioners are prepared to make spare time available for training, they may already be highly motivated and nothing more may need to be done. However, an *introductory talk* that summarises existing knowledge in this area and emphasises the advantages to be gained, in terms of improved patient and doctor satisfaction, from participating in such training may be helpful. This introductory talk should include a brief slide show relevant to the cultural setting, preferably including local epidemiological material accompanied by videotapes from the particular culture in which the teaching is occurring if available.

The "Depression Attitude Scale" presented in Appendix 1 may be useful tool for assessing participants' attitudes. You can also just employ a simple scale that asks how confident participants feel in dealing with emotional problems and about their attitudes towards patients with such problems. If such simple measures were administered before the start of the session, the trainer can incorporate some of the findings in the preliminary talk. However, it is important to take into account what you know about your colleagues who will be participating in the training: some doctors find completing questionnaires rather persecutory and, if this is the case, use of such questionnaires can be counter-productive.

Assessing educational need: Knowledge deficits

The introductory lecture should be followed by a discussion with the doctors who are attending, during which the trainer may attempt to assess the *knowledge deficits* of the group. This may be done by asking the doctors how often they encounter depressed patients in their practice, and how they treat them. This can lead to a discussion of commonly employed treatments for depression. When "counselling" is mentioned, ask the participants about any problems they may have encountered while engaged in this type of intervention. Finally, ask whether they find that depression ever occurs in those with undoubted physical illnesses; and, if it does, how they treat it.

Teaching skills

However, the most important task in this kind of teaching is the provision of new skills. In practice, the methods used will be partly determined by the time available to both the trainers and the participating general practitioners. Only very limited information can be learned in a single session, especially a short one. In general terms, the trainee must first be motivated to learn, then must see desirable behaviours modelled, and then must practice these new behaviours

Teaching based on actual consultations: Using videotapes

When showing a videotape, it is extremely important that the teacher ask the doctor who made the tape for permission to show it and invite that doctor to comment before inviting comments from anyone else. The person who made the tape will often make the most critical remarks about his or her own performance, while other participants will be more supportive in their comments. If someone makes a critical comment, ask that person what he or she would have done in such a situation, before asking others. In general, the teacher elicits responses *from the group* rather than allowing the group to view the teacher as an all-knowing "guru". Suggestions on how to use videotapes sensitively and effectively to teach in a group setting, developed after many years of research and practice, are shown in Table 4.4.

Facilitation means eliciting responses *from the group* rather than simply showing or demonstrating to the group how you as the teacher would tackle this situation. Active learning, which is more effective than passive 'spoon-fed' learning, involves getting the group to do the work and come up with suggestions rather than always having the teacher provide them. Although it might seem more efficient for the teacher to do so, this is a false economy of time because little thinking is going on and the group is simply sitting back and watching the teacher do the work!!

TABLE 4.4

Guidelines for group video feedback

1. Set ground rules	• Ask if the person has seen him- or herself on video before. Ensure that the group realises this may be difficult and elicit support. • Anyone can stop the tape, but if they do, that person must say what he or she would have done or said differently at that point. • Confidentiality is essential, both for the group and also for the patient if this is a real consultation.
2. Set an agenda	• Clarify the purpose of the session. • Fill in background. • Engage the group in asking questions. • What does the person showing the tape want from the group?
3. Provide opportunities for rehearsing new skills	• Stop the tape regularly at key points and invite the rest of group to do so also. • Ask the group for comments on what has happened and whether anyone would do things differently. • Give the person showing the tape the first opportunity to comment. • Label key skills and strategies that are being used on the tape or that have been suggested by the group.
4. Be constructive	• Comment on things done well as frequently as you can without seeming false. • Provide positive comments first, followed by a discussion of things that might have been done differently
5. Make the group do the work	• Facilitate, don't demonstrate. • Summarise suggestions and keep the session flowing. • Ensure that the group keeps to the agenda.
6. Conclude positively	• Summarise and ask for feedback from the person showing the tape and from the group. • Facilitate development of an action plan for future consultation if this is a real patient. • Assist in formulating new learning goals.

Where videotapes of real patient material are being used, members of the group should respect normal medical **confidentiality** outside the group. They should also agree not to talk about other people's performance outside the group—otherwise, it can be difficult for the group to relax and work productively. This is especially important if the group meets on several occasions and doctors take the risk of sharing consultations with the group that deal with issues they personally find particularly difficult.

The teacher should draw attention to behaviours consistent with those shown in Tables 4.2 and 4.3, using the terms presented in those table to **label** the behaviours to which attention is drawn. For example, a *closed question* refers to one that can be answered by a simple "yes" or "no", such as "Is it a sharp pain?" or "Do you wake early in the mornings?" An *open-ended question* is one that requires the patient to put his or her experience into words, such as "Can you describe the pain to me?", or "Tell me how you have been sleeping". A *non-verbal cue* is something about the patient's behaviour that indicates emotional distress—perhaps he or she is tearful, or speaks in an anguished way, or has a tremor. The doctor responds to such cues by drawing attention to them, for example "I can see that you're still upset by your mother's death", or "you seem to be quite nervous about this". The doctor should "control" the interview by helping shy, defensive people describe their experiences or, conversely, by gently reminding an over-talkative patient of the issues you need to hear about "Maybe we can come back to that later, but first I need to hear a bit more about your pain".

Negotiation refers to suggesting things to the patient in a tentative way, which allows the patient to disagree with what you have said. For example, the doctor could say "You seem quite depressed to me—would you like to have something to speed up the process of getting better?" rather than "You are suffering from major depression, and I am going to give you some tablets for it". Videotapes are available that illustrate the process of *problem solving* with patients (see Appendix 3). Basically, this process consists of identifying a problem that is appropriate for immediate action, and asking the patient to describe various alternative ways of dealing with it. The patient systematically examines the pros and cons of each alternative, selects the best option, then works through the steps required to achieve this. The key difference from what doctors usually do is that *the patient* rather than the doctor is generating the list of alternatives and rehearsing how he or she might go about achieving the goal. This is quite the opposite of giving advice, and seems to be effective in the management of depression in primary care settings. It can also be learned more quickly than other therapies such as cognitive-behavioural therapy.

At the end of each training session, it is helpful to leave time to ask the group about problems that they have experienced with emotionally distressed patients. Get the person presenting the problem to reflect on how they dealt with it and always allow others to comment on how they handle such problem situations.

EVALUATION OF TRAINING: THE RESEARCH EVIDENCE

Evaluation of Group Video Feedback Training

In one study, general practice trainees were offered weekly sessions using the methods described above over the course of 6 months. In this study, participants who were least able to interview well showed the greatest improvement scores at the end of the course (Gask et al. 1988). In another study, teaching was offered to a group of established general practitioners (Gask et al. 1987) in which participants were shown a clear model for interviewing patients and then met in groups to discuss one another's techniques. The teacher offered his or her own views if necessary, but most of the helpful comments came from the other participants. The doctors were encouraged to become aware of cues (e.g., quality of the patient's voice, patient's posture, any spontaneous movements by the patient) that they might otherwise have ignored. This training was shown to achieve lasting effects, with the scores of the doctors who participated in the training improving still more when they were tested a year later (Bowman et al. 1992).

These methods were later taught to general practitioner trainers in both London and Manchester. It was found that it was critical to offer potential teachers feedback on their own interviewing techniques—so that they, in effect, experienced the teaching that they themselves would then be offering to trainees (Gask et al. 1991). Additional feedback on their own teaching sessions and earnest discussions and advice about their teaching methods added little to this.

The effect of training to increase psychiatric skills has been studied by Gask and Goldberg (1993). Overall there has been a trend towards improved clinical outcomes in patients of doctors who have been trained, with the greatest impact seen in patients who were both depressed and anxious, due to decreased anxiety. Trained doctors were also significantly better at detecting disorders and gave more information to their patients, and the patients felt that their problems had been understood. Likewise, Scott et al. (1999) reported that general practitioners who receiving training in problem-based interviewing were better at both detecting and managing psychological problems, and that lengths of interview did not differ between the trained and untrained groups.

Evaluation of Training on the Assessment and Management of Depression

Most of the research on educational interventions for depression has been carried out in countries where the mental health training of primary care physicians at undergraduate and postgraduate level is considerably more extensive than in developing countries.

In the United Kingdom, the Defeat Depression Campaign, jointly run by the Royal Colleges of Psychiatry and General Practice, produced a consensus statement on good practice and ultimately led to a major evaluation called the Hampshire Depression Project (Thompson et al. 2000). Despite the training experience offered to general practitioners, the clarity of the treatment guidelines, and the reasonableness of the teaching methods adopted, the project did not produce a lasting effect upon the treatment behaviour of the general practitioners who collaborated in the study. This echoes similar findings from the United States, where Lin and colleagues (1997) showed that extensive physician education over a period of 1 year, which included didactic advice on prescribing, role plays of good practices, good practice guidelines about treatment, and use of a reference handbook, failed to produce a measurable effect on patient outcomes. The authors concluded that the presence of mental health personnel on-site in primary care, who were available to see patients referred by primary care physicians and monitor patient progress and treatment adherence, seems to be necessary to produce improved outcomes (Such programs are called collaborative care and are described elsewhere in this programme). However in looking at study outcomes, it is important to distinguish between training that focussed primarily on adherence to a set of guidelines or a treatment protocol, which was the case in the Hampshire project (Thompson et al. 2000), and training that is primarily concerned with acquisition of a range of *new* clinical skills.

Other studies that have focussed more on **skill acquisition**, have shown similar but more promising findings. In a study in the Netherlands, Van Os and colleagues (1999) found that there was a training effect at 3 months that had disappeared by 1 year and concluded that the effect of training was to promote faster recovery and a shorter duration of illness in patients. The effect of training was weaker in the sub-group of physicians who had previously been involved in research projects with the centre.

Gask and her colleagues have carried out an intensive training programme focused on depression in primary care, which involved their general practitioners attending 10 hours of training that included videotapes, role playing, and viewing tapes of their own consultations. These doctors received training in both problem solving and cognitive techniques relevant to depression. The doctors were rated by their role played "patients" as better communicators as a result of this training, and the doctors indicated that they felt more confident about managing their depressed patients (Gask et al. 1998). In a randomised, controlled trial

of this training, these investigators found no overall impact on patient outcome (Gask et al. 2004), but there was a difference between centres, with a significant impact, which was greatest in the first 3 months, in the centre where doctors had had the least exposure to previous training. This supports findings from earlier work that less skilled doctors have the greatest chance of acquiring new skills in training courses.

Therefore, it remains to be shown what impact such training would have in countries where there is a considerable deficit in skills, knowledge, and attitudes with respect to depression in primary care, but early findings suggest that the gains could and should be considerable (Zakroyeva et al. 2008).

A framework for evaluating courses based on the work of Kirkpatrick (1994) is presented in Table 4.5.

CONCLUSIONS

Teaching of the kind described here is suitable for doctors working in community settings as well as those working in hospital or occupational health settings. Doctors with whom you are collaborating within the profession will advise you about any knowledge deficits in the particular groups being trained, but you should not suppose that hospital doctors are any more sophisticated than general practitioners with regard to a knowledge of mental disorders. The training described here can also be effective with non-medical workers. There is also no reason why interested final year medical students should not benefit from such teaching, provided that staff time is available to supervise them. Indeed, with the current focus on improved training in communication skills in medical schools world-wide, students in many medical schools are now likely to be very receptive to the methods described here and to be well accustomed to participating in role-playing and use of video feedback for teaching purposes.

Training is most likely to be effective when:

- **It clearly meets local needs.** One must determine what exactly is needed in a particular location—a change in knowledge, skills, attitudes or all of these? The most effective educational interventions are multifaceted, offering a range of possible options that doctors can learn from and meeting a range of different needs.
- **It is clearly relevant to primary care.** Educational interventions should preferably be planned and delivered in partnership with primary care at a time and place that workers in these settings can easily access.
- **It is focussed on those who need it.** The studies reviewed above show that it is best for depression training to be specifically targeted to those who *really need it* and to *their specific needs*. In many countries, interested doctors will have already received some training. Therefore, training in newer skills, such as how to manage somatisation, may have a potentially greater impact because these ideas will be fairly new to almost all participants.

To be most effective, training needs to be 'sold' to the target audience by emphasising potential benefits to doctors as well as patients. Based on their work, Lin and colleagues (1997) stressed the need to ensure that *training is linked to the existing mental health care system*, because doctors need to know what to do when they are faced with patients they feel unable to manage themselves. Without this knowledge, enthusiasm will wane. In addition, just as with therapeutic interventions, training courses need review, booster sessions, and follow-up—there is no simple 'magic bullet' for improving the treatment of mental health problems in primary care in one fell swoop!

TABLE 4.5

Kirkpatrick's levels of evaluation for education about depression in primary care

Level	Evaluation type (what is measured)	Examples of measures	Relevance and practicability
Reaction	Reaction evaluation is how the participants felt about the depression course	Satisfaction of trainees with depression course Self-rated measures of morale and confidence before and after training Interviews/questionnaires with trainees	Quick and very easy to obtain Not expensive to gather or analyse
Learning	Learning evaluation is the measurement of the increase in knowledge about depression.	Simple measurement before and after training using reliable tools: • Knowledge tests • Attitude tests (e.g., DAQ) • Skills acquisition using blind ratings of role-played interviews	Relatively simple to set up when clear-cut measurement of quantifiable skills is involved Less easy to measure complex learning
Behaviour	Behaviour evaluation concerns 'back on the job' implementation	Ratings of real consultations with patients before and after training	Measurement of behaviour change is more complex, requiring, for example, audiotapes of consultations
Results	Results evaluation is the effect on the Organization and the public health impact	Organisational: • Impact on process and outcome of clinical care (e.g., actual antidepressant prescribing behaviour) • Real clinical outcomes for patients. • Public health (e.g., suicide rates)	Individual measure of results (e.g., audit) not difficult Measuring results for Organization as a whole is more complex and requires good information systems National statistics

Source: Kirkpatrick DL. Evaluating training programs: The four levels. San Francisco: Berrett-Koehler; 1994.

Methods of training and education about depression

Training can be focused on:

- Knowledge
- Attitudes
- Skills

Example: using antidepressants to treat depression

Knowledge	Pharmacology of antidepressants Guidelines for use
Attitudes	Depression is treatable – these people are not simply wasting the doctor's time!
Skills	Providing information Negotiating skills

Acquiring the knowledge

- ***Brief*** lecture presentations using overhead projection or slides
- Opportunity for questions and discussion
- Brief handouts with key references and web links

Changing attitudes

- Discussion triggered by
  - Case discussion- real cases
  - Videotaped interviews
  - Real patient experience

Working from case studies 1

- Presentation of a case for discussion
  - Instalments
  - Questions for discussion

Working from case studies 2

- Problem- solving approach to a case

Problem-solving guide to group discussion of a case

- What is the problem with this patient?
- What do I want to achieve?
- What are the key sources of support that I have?
  - Can I make use of them?
  - If not, why not?
- What sources of relevant training do I have access to?
  - Can I make use of them?
  - If not, why not?

KEY SLIDE 8

Problem-solving guide to group discussion of a case

- Am I guilty of undervaluing what I have achieved so far?
- What are my options?
  - Advantages and disadvantages
  - Preferred option

What is my plan of action now?

KEY SLIDE 9

Acquiring new skills

- See it done
  - Modelling
    - live
    - video
- Practice it
  - Role-play
  - videofeedback
  - microskills training

Skills: some definitions

An OPEN QUESTION is one that does not suggest what the patient should tell you

eg: How have you been feeling?

A DIRECTIVE QUESTION, suggests a topic, but lets the patient say what they like:

eg: Can you describe the pain?

A CLOSED QUESTION can be answered with a simple "yes" or "no"

eg: Are you waking early?

Aspects of GP's interview style

Early in the interview:

- Makes good eye contact
- Clarifies presenting complaint
- Uses directive questions for physical complaints
- Begins with open questions, moves on to closed questions later

A "cue" suggesting emotional distress:

NON-VERBAL:

- Blushing, weeping, tremor, nervous manner
- quality of the patient's voice
- restlessness, agitation

VERBAL:

- Spoken words indicating distress

Dealing with over-talkative patients:

- Pick up a verbal cue from the many offered
  - eg: could you first of all tell me about the pain you mentioned?
- Promise to come back to it later:
  - eg: we'll come back to that later, but first of all I need to hear all about that pain
- Speak when they breathe in!

Sensitive doctors:

- Make empathic comments
- Pick up verbal cues
- Pick up non-verbal cues
- Do not read notes while patient is speaking
- Deal with over-talkativeness
- Ask fewer questions about the past

Clarification of the presenting complaint:

Getting the patient to say in own words, exactly what s/he has experienced

Avoid use of jargon or technical terms

Making sure you understand what **this** patient has experienced

Deal with emotion by drawing attention to it:

OBVIOUS DISTRESS:

"You still seem very upset by your mother's death"

ANGER:

"You seem very angry about this. Tell me about it"

EMBARRASSMENT:

"This is something that is difficult for you to talk about"

Make supportive comments when needed:

"You've been going through a bad time"

"Things have been very difficult for you"

"That must have been really frightening"

Draw attention to non-verbal cues:

"You look quite sad"

"You sound very upset about this"

"You've got quite a tremor when you talk about this"

Tasks 1: Assessment of Depression

Psychological

- severity of illness
- suicide risk, deliberate self harm
- anxiety symptoms
- duration, chronicity
- pattern of illness
- past history
- alcohol and drug use
- psychotic features

Social

- social difficulties
- social support or
- Lack of confidants or lack of background vulnerability factors
- family history

Physical

- examination/investigation causes
- co-morbidity

Tasks 2: Management within the consultation

- Listen, empathise
- Explain diagnosis
- Explain somatic symptoms
- Address patients ideas and concerns
- Agree problem list
- Agree management plan
- Self-help literature
- Antidepressants
- Build trust
- Arrange follow-up monitor progress

Brief psychological interventions

- Behavioural activation
- Self-help
- Problem-solving approach
- Anxiety management
- Simple motivational strategies

Negotiating antidepressants

- Inform patient of efficacy and benefits
  - Mode of action
  - Not addictive
  - Side effects
  - 10-14 days before start to work
  - When to take treatment
  - Length of treatment
  - Withdraw gradually
- Address patient's ideas, concerns

Behavioural activation

- 'Acting our way out of depression'
- Setting achievable goals
  - Re-establishing daily routines
  - Increasing pleasurable activities
  - Addressing necessary issues

Steps in Problem Solving

Work through each stage systematically

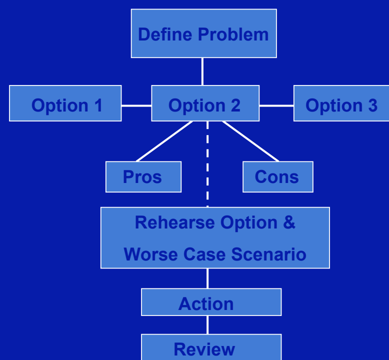
- Define problem to be tackled
  - May take time
  - Needs to feel comfortable with choice
- Generate options for dealing with problem
  - Needs to feel comfortable with choice
  - Allow off the wall or unlikely solutions

Steps in Problem Solving

- Examine advantages & disadvantages (pros & cons) of each option
- Choose the best option
- Rehearse the option in imagination (including worse case scenario)
- Carry out option
- Review what happened

Encourage the person to do this for themselves

Do not take control or be prescriptive



Tasks 3: MANAGEMENT in your health care system

- What are the resources in your team/area?
- Establish liaison ,communication, case discussion
- Develop services

Using video

- To make 'demonstration' tapes to keep
  - Culture specific
- 'Disposable' video
  - For teaching skills
  - Role play or real patient interviews
  - Watch in group setting

ROLE-PLAY- three methods

- PAIRED ROLE PLAY
- TRIOS
- GROUP METHOD

Using recorded consultations

- Real patients
- Role-played patients- get clinicians to play scripted patients or their own patients
- Simulated patients (trained actors who can be briefed to play wide range of roles)
- Standardised patients (trained lay people who can reliably play limited range of scripted patients and provide feedback in and out of role).
- Using audiotapes

Basic rules for giving feedback

When giving feedback:

- Person trying out new skills gets to feedback first
- Always be positive about the other's performance
- Identify the good parts of the interview: be specific about what was good and why
- Discuss the parts which could be improved
- Always suggest positive alternatives

Giving feedback

- **Doctor**
  - What went well?
  - What could I have done better/differently?
- **Patient**
  - What went well?
  - What could have been done differently?
  - What would I have done?
- **Observer**
  - What went well?
  - What could have been done differently?
  - What would I have done?

Video group feedback sessions

- Set ground rules
- Set an agenda
- Provide opportunities for rehearsing new skills
- Be constructive
- Make the group do the work
- Conclude positively

Set ground rules:

Check whether person has seen video themselves; obtain their permission to go on

Ensure group realises this may be difficult for the doctor being shown

Anyone can stop tape - and say what they would

have done

Ensure group realises this is a real consultation - thus, confidentiality

Set an agenda:

Clarify purpose of the session

Fill in background

Engage group in asking questions

What does person being shown want from group?

Provide opportunities for learning new skills:

Stop the tape at key points; encourage others to stop it as well

Ask group to comment on what they have seen

- how do they deal with situations like this?

Label key skills yourself throughout

Invite person suggesting new skill to demonstrate it, becoming patient yourself and giving them a cue to start

Make group do the work:

Facilitate the group, don't demonstrate to them

Summarise suggestions and keep session flowing

Ensure group sticks to the agenda

Conclude positively:

Summarise

Ask feedback from person being shown

Facilitate development of action plan for future consultation with this patient

Assist formulation of new ,earning goals

Evaluation: impact on clinicians

- Is it possible to bring about a change in clinician knowledge, attitudes or skills?
- Does the intervention improve morale or confidence?
- How satisfied are the clinicians with the intervention?

Assessing knowledge

- Self-evaluation
- Instructor's opinions
- objective measures

Attitudes

- Questionnaires (e.g. Depression Attitude Questionnaire)
- Interviews
  - structured
  - semistructured

Skill acquisition

- Videotaped interviews with real or role-played patients
  - rated 'blind' using structured rating scales
- Observed Structured Clinical Examinations
  - rate against predefined scorecard.
- Changes in ability to identify or assess accurately emotional disorder using comparison of patient GHQ rating and PCP rating.

Improvement in morale/ confidence

- Self-rated linear analogue scales
- Interviews
- Post-training assessment rated against pre-training self-assessment of needs/objectives

Clinician Satisfaction

- Questionnaires
- Interviews

Evaluation: Impact on process and outcome of care

- Process of care:
  - frequency and length of visits
  - prescription of medication
  - referrals
  - use of investigations
  - hospitalisations

Evaluation: Impact on process and outcome of care

- Patient satisfaction
- Compliance
- Clinical outcome
  - symptoms
  - disability
- Social functioning
- Economic outcome

Evaluation: Public health impact

- Changes in level of mortality/ morbidity
  - e.g. Suicide rate

Planning a course- the basics

- Knowledge, attitudes or skills?
- Collaboration with primary care teachers
- Timing/incentives
- Responsive to local agenda
- Real material
- Training co-teachers
- Linking into the healthcare system- consultation and support

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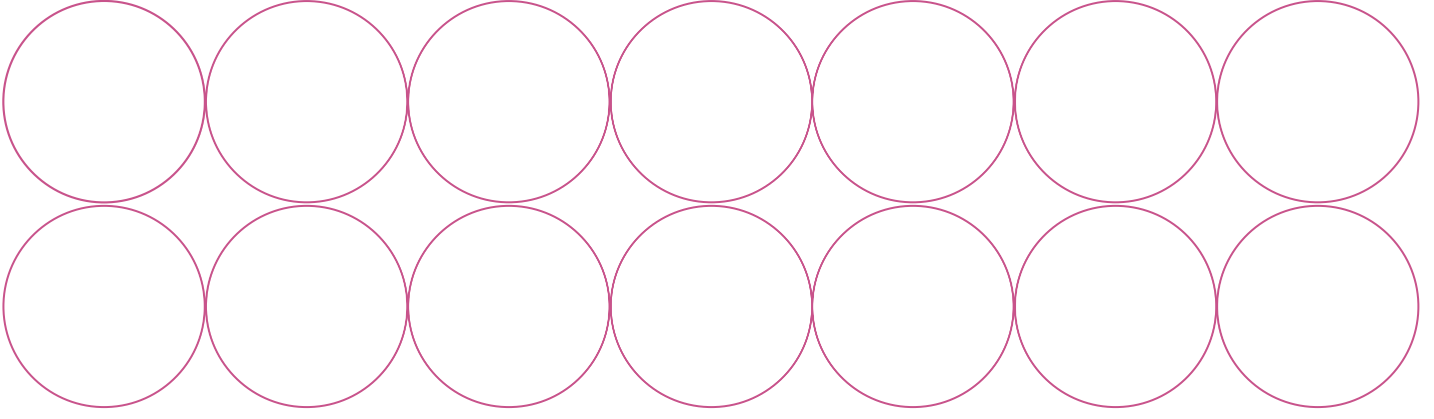


Appendices

Appendix 1

Depression Attitude Questionnaire*

The purpose of this study is to explore the range of medical views on depression. We are interested in your observations derived from day-to-day medical practice. In completing the items, please consider as depressed those patients in whom you recognise depression to be a significant part of the clinical picture, not just those who happen to be seeing a psychiatrist. All information will be treated in strict confidence.

Thank you for co-operating and adding any comments you think appropriate.

Your age:	yrs	Sex:	M F
Year of gaining MB or equivalent:			
Time working as a general practitioner in years:	less than 1 1-2 3-5 6-7 8-9 10+		
At present are you working in general practice:	full time part time		

The questionnaire contains statements that reflect different viewpoints on depression. Under each statement there is a line with strongly disagree at one end and strongly agree at the other. Please indicate a point on each line which best reflects your daily clinical experience.

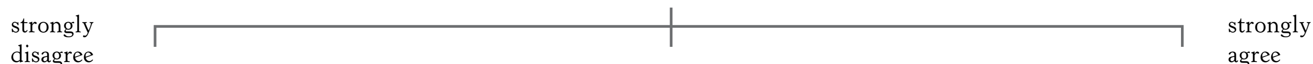
For example:

a. Work in primary healthcare involves dealing with depressed patients.

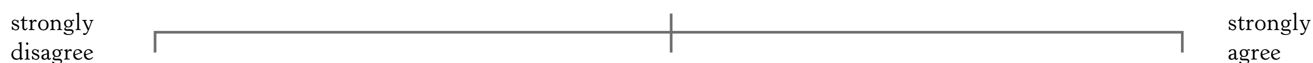
This response would indicate more agreement than disagreement but with some uncertainty.

*Adapted from Botega et al. 1992

1. During the last five years, I have seen an increase in the number of patients presenting with depressive symptoms.



2. The majority of depression seen in general practice originates from patients' recent misfortunes.



3. Most depressive disorders seen in general practice improve without medication.

4. An underlying biochemical abnormality is at the basis of severe cases of depression.

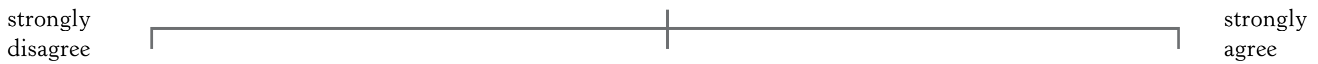
5. It is difficult to differentiate whether patients are presenting with unhappiness or a clinical depressive disorder that needs treatment.

6. It is possible to distinguish two main groups of depression; one psychological in origin and the other caused by biochemical mechanisms.

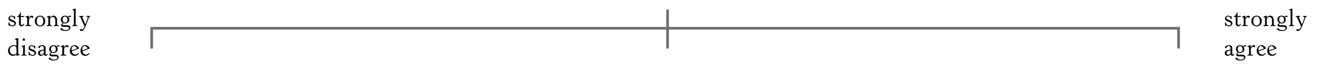
7. Becoming depressed is a way that people with poor stamina deal with life difficulties.

8. Depressed patients are more likely to have experienced deprivation in early life than other people.

9. I feel comfortable in dealing with depressed patients' needs.

strongly disagree  strongly agree

10. Depression reflects a characteristic response in patients which is not amenable to change.

strongly disagree  strongly agree

11. Becoming depressed is a natural part of being old.

strongly disagree strongly agree

12. The practice nurse could be a useful person to support depressed patients.

strongly disagree strongly agree

13. Working with depressed patients is heavy going.

strongly disagree strongly agree

14. There is little to be offered to those depressed patients who do not respond to what general practitioners do.

strongly disagree strongly agree

15. It is rewarding to spend time looking after depressed patients.

strongly disagree strongly agree

16. Psychotherapy tends to be unsuccessful with depressed patients.

strongly disagree strongly agree

17. If depressed patients need antidepressants, they are better off with a psychiatrist than with a general practitioner.

strongly disagree strongly agree

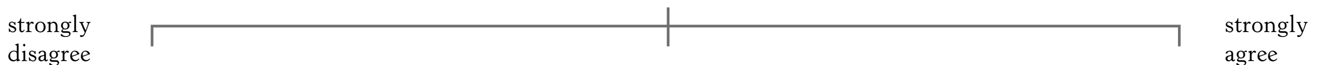
18. Antidepressants usually produce a satisfactory result in the treatment of depressed patients in general practice.

strongly disagree strongly agree

19. Psychotherapy for depressed patients should be left to a specialist.

strongly disagree strongly agree

20. If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed patients.

strongly disagree  strongly agree

What percentage of patients have you seen over the past 3 months in whom you would estimate depression to be a significant part of the clinical picture?

under 5% 6-10% 11-20% 21-30% 31-40% 41-50% 51-60% 61-70% over 70%

What percentage of these depressed patients have you decided required an antidepressant?

under 5% 6-10% 11-20% 21-30% 31-40% 41-50% 51-60% 61-70% over 70%

Each item is scored individually–there is no total score

Appendix 2

Example Role Play: Negotiating Treatment

The ROLE PLAYS must be printed on three separate sheets of paper, so there is one for each student. Initially, we will divide the students into groups of 3 and give each student only one sheet, so that within each triad, there is a "doctor", a "patient", and an observer.

ROLE PLAY: DEPRESSION: NEGOTIATING TREATMENT

The Patient (your own gender and age)

You went straight to work in an office after leaving school and always enjoyed the responsibility of your job. Four months ago, you suddenly were told that your job no longer existed and you found yourself out of work for the first time in your life. Money is now very short and you have not been able to find another job.

Disability

You are finding it very hard to get out of bed in the morning. You feel very down in spirits, have stopped taking as good care of yourself as you used to, and have lost interest in things you used to enjoy. The only time of day that you begin to feel a little better is in the evening. There have been fleeting thoughts of suicide but no plans. Your appetite is poor and you have lost weight. You are fidgety and restless, but find it difficult to concentrate on anything at all—even watching television.

Family

Your husband/wife (use your real family) is supportive but is beginning to get impatient with you and thinks you have given up. Your son/daughter has started to avoid you and stopped talking to you. You think that you embarrass him or her.

Your beliefs

You do not know what is wrong with you but you remember that your mother had problems with 'nerves' and you are suspicious about having any sort of mental health treatment. You would like something from the doctor to help you sleep.

The Doctor

What the clinic knew about this patient:

One of your colleagues saw this patient a month ago. He noted that he thought the patient was depressed but he didn't arrange any treatment at all and advised him just to rest and come back if he was not any better.

You haven't seen this patient before.

Observer

What you are looking for during the interview:

- S/he should carefully establish both current symptoms and the associated disability
- S/he should enquire about social adjustment
- S/he should establish patient's beliefs both about what is wrong and what sort of treatment is needed.
- S/he should negotiate a diagnosis with the patient
- S/he should negotiate a treatment plan to include:
  - Agreed list of current problems
  - Treatment with antidepressants
  - A plan for the future that includes a specific date for reviewing progress of the treatment.

After the enactment

1. Ask the doctor how s/he felt the interview went. What pleased you? Was there anything that could have been improved?
2. Start by asking the "patient" how s/he felt the problem was handled. After the "patient" has finished replying, [if necessary] ask what the "patient" liked; and disliked about the way the doctor handled things
3. Give the doctor your own feedback, based upon your observations.

Appendix 3

Training Videotapes

1. Managing somatic presentation of emotional distress (Reattribution: 2nd edition)
2. Helping people at risk of suicide or self-harm
3. Depression: from recognition to management
4. Counselling depression in primary care
5. Problem-based interviewing general practice.

All available from Nick Jordan (Nick.Jordan@manchester.ac.uk)

1. Anxiety (non-pharmacological approaches)
2. Dementia
3. Chronic fatigue
4. Psychosis in general practice
5. WPA video collection (anxiety, chronic fatigue, dementia plus depression from recognition to management and managing somatic presentation of emotional distress)

All available from Professor Andre Tylee, Institute of Psychiatry, De Crespigny park, Denmark Hill, London, SE5 8AF Tel. +20 7235 3150

1. Alcohol problems

Available from Dr Barry Lewis, Castleton Health Centre, Rochdale, Lancs OL11 3HY Fax. +1706 358900 (BarryLewis@doctors.org.uk)

The World Psychiatric Association