



THE HELPS TOOLKIT –

**A TOOL TO PROMOTE
THE PHYSICAL HEALTH OF RESIDENTS
IN PSYCHIATRIC FACILITIES**

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A TOOL TO PROMOTE THE PHYSICAL HEALTH OF RESIDENTS IN PSYCHIATRIC FACILITIES ACROSS EUROPE

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The HELPS Toolkit represents the view of the multidisciplinary European HELPS Network, which was arrived at after careful consideration of the evidence available. However, the HELPS Toolkit does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient.

For more information

To find out more about the HELPS toolkit visit our website: www.helps-net.eu or contact your local HELPS centre.

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INTRODUCTION

1. INTRODUCTION

1.1 The HELPS Project

Background: People with mental disorders have a higher prevalence of physical illnesses and reduced life expectancy as compared with the general population. However, there is a lack of knowledge across Europe concerning interventions that aim at reducing somatic morbidity and excess mortality by promoting behaviour-based and/or environment-based interventions.

Methods/design: HELPS is an interdisciplinary European network that aims at (i) gathering relevant knowledge on physical illness in people with mental illness, (ii) identifying health promotion initiatives in European countries that meet country-specific needs, and (iii) at identifying best practice across Europe. Criteria for best practice will include evidence on the efficacy of physical health interventions and of their effectiveness in routine care, cost implications and feasibility for adaptation and implementation of interventions across different settings in Europe. HELPS will develop and implement a “physical health promotion toolkit”. The toolkit will provide information to empower residents and staff to identify the most relevant risk factors in their specific context and to select the most appropriate action out of a range of defined health promoting interventions. The key methods are (a) stakeholder analysis, (b) international literature reviews, (c) Delphi rounds with experts from participating centres, and (d) focus groups with staff and residents of mental health care facilities.

Meanwhile a multi-disciplinary network consisting of 15 European countries has been established and took up the work. As one main result of the project they expect that a widespread use of the HELPS toolkit could have a significant positive effect on the physical health status of residents of mental health and social care facilities, as well as to hold resonance for community dwelling people with mental health problems.

Conclusions: A general strategy on health promotion for people with mental disorders must take into account behavioural, environmental and iatrogenic

health risks. A European health promotion toolkit needs to consider heterogeneity of mental disorders, the multitude of physical health problems, health-relevant behaviour, health-related attitudes, health-relevant living conditions and resource levels in mental health and social care facilities.

1.2 Building the best physical health intervention with HELPS

People with a mental disorder are at increased risk for physical illness and therefore their risk of premature death is raised. An unhealthy lifestyle, living conditions, medication side-effects and a lack of physical health monitoring are regarded as the main causes of high somatic morbidity. HELPS is intended to help mental health professionals think through and develop the structure of health promotion programmes and measures to motivate them for changing their unhealthy behaviour towards a healthy lifestyle with the intention to prevent and reduce physical illness and complaints. Moreover, clients should be empowered managing their everyday lives toward healthy lifestyle.

Preventing and managing physical illness in consequence of an unhealthy lifestyle is a complex problem, with no easy answers. The HELPS Toolkit offers intervention measures and practical recommendations based on the evidence. But health professionals working directly with the clients also need to be aware of the many factors that could be affecting a person's ability to reach and stay a healthy lifestyle and good physical health. Barriers to lifestyle change should be explored. Possible barriers are for example:

- Lack of knowledge, e.g., how an unhealthy lifestyle (poor diet, sedentary lifestyle, poor oral hygiene practice, and excessive smoking and alcohol consumption) affect the physical health
- Environment, e.g., no possibilities for physical activities (fitness, exercise) nearby
- Social environment, e.g., the view of family, friends, flatmates, and the neighbourhood
- The financial situation of the client
- Lack of skills and/or low self-esteem



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2. THE HELPS TOOLKIT

2.1 Overview of the HELPS Toolkit

The HELPS toolkit consists of a series of intervention measures where mental health practitioners help people with severe mental illness living in health care facilities to develop personalized strategies for changing and managing their behaviour toward a healthy lifestyle. Furthermore, the toolkit includes instruments for screening the physical health status of their clients and assessing unhealthy behaviour patterns in the fields of nutrition, physical activity, smoking, alcohol, and oral health and hygiene. The HELPS toolkit can be provided in an individual or group format. In the sessions, practitioners work collaboratively with residents, offering a variety of information, opportunities and skills that people can use to further their healthy lifestyle and their own physical health. There is a strong emphasis on empowering based on helping people set and purpose personal goals and helping them put strategies into action in their everyday lives.

Practitioners can come from a wide range of clinical backgrounds, including but not restricted to the following: psychiatry, psychology, nursing, social work, and counselling.

2.2 What is provided in the HELPS TOOLKIT?

You will receive intervention programmes, manuals, handouts and worksheets, a screening and monitoring sheet, recommendations and information about existing intervention measures as well as questionnaires to assess the (un-) healthy situation and behaviours of your clients in the fields of nutrition, physical activity, smoking and alcohol consumption as well as oral health and oral hygiene practice.

In detail:

- **Assessment Questionnaires :**

Short questionnaires for assessing the current situation, behaviour and habits of your clients in the fields of

- nutrition
- physical activity
- smoking
- alcohol consumption, and
- oral health and oral hygiene practice.

These assessing instruments will help you to detect the need for intervention in the fields stated above.

- **Screening and Monitoring Sheet**

The Screening and Monitoring Sheet should help practitioners to plan and monitor the physical health status of their clients.

- **Intervention measures:**

- PROMOZIONE DELLA SALUTE FISICA: un intervento con i pazienti Psichiatrici (L. Burti, L. Berti)
- MY HEALTH – I CARE – composite wholesome program for patients with severe mental illness (K. Lech)
- Booklets for information purposes (P. Hjorth)
- Motivational Interviewing with people with mental illness adapted to the fields of nutrition, physical activity, smoking cessation, and oral health and oral hygiene practice (P. Weiser)
- Motivational Enhancement Therapy – The MET Manual (Miller et al.)

- **International Intervention Programmes and Measures–Catalogue**

The International Intervention Programmes and Measures-Catalogue gives you an overview about existing interventions concerning improving the physical health of people. It is a collection of information, publications, and contact addresses based on research activities conducted in 14 European countries. Moreover, the catalogue includes findings from international searches including all countries of the world.

- **Feasibility Feedback Questionnaire:**

A fidelity scale to measure whether the HELPS toolkit is being implemented as designed. This feedback questionnaire concerns the acceptability, the content, the delivery/practicality, the source material, and the effectiveness.

2.3 Format of the HELPS Toolkit

HELPS Intervention measures can be taught using either an individual or group format. Each format has its advantages and depends on the clients which one is the most suitable. The primary advantages of the individual format are that the teaching can be more easily paced to meet the client's needs, and more time can be devoted to addressing his or her specific concerns. The main advantages of the group format are that it provides clients with more sources of feedback, social support, ideas and role models. Group sessions may also be more economical. But you could be flexible and combine individual with group sessions.

2.4 Evaluating the HELPS Toolkit

Evaluations and process measures give you the opportunity in an objective, structured way to determine if you are delivering services in the way that will result in desired outcomes. Therefore, and as part of our commitment to improving the HELPS toolkit and service we provide, we give the users of the HELPS toolkit a questionnaire, the "HELPS Toolkit Feedback Questionnaire". We would be grateful if you could help us by completing this form and returning it to your local HELPS centre. Please be assured that the survey is completely confidential and unless you complete your details at the end, we will not know who has taken part.



ASSESSMENT QUESTIONNAIRES (AQ)

Dear participant,

here are some of the things which other patients have told us about their eating and dietary habits. For each statement please could you be so kind and circle the “Y” (this means yes) or “N” (this means no) to say whether the statement affects you.

1.	Have you ever felt bad or guilty about your eating habits or poor diet?	Y	N
2.	Have you ever felt that you should change your dietary habits?	Y	N
3.	I enjoy eating, but sometimes I eat too much	Y	N
4.	My eating habits or poor diet are sometimes a problem	Y	N
5.	I am at the stage where I should be thinking about eating more healthily	Y	N
6.	I have physical problems due to my eating habits and poor diet	Y	N
7.	If I were to reduce my unhealthy nutrition consumption (e.g. sweets and salty snacks), I could improve my physical well-being	Y	N
8.	My eating habits and poor diet harms my body	Y	N
9.	Have people annoyed you by criticizing your eating or dietary habits?	Y	N
10.	It would be good for my body if I were to eat more healthy food	Y	N

Thank you for your cooperation!

Dear participant,

here are some of the things which other patients have told us about their physical activity habits and sedentary lifestyle. For each statement please could you be so kind and circle the “Y” (this means yes) or “N” (this means no) to say whether the statement affects you.

1. Have you ever felt bad or guilty about your sedentary lifestyle or physical inactivity?	Y	N
2. Have you ever felt that you should become more physically active?	Y	N
3. I enjoy my sedentary lifestyle, but often I do too little exercise	Y	N
4. My sedentary lifestyle or physical inactivity are sometimes a problem	Y	N
5. I am at the stage where I should think about being more physically active or becoming a more sporty person	Y	N
6. I have physical problems due to my sedentary lifestyle	Y	N
7. If I were to become more physically active, I could improve my physical well-being	Y	N
8. My sedentary lifestyle and my physical inactivity harms my body	Y	N
9. Have people annoyed you by criticizing your sedentary lifestyle?	Y	N
10. It would be good for my body if I were to become more physically active	Y	N

Thank you for your cooperation!

Dear participant,

here are some of the things which other patients have told us about their tobacco consumption and smoking habits. For each statement please could you be so kind and circle the “Y” (this means yes) or “N” (this means no) to say whether the statement affects you.

1.	Have you ever felt bad or guilty about your tobacco consumption or smoking habits?	Y	N
2.	Have you ever felt that you should cut down on you tobacco consumption?	Y	N
3.	I enjoy smoking, but sometimes I smoke too much	Y	N
4.	My tobacco consumption and smoking habits are sometimes a problem	Y	N
5.	I am at the stage where I should think about smoking fewer cigarettes	Y	N
6.	I have physical problems due to my tobacco consumption	Y	N
7.	If I were to reduce my tobacco consumption, I could improve my physical well-being	Y	N
8.	My tobacco consumption and smoking habits harm my body	Y	N
9.	Have people annoyed you by criticizing your tobacco consumption or smoking habits?	Y	N
10.	It would be good for my body if I were to smoke fewer cigarettes	Y	N

Thank you for your cooperation!

Dear participant,

here are some of the things which other patients have told us about their oral health and hygiene. For each statement please could you be so kind and circle the “Y” (this means yes) or “N” (this means no) to say whether the statement affects you.

1. Have you ever felt bad or guilty about your dental health or oral hygiene?	Y	N
2. Have you ever felt that you should improve your oral hygiene?	Y	N
3. I do oral hygiene, but sometimes I neglect it for several days or weeks	Y	N
4. My oral hygiene is sometimes a problem	Y	N
5. I am at the stage where I should think more about oral hygiene and dental health	Y	N
6. I have physical problems due to my poor oral hygiene	Y	N
7. If I were to improve my oral hygiene, I could increase my physical well-being	Y	N
8. My poor oral hygiene harms my body	Y	N
9. Have people annoyed you by criticizing your oral hygiene or poor dental health?	Y	N
10. It would be good for my body if I were to improve my oral hygiene	Y	N

Thank you for your cooperation!

Dear participant,

here are some of the things which other patients have told us about their alcohol consumption and drinking habits. For each statement please could you be so kind and circle the “Y” (this means yes) or “N” (this means no) to say whether the statement affects you.

1. Have you ever felt bad or guilty about your drinking?	Y	N
2. Have you ever felt that you should cut down on you drinking?	Y	N
3. I enjoy my drinking, but sometimes I drink too much	Y	N
4. My drinking is a problem sometimes	Y	N
5. I am at the stage where I should think about drinking less alcohol	Y	N
6. I have physical problems due to my alcohol consumption	Y	N
7. If I would reduce my alcohol consumption, I could improve my physically well-being	Y	N
8. My alcohol consumption harms my body	Y	N
9. Have people annoyed you by criticizing your drinking?	Y	N
10. It would be good for my body if I would drink less alcohol	Y	N

Thank you for your cooperation!



THE SCREENING AND MONITORING SHEET

Patient name: _____

Medication prescribed: _____

Date started: _____

Personal and family history for physical problem (clinical interview, baseline):

Weight / BMI

Date								
Score								
Date								
Score								

Waist circumference – measure at level of umbilicus

Date								
Score								
Date								
Score								

Blood Pressure

Date								
Score								
Date								
Score								

Fasting Plasma Glucose

Date								
Score								
Date								
Score								

Fasting Lipid Profile

Date								
Score								
Date								
Score								

Recommendations for Screening and Monitoring

		Baseline = month1	month2	month3	month4	month5	month6	month7	month8	month9	month10	month11	month12
	Personal/ family history	X											
	Weight gain												
	Weight / BMI	X	X	X	X	X	X			X			X
	Waist circumference	X	X	X	X	X	X			X			X
	Diabetes												
	Fasting plasma glucose	X		X			X						X
	Cardiovascular disease												
	Blood pressure	X											
	ECG	X											
	QTc interval	X											
	Hyperlipidemia												
	Fasting lipid profile	X					X						X
	Total cholesterol	X		X			X						X
	HDL	X		X			X						X
	LDL	X		X			X						X
	Triglycerides	X		X			X						X
	Hyperprolactinemia												
	Serum prolactin	X											
	Hepatitis												
	Liver function	X											
	Smoking												
	Clinical interview	X											
	Chest X-ray	X											
	Sexual function												
	Clinical interview	X	X	X	X	X	X			X			X
	Dental status												
	Examination by dentist	X					X						X
	Skin disease												
	Inspection	X											X
	Medication side effects (extrapyramidal side effects and tardive dyskinesia)												
	Neurological examination for EPS	X											X
	Neurological examination for TD	X											X
		Baseline = month1	month2	month3	month4	month5	month6	month7	month8	month9	month10	month11	month12



INTERVENTION MEASURES

Intervention Measure

Promozione della Salute Fisica (PDSF)

un intervento con i pazienti psichiatrici

Responsible person / Contact:

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The intervention *Promozione della Salute Fisica (PDSF)* builds upon the experience acquired in an exploratory project on health education for diet and physical exercise. It has been designed and performed at the South-Verona Community Mental Health Service (CMHS) in 2006, in collaboration between the Section of Psychiatry and Clinical Psychology (Department of Public Health and Community Medicine, section of Psychiatry and Clinical Psychology) and the Department of Prevention of the Verona health authority (Ulss 20), Italy. It aims at implementing health promotion strategies related to dietary habits and physical exercise in psychiatric patients. The intervention package consists of the following elements:

- evaluation of food delivered to patients at the psychiatric service;
- educational sessions on the importance of diet and fitness;
- regular physical exercise under the guide and supervision of an expert trainer;
- motivational interviews to maintain participants in the program, to discuss participants' physical conditions, habits and opinions as to diet and fitness;
- monitoring the participation in the program and health behaviour, specifically for diet and fitness, and adherence to the intervention on diet and fitness.

PHYSICO - Verona

INTERVENTION PROGRAMME

The intervention builds upon the experience acquired in an exploratory project on health education for diet and physical exercise. It has been designed and performed at the South-Verona Day Centre in 2006 in collaboration between the South-Verona Community Mental Health Service (CMHS) and the Department of Prevention of the Verona health authority (Ulss 20).

Thus clearly, the implementation of the intervention programme requires knowledge, experience and resources from both the psychiatric and the physical health promotion backgrounds. In particular:

- the psychiatric tasks are: discussing with patients about healthy food choices at lunch time; working on the motivation of patients and also on health care workers' motivation to change daily lifestyle; checking and compiling a report of blood pressure and other relevant health related data; promote and support the physical activities (for example being walking leaders for the walking group); organizing the programme's time schedule; and recruiting participants. Psychiatric personnel involved can be psychiatrists, psychologists, nurses, health visitors and educators depending on the local resources.
- the local specialists in physical health promotion take care of all the public health related issues involved in the intervention, such as: checking and improving food offered to patients attending the psychiatric facilities; discussing with psychiatric personnel and patients why physical activity and adequate healthy eating are so important for health; and promoting the motivation to lifestyles changes in both patients and personnel, providing information about healthy diet and exercise habits. Personnel involved can be doctors, nurses, dietist, psychologists, food safety expert and physical activity trainers depending on the local resources;

Interventions are mainly based on groups of 10-20 patients with the participation of psychiatric personnel.

Materials and resources needed:

- guidelines on healthy nutrition;
- recommended levels of food and calories intake for the populations;
- calorie charts and meal menu in the lunchroom;
- food quality survey form;
- data sheets to monitor physical parameters (anthropometric data, weight, height, Body Mass Index (BMI), abdominal circumference, blood pressure, glycaemia, total cholesterol and HDL, triglycerides, smoking habit);
- form and instruments to collect and monitor diet and physical activities: "Talk test", "Borg scale of perceived exertion", pedometer, questionnaire on nutrition habits (e.g. weekly frequency of fruit and vegetables intake);
- monitoring schedule on daily food orders and leftover in the lunchroom;
- items for diet and fitness education workshops;
- consulting and paid collaborations for special workshops on cuisine and table/buffet preparation.

1. Motivational interview to enrol participants in the programme

Since lifestyles are widely regarded as a main cause of somatic co-morbidity in people with functional psychoses, it is important to develop strategies to improve them. To succeed in the change of behaviours and unhealthy life habits (e.g. promoting physical activity and healthy diet habits) patient needs to be an active, vigilant decision maker. Motivational interview is a style of speech with a specific objective, user-centred, designed to emphasize the need for change by helping people address and resolve the conflict of ambivalence towards a change in behaviour. Several studies in literature provide evidence about how empathy, support, quality and quantity of information received, and sharing the action plan will affect the patient in terms of satisfaction, adherence to therapy and clinical outcomes.

Thus, the importance of providing an intervention of individual motivation for patients that are going to participate in a programme to promote physical health is acknowledged. Motivational interview can be used to involve and maintain participants in the programme.

For this reason one group session should be held to discuss the programme with all the psychiatric personnel involved, exploring barriers and advantages in participating to the educational programme. Particular attention should be spent to illustrate the need to implement new strategies of intervention in order to influence risk factors for physical disease in psychiatric patients, which can represent important morbidity and mortality determinants in this group. In this way, motivation of psychiatric personnel can be improved in order to remove obstacles to the desired changes in routine practices of the Psychiatric Service. Mental health workers will learn how to support the participation of patients in the programme.

Hence, the present programme includes one group motivational session and several informal actions for patients held by psychiatric personnel.

So that the subjects feel ready to change, they must consider important in their scale of values the desired behaviour and have positive beliefs and expectations about it; it is also necessary that they have sufficient self-confidence and a sense of self-efficacy relative to their ability to succeed. These issues should be carefully evaluated to understand at what level of the motivational change process is the patient. One should also take into account the stage of change (Prochaska & Di Clemente, 1986) in which the patient is to implement specific actions aimed at supporting the advancement of the subject through the various stages.

2. Evaluation of food prepared and delivered to patients at the PS

The intervention must be carried out by a dietist and a medical doctor: it aims to evaluate dietary and qualitative aspects of meals, with reference to the national guidelines for healthy nutrition and recommended food and calories intake levels, with particular attention to the addition of vegetables, fish and fruit in the proposed menu.

The meal at the Day Centre represents a central part of the intervention as a moment of eating education and counselling on the patients' food choices.

The amount of food eaten by patients must be recorded by the psychiatric personnel on specific study meal schedules prepared to monitor: vegetables and fruit consumption, quality and amount of food leftover (for at least 3 weeks).

Subsequent evaluation of meals at lunch time must be performed by a dietist to assess dietetic and organoleptic characteristics of food (using an ad hoc food quality survey forms).

The menu must also be discussed with service providers, asking to balance the intake of nutritional components and to adjust calorie charts, providing a wide range of vegetables, fish and fruit. It is of basic importance the involvement of the catering agency and its collaboration with the dietist.

In this phase it is necessary to monitor the patients' food choices, that is food orders and food leftover, with the appropriate form.

Moreover, psychiatric personnel who attend lunch delivery must be trained to appropriately counsel patients about healthy choices for food.

It is desirable to integrate the intervention with support actions such as, for example: the inclusion of fruit/vegetables snacks, yoghurt and water in the Day Centre automatic machines; and social marketing actions.

3. Educational sessions about: the importance of diet and exercise for health, participants' physical conditions, habits and opinions as to healthy diet and physical activity

The educational programme should be carried out in separate sessions for mental health workers and patients.

The educational sessions for patients aim at increasing knowledge, improving attitudes and enhancing self-efficacy regarding healthy lifestyle choices and behavioural changes not only at the psychiatric facilities but also at home in their daily life. Specific objectives could be: improving diet habits, through the increment of fruit and vegetables intake and with the objective of reaching 5 daily portions; increasing awareness in grocery shopping and organizing purchasing groups; increasing walking and biking for transportation and free time sports, besides the use of stairs instead of elevators; practicing gardening, homework and other energy-consuming daily activities; attending physical activity facilities, green spaces and so on. Since many of these are group activity, participation can also be very useful to better integrate patients in social life, mainly in their neighbourhoods.

In order to acquire a better understanding of successful health promotion behaviours, 4 educational sessions should be carried out to discuss existing knowledge on physical activity (PA), diet and health, such as:

- hygiene of food processing;
- basic nutritional informations about: carbohydrates, proteins, fats, vitamins and minerals; fiber intake;
- healthy eating guidelines: kind and amount of food in daily healthy diet;
- healthy cooking of food;
- amount of servings;
- dietetics by volumes (2 sessions about: fruit and vegetables portions and snacks);
- evidence-based information on the effects of PA;
- amount of PA needed to maintain health and prevent chronic diseases;
- how to better perceive PA intensity;
- ways to practice PA safely: intensity and graduality of training;
- PA initiatives and resources and walking groups in local neighbourhoods.

Instead, practical sessions (3) should focus on meal choice criteria (1 practical session) and cuisine workshops (2 sessions: creative preparation of fruit and vegetables servings). The workshops can focus on vegetable and fruit cooking with practical sessions (held by a restaurant chef or for example by a teacher from the local hotel management and catering school) where attendees can learn how to cook food in a healthy way and particularly how to arrange vegetables and fruit servings in order to make them as tasty and appealing as possible. A typical workshop could consist of a 3 hours session in which the teacher shows how to cut and serve vegetables making them more appealing to the eye and involves participants in this process. At the end of the workshop the vegetables and fruit prepared can be eaten by the participants. Patients and psychiatric workers participate to the workshops actively. It is really important that patients find all the activities pleasant, therefore all the activities should be



Figure 1 Examples of fruit and vegetables servings prepared during the workshops

proposed in a “light” and interactive way, as a play, role playing or practical exercise and with sensory and emotional involvement.

An important part of the educational intervention must be carried out later by psychiatric workers in their daily contact with patients. It is very important to reinforce healthy choices during meals and in every day activities at the Psychiatric Centre. Thus, similar topics need to be discussed in a more technical way during 4 educational sessions and 3 practical sessions with mental health care workers. The educational programme in this case aims to increase knowledge, to improve attitudes and to enhance self-efficacy about counselling patients on active living, healthy food and lifestyle choices.

Existing knowledge on PA, diet and health should be discussed in order to improve psychiatric personnel ability in implementing a successful health promotion intervention (4 sessions). Besides the topics already described some more need to be taken into account:

- health promotion techniques;
- walking groups (information required for a walking leader or other experiences in local settings);
- purchasing groups;
- social marketing.

Social marketing techniques could be used to promote healthy food choices, with particular reference to the use of posters and slogans in the Day Centre and its lunchroom.

Of course, a considerable amount of time needs to be spent discussing with psychiatric personnel theoretical and practical issues and barriers to both healthy lifestyles in one’s private life and patients’ counselling.

After giving basic information on PA, nutrition and health, group sessions should be held to inform psychiatric personnel on the way to have patients acquire practical abilities and afford psychological resistance to healthy lifestyles and specifically on:

- barriers to PA and healthy eating in one’s daily life (role playing and problem solving techniques);
- counselling patients about chronic physical diseases, PA and food (role playing);

- ability to choose healthy food (group work);
- ability to perform as a walking leader (group walking simulations).

In order to improve practical ability and motivation, group sessions should also be focused on practical abilities regarding eating habits, such as:

- how to choose healthy food;
- how to increase quantity of fruit, vegetables, high fiber food and fish in daily diet;
- how to reduce unhealthy snacks

4. Physical exercise under the guide and supervision of an expert trainer

The main steps to develop the PA intervention are: locating possible paths in the surroundings; arranging walking sessions with muscular stretching and mobility exercises, under the guide of an expert trainer; training a walking leader; and carrying out self-managed walking sessions with periodical support from experts.

The walking leader should know about:

- basic medical aid procedures and how to front accidents;
- basic safety measures related to walking;
- how to do warm up and stretching exercises;
- usual walk routine and walking leader role;
- general health and social advantages of walking
- how to prevent falls
- the number and frequency of walking sessions needed to obtain improvements in health conditions.

He/she should also pay attention to the following steps:

- Carry a medical aid kit and a mobile phone
- Inform patients about physical activity effects that they could experiment during the walk (heartbeat and breathing increase, feeling hot etc.)
- Record the number of participants
- Try to stay in the middle of the group to observe possible problems
- Regulate walking pace according to the group walking pace
- Encourage patients to enhance the speed and/or distance

One possible schedule is the following: 24 physical activity sessions of brisk walking completed with muscular stretching (here for details <http://prevenzione.ulss20.verona.it/docs/AttivitaMotoria/CamminoBiciScale/Cammino/WalkingLeaderEng.pdf>) and mobility exercises, held twice a week with participating patients in the surroundings of the Psychiatric Service.

The first six sessions must be held under the leadership of an expert physical trainer; later the group can be conducted by nurses, health visitors or educators of the psychiatric care service (previously trained by attending the first six sessions and discussing with the expert any doubts and barriers about the role of the walking leader health professional).

During each session participants must walk slowly for 5 minutes (warming up is important for people that are not trained yet, to avoid accidents), then walk briskly for at least 30 minutes, then again walk slowly for 5 minutes before stopping. Stretching exercises, strength training and exercises for the shoulders and upper limbs could usefully be added to make sessions more satisfying regarding both health and pleasure of the participants.

Walking pace should be regulated using easy tools for measuring PA intensity and the length of every walking session should be increased gradually, starting from sessions around 30 minutes long.

Different methods to assess the intensity of physical activity exist. Some are less precise but easier to utilize and can be used with people of different cultural levels (for example the "Talk Test" and the "Borg scale of perceived exertion"), others are more technical and difficult to implement in this particular situation. The "talk test" categorizes the level of physical activity in this way:

- Mild activity: it can be conducted while singing or spouting;
- Moderate activity: it can be conducted while talking;
- Intense activity: it is not possible to talk.

The Borg scale of perceived exertion goes from a minimum value of 6 (no exertion) to a maximum of 20 (maximum exertion). A level of 9 corresponds to walking slowly at one's own pace, a level of 13 corresponds to a moderate activity that can be easily continued, at a level of 17 a person can still go on but the exertion is intense, a of level 19 represents for most people the most intense exertion ever experienced.

5. Monitoring the participation in the programme and health behaviour, specifically for diet and PA, and adherence to the intervention on nutrition and PA

The participation to the intervention programme must be monitored by recording the names and/or number of patients attending educational sessions workshops and walking sessions, while nutrition habits must be monitored at the beginning and at the end of the intervention and must be reported on simple data sheets specifically prepared (e.g. questionnaires on the weekly frequency of vegetables and fruit intake, see attachment A questionnaire). Meal orders and food leftover should be monitored periodically on study meal schedules (Attachment B). PA practiced during walking and exercise sessions can be measured with a pedometer and recorded by psychiatric personnel on specific study data sheets (see attachment C: example of patient chart).

Height, weight and waist should be measured at the beginning and at the end of the programme and the BMI before and after the intervention should be calculated for each participant.

Individual interventions to reinforce planning ability can be arranged, such as motivational counselling and a nutrition diary with support from the psychiatrist or the dietist.

ATTACHMENTS

A QUESTIONNAIRE ON FRUIT AND VEGETABLES INTAKE

1. How many times a week do you eat vegetables?

- ☐ Everyday
- ☐ 4/6 days
- ☐ 2/3 days
- ☐ 0/1 day

2. Generally you eat them more frequently:

- ☐ At lunch
- ☐ At dinner
- ☐ At lunch or dinner
- ☐ Both at lunch and at dinner

3. How many times a week do you eat fruit?

- ☐ Everyday
- ☐ 4/6 days
- ☐ 2/3 days
- ☐ 0/1 day

4. Generally you eat it more frequently:

- ☐ At lunch
- ☐ At dinner
- ☐ At lunch or dinner
- ☐ Both at lunch and at dinner

5. How many times a week do you eat vegetable soup (included legumes soup)?

- ☐ Everyday
- ☐ 4/6 days
- ☐ 2/3 days
- ☐ 0/1 day

6. Generally you eat it more frequently:

- ☐ At lunch
- ☐ At dinner
- ☐ At lunch or dinner
- ☐ Both at lunch and at dinner

7. How many times a week do you eat legumes (peas, beans, lentils etc.)?

- ☐ Everyday
- ☐ 4/6 days
- ☐ 2/3 days
- ☐ 0/1 day

8. Generally you eat them more frequently:

- ☐ At lunch
- ☐ At dinner
- ☐ At lunch or dinner
- ☐ Both at lunch and at dinner

9. How many times a week do you eat potatoes?

- ☐ Everyday
- ☐ 4/6 days
- ☐ 2/3 days
- ☐ 0/1 day

10. Generally you eat them more frequently:

- ☐ At lunch
- ☐ At dinner
- ☐ At lunch or dinner
- ☐ Both at lunch and at dinner

11. On average, during the day how many times do you eat vegetables?

- ☐ Never
- ☐ 1/2 times
- ☐ 3 or more times

12. On average, during the day how many times do you eat fruit?

- ☐ Never
- ☐ 1/2 times
- ☐ 3 or more times

B

MEAL: DAILY ORDERS OF VEGETABLES AND FRUIT

Day		M T W T F S <i>(cerchiare)</i>		____/____/____
Total meals ordered				N° _____
Food Type		Number	Percentage	Leftover
S i d e d i s h	Potatoes	_____	_____%	_____/total
	Vegetables	_____	_____%	_____/total
	Fruit	_____	_____%	_____/total

C EXAMPLE OF PATIENT CHART

	1	2	3PATIENT CHART													NOTES	walking group (number of steps)	walking group (number of sessions)	participation (number of sessions)
	FRUIT and VEGETABLES	PHYSICAL ACTIVITY	gender	birth date	age	weight	height	BMI	abdominal circumference	blood pressure (systolic)	blood pressure (diastolic)	smoking	glycaemia	total cholesterol	HDL	triglycerides			
1																			
2																			
3																			
4																			
5																			

Booklets for information purposes

- Blood pressure
- Cholesterol
- Sex and living together

Responsible person / Contact:

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Know your blood pressure

One out of five Danes has hypertension. More than 260,000 Danes have hypertension without knowing it. It is important to know your blood pressure to avoid heart and circulatory diseases and to get the proper medication for hypertension.

You can live several years with hypertension without realising it. Nobody knows their blood pressure before it is measured.

You can have your blood pressure measured at your general practitioner and at health centres.

Maybe it is necessary to measure the blood pressure through out day and night in familiar settings at your own home.

Everybody older than 50 years ought to have their blood pressure measured every year. If you already have hypertension, you should have it measured every six months.

Use and benefit from your local health centre.

The Danish Hearth Foundation has health centres all over the country. They offer special activities and individual guidance on healthy lifestyle. It is possible to measure the blood pressure and through blood tests measure cholesterol and blood glucose level. Call us now and book an appointment.

Here are different addresses of local centres in Denmark

- 1:
- 2:
- 3:
- 4:

Hearth line -free telephone counselling

Open everyday 9am-3pm

Telephone: +45 80203366

Become a member of the Danish Hearth Foundation for free the first year

Hypertension

How to decrease your blood pressure

What is blood pressure?

The blood pressure is the pressure in the body's arteries. The pressure is highest when the heart is pumping blood out into the body - the systolic blood pressure. When the heart is relaxing between two contractions, the pressure is decreasing - the diastolic blood pressure.

The blood pressure fluctuates during day and night. When you are doing physical exercise, working, taking a cold shower, or getting excited your blood pressure will rise. The blood pressure will drop when you relax, and it is at its lowest when you sleep. So, normally it is best to measure the blood pressure after 5- 10 minutes of rest. It is necessary with several measurements during a period of time to establish the correct blood pressure.

In Denmark, the recommendation is that the systolic blood pressure should be below 140 and the diastolic below 90. If the blood pressure is more than 140/90, it is raised. This condition is called hypertension, and you should consider discussing treatment with your general practitioner.

Persons with diabetes should have a blood pressure below 130/80

If the blood pressure is slightly elevated compared to the recommended 140/90 and 160/100, you ought to have it measured several times and let your general practitioner evaluate the need for medical treatment. Blood pressure exceeding 160/100 will normally require medical treatment.

In case one of your parents has hypertension you have an elevated risk of getting it also. The risk is even bigger if both your parents have hypertension.

How does hypertension affect you?

Hypertension increases the risk of heart and vascular diseases. The risk multiplies if you smoke, have raised cholesterol in the blood, have diabetes, drink big amount of alcohol, or are stressed.

Hypertension affects:

Heart- your heart is forced to work harder to pump the blood around the body, and as the years pass by, the heart is weakened and growing too big. The symptoms are palpitations, difficult in breathing when doing physical exercise and swollen legs.

Blood vessels- arteriosclerosis develops faster if you have hypertension, especially in the coronary artery. You risk heart attack and thrombosis in the heart.

Brain- hypertension is a major cause for developing thrombosis in the brain or cerebral haemorrhage. Every year, almost 15,000 Danes experience heatstroke.

Kidneys- Hypertension might injure the kidneys. Furthermore, kidney disease can cause hypertension.

It is extremely important to detect hypertension as early as possible. The treatment consists of a change to a healthy lifestyle, and several also need medical treatment. All together it will lead to a better and longer life.

Ways to lower your blood pressure

Stop smoking- when you are smoking the risk of getting heart and vascular diseases increases. The blood vessels will be injured and the tendency for the blood to clot will be bigger. That is the main reason why smokers have more thromboses. Already 24 hours after smoking cessation the risk of thrombosis is halved.

Loose weight and economize with the salt- Your circulation system will be heavily loaded by overweight. The easiest way to loose weight is to eat less and healthier. If you lower the consuming of salt, your blood pressure may lower too.

Only drink little alcohol- Do not drink more than 2 glasses of wine or beer daily. If you drink more, the alcohol may harm your body, brain and cause hypertension.

Physical training- Go for a quick walk, mow the lawn, swim, dance - any exercise will do your body good. Make sure to exercise for at least 30 minutes or more daily.

Avoid stress- It is not a problem to be busy but stress may cause hypertension. Stress may arise when you feel you have lost control over your life and work and have lost the capability to relax sufficiently.

Take your medication- If you have been prescribed medication, it is very important to take it as described by your general practitioner. It can be necessary with more types of medication to lower the blood pressure to under 140/90. Never stop the medication without acceptance from your general practitioner.

Fish

Eat 300 grams of fish every week. For lunch and dinner at least twice a week. If you eat fish instead of meat, you will have more of the healthy unsaturated fat and less of the unhealthy saturated fat. All kinds of fish are healthy - fresh, frozen or canned.

Fruit and vegetables

Eat at least 600 grams of fruit and vegetables every day (including frozen fruit and vegetables). Fruit and vegetables should make up 2/5 or half of your meal and remember to eat it as snacks during the day. Do not forget to eat cabbages and root vegetables. Fruit and vegetables contain antioxidants and dietary fibre which help lower the influence of the bad cholesterol on the blood vessels.

Wholegrain and dietary fibre

Eat whole-grain bread every day with at least 5 grams of dietary fibre per 100 grams of bread. Dietary fibre lowers the cholesterol level. Especially fibre from rye and wheat has a positive impact on the cholesterol level. Eat (and here are some local Danish suggestions for healthy meals during the day).

Use your local health centre

In your local health centre you can be advised on heart diseases and ways of healthy living. They can measure your cholesterol level, blood sugar and blood pressure.

The Heart Line

Free telephone advice on health issues.

Open every day 9 AM to 3 PM.

Telephone number: +45 80 20 33 66

Heart Life: See our homepage:

www.hjertelinien.dk or call +45 33931788

Know your cholesterol level

How to lower your cholesterol level

The Danish Heart Foundation

More than 2 of 3 Danes have a high cholesterol level in the blood. Cholesterol is a fatty substance that is gradually deposited in the blood vessels. It can, eventually, lead to thrombosis. Thrombosis may occur in many places, but most often in the heart or the brain. The risk of getting a thrombosis depends among other things on the cholesterol level in the blood. Blood pressure, smoking, food and exercise habits have also an important role.

Healthy food and good exercise activities can lower the cholesterol level, and reduce or stop the deposit of cholesterol in the blood vessels.

A healthy lifestyle can get you far. If this is not enough, a high cholesterol level can be treated with medicine.

Smoking increases the risk of thrombosis. Smoking cessation have no direct impact on the cholesterol level, but smoking increases the risk of circulatory disease and therefore smoking is particularly unhealthy for people with a high cholesterol level.

The healthy unsaturated fat comes in a liquid form in the fridge, whereas the unhealthy saturated comes in a hard form in the fridge.

What is cholesterol?

Cholesterol is a fatty substance which runs in the blood stream. A certain amount of cholesterol in the blood is necessary for several important functions in the body. Cholesterol consists of more substances with different functions. LDL- cholesterol is the bad or nasty cholesterol which increases the risk of thrombosis.

HDL- cholesterol is the good and helpful cholesterol protecting against thrombosis.

The total amount of cholesterol in the blood is measured by the cholesterol level and a high level indicates an increased risk of thrombosis.

Fat is not just fat

Most of the cholesterol is produced in the liver. The fattier the food is the more cholesterol is produced in the liver. It is of great importance what kind of fat we eat. The saturated fat increases the level of cholesterol whereas the unsaturated fat decreases the cholesterol level. Therefore: eat the unsaturated and healthy fat in limited amounts.

Have your cholesterol level measured.

You can have your cholesterol level, LDL and HDL measured at your GP, the health centre and maybe at the pharmacy.

We are born with a cholesterol level of 2.5 which is all we need. On average, Danes have a cholesterol level of 6.0. The Danish Heart Foundation recommends:

Total cholesterol of no more than 5 mmol/l

HDL-cholesterol of more than 1 mmol/l

LDL-cholesterol of less than 3 mmol/l

In case heart disease or diabetes, the cholesterol should be less than 4.5 mmol/l.

Control your cholesterol

Physical activity

Physical activity for at least 30 minutes a day. Physical activity improves the composition of the cholesterol in the blood and activates formation of the good cholesterol which removes the bad cholesterol from the blood vessels. In case of high level of cholesterol, it is important to do exercise equivalent to 20-30 km walking or jogging a week. Swimming, bicycling, dancing, gardening and all kinds of physical activity are good as long as the intensity makes it difficult to talk while exercising.

Fat

Choose the liquid and soft forms of fat – in small amounts.

Choose cheese, milk and meat with a low fat content.

A good sex life and life together is one of the cornerstones in life. Problems with the sex life affect you and your partner and change your quality of life in general.

Unfortunately, there are still many taboos as regards sex. Especially, the absence of sexual desire and or erectile dysfunctions can be difficult to talk about.

Heart disease and arteriosclerosis can affect sex life in men and women. Men experience problems with erection and women feel the desire for sex disappear. If you can talk about the problem, it is also possible to get help.

Involve your partner in the problematic sex life.

When talking about possible causes to lack of or reduced sexual activity, you and your partner might find a common understanding of the problem and share the responsibility for finding a good solution. Your partner can feel the weight of the problems in the same way as yourself and experience less libido because of great concern.

Remember that hugs, kisses and close intimate body contact are very important during periods with problems with your sex life.

Use and benefit from your local health centre

The Danish Hearth Foundation has health centres all over the country where both patients and relatives can get individual counselling. You can talk to a nurse about your illness, the anxiety, the medication, symptoms and life together. It is also possible to measure the blood pressure and through blood tests measure cholesterol and blood glucose level. Call us now and book an appointment.

Here are different addresses of local centres in Denmark

- 1:
- 2:
- 3:
- 4:

Hearth line -free telephone counselling

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Become a member of the Danish Hearth Foundation for free the first year

Sex and living together

Good sex life – even when you're living with a hearth disease

It takes two

If you have been hospitalised with a heart disease, questions about sex may appear. The majority of patients can resume a normal sex life after discharge from hospital. Nevertheless, some may even find that sex has disappeared from their life. Sexual activity might change for many after having had a heart disease, arteriosclerosis or a thrombosis in the heart. Some may experience decreased libido and less sexual activity. This can be caused by both physical and psychological factors. It can often be caused by uncertainty and lack of knowledge of how to live with a heart disease.

Anxiety and uncertainty

Many who have just been diagnosed with a heart disease feel tired and not in form, and it is a natural reaction that the libido and the desire for sex are decreased 1-3 months after discharge from hospital. A sudden heart disease affects the personal idea of your life and sex life. Some feel their self-esteem is changed. This can lead to decreased libido. Anxiety and uncertainty may cause the desire for sex to disappear.

Myth: Physical activity from making sex may provoke a new thrombosis

Fact: You do not expose yourself to an increased risk when making sex. Sex is good exercise and strengthens the hearth.

Circulation

Four out of ten men with heart disease experience problems with erection. Erection problem is a lack of ability to get and maintain erection making it possible to carry through a satisfactory intercourse. A heart disease can affect the blood supply to the penis. There might be constrictions in the arterial resulting in insufficient blood to a satisfactory erection. Men with diabetes and heart disease are especially vulnerable to erectile problems. Diabetes can also give constrictions in the arterial and, furthermore, affect the sensibility in the nerves.

Sex is good exercise

Sexual activity can be seen as plain exercise and it is good for your hearth. The physical action from making sex is measured by the intensity and the duration. Generally, sex can be comparable with the physical activity from climbing the stairs to the second floor, mowing the lawn, or cleaning the house vigorously. Every time you do exercise you improve the functioning of the heart. Regular exercise can minimise the risk of getting heart pain during sex.

Through exercise you learn how your body functions when doing exercise. You know when you are breathless and when you might have pain in the heart. Regular training gives you a feeling of security when making sex. If you are unpleasantly affected from making sex, you can take your prescribed medication for heart pain as you normally do.

Seek advice and help

If you have persistent erectile dysfunction and lost libido, you should consider seeking help and guidance from your general practitioner.

There are more options for help:

- *Medical treatment
- *Psychological advice
- *Sexological advice
- *Aids and appliances
- *Surgical treatment.

In co-operations with your general practitioner you will find the best solution.

Sex and medication

To many an adjustment of the medicine may help on the erectile dysfunction. Beta-blocker, dioxin and some diuretic medicine can cause erectile dysfunction. Many men with erectile problems can benefit from Viagra or Levitra-PDES inhibitor. The drug increases the erectile function, but at the same time the blood pressure is decreased. So, please notice that at least 24 hours should pass from you take Viagra or Levitra till you take nitro-glycerine. If you have a heart disease, you should consult your general practitioner before taking Viagra or Levitra.

You can always seek help and advice at the Danish Heart Foundation

Intervention Measure

MY HEALTH – I CARE

I WISELY CHOOSE WHAT I EAT AND I'M ACTIVE EVERY DAY

Composite wholesome program for patients with
severe mental illness

Responsible person / Contact:

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COMPLEX HEALTH-PROMOTING PROGRAM FOR PSYCHIATRIC OUTPATIENTS - Introduction

An important and increasingly common sign reported in patients treated for severe psychiatric disorders is excessive weight gain. It can become the cause of isolated abdominal obesity, metabolic syndrome or type 2 diabetes. As a consequence, in the recent years the risk of death from cardiovascular complications in this group of patients steadily increases. Moreover, in patients treated with neuroleptics, non-compliance or cessation of pharmacotherapy correlates with a BMI increase, what may result in worsening of the mental health, increasing the number of relapses, hospitalizations and further treatment difficulties. It's also important to point out the lowered quality of life in the population of obese patients who don't have an additional burden of psychiatric illness. These patients have lower self-esteem, experience periods of depression, don't accept their physical looks, and it all results in social isolation. The above mentioned factors also cause problems at work, and as a consequence – early disability pension and lowered income. If a patient with serious psychiatric illness also becomes obese, with all corresponding factors increasing the probability of lowering the quality of life, his social isolation and degradation becomes extremely likely in no time. Taking all this into consideration we've introduced a complex health-promoting program for patients treated in Zespol Leczenia Środowiskowego Instytutu Psychiatrii i Neurologii in Warsaw.

The aim of the Program is to:

- Start the weight loss program for obese patients
- Permanently modify dietary habits in patients
- Create the need for daily physical activity
- Increase patient's motivation to take responsibility for his/her own health

As a consequence:

- Enhance patient's resources
- Maintenance of effective pharmacotherapy
- Decrease the number of relapses and re-hospitalizations.

The range of Program's actions is based on the model of environmental psychiatric therapy, where we work with patients on an outpatient basis through

individual and group-based interactions. This model also encompasses the cooperation with Poradnia Zdrowia Psychicznego (psychiatric outpatient clinic) and psychiatric ward. We also appreciate cooperation with patients' families. Basing the Program on the environmental psychiatry model increases patient's chances to participate in the program independently of periodical changes in his/her mental health status. Moreover it allows us to modify the range and form of interaction depending on the patient's present needs and abilities.

The program encompasses individual consultations, weekly group workshops, lectures and workshops on a 24 h hospital ward and rehabilitation period attendance. In the future we also plan to conduct training for trainers selected from among program participants, so as patients could spread among themselves their own knowledge and experience in the field of health promotion. We plan to gradually include patients' families into the program, so as they could also change their dietary and exercise habits to help their loved ones.

Individual consultations last 20 to 45 minutes each, depending on the patient's individual needs. Patients report spontaneously or are referred by a ZŁS therapist, specialist from an outpatient clinic or hospital ward. The number of individual consultations vary. Some patients prefer only this form of therapy. After discussing it with their therapist a patient may also join a group. Patient's rehabilitation period attendance is also agreed on during individual consultations (sessions?). This form of therapy may claim as successful if a patient stops gaining weight, gradually loses weight, his/her biochemical parameters improve, patient gains knowledge about proper diet and introduces physical activity adequate for his/her abilities.

Weekly group workshops function as support groups in an open form. During each session activities include 30 minutes of physical exercises (dances in a circle), 30 minutes of relaxation music and 30 minutes of group work regarding positive change in feeding and exercise behaviour. Dances in a circle, apart from being a pleasant experience in the field of exercising and beside burning calories have also additional therapeutic benefits. They aim for integrating the group. Coherent musical structure enhances patient's personality rebuilding process. Participation in group interactions in dance form, an individual gains a wider range of his/her social competence. After a while, as patients gain new dancing abilities, also their self-esteem improves. Music creates „safe space” that mediates this relation. Rhythm, dynamics, melody and timbre of musical pieces

all increase the willingness to be physically active, help to release emotions. It seems that dances in a circle as well as relaxation music can be replaced by other form of physical activity and relaxation, depending on the abilities of a particular center and on qualifications of the therapist. Most important is the group work with the aim of continuous alimentary education and mutual support among patients, who gradually change their eating and exercising habits.

Lectures and workshops on a 24 h hospital ward are part of a 6-week teaching cycle for patients of the hospital ward. In each cycle there is an hour-long workshop aiming for sensitizing patients to the problem of gaining weight, causes and imminent as well as long-term consequences of obesity. During workshop patients have a possibility to individually calculate their daily requirement of proteins and fats. They learn how to improve hospital meals with adequate amount of fruit and vegetables. Participants try to find an alternative to overeating simple carbs. They get to know other elements of the program they may participate in after being discharged.

Rehabilitation periods last for 10 to 14 days, are meant for participants of group therapy as well as for those working individually on changing dietary habits. During one period there are intensive group interactions scheduled daily; in the form of:

- 30 minutes of morning exercise and/or walk
- 30 minutes of group therapy
- 60 minutes of cooking workshops
- 30 minutes of relaxation with classical music
- 45 minutes of dances in a circle

During the day a patient may also participate in individual conversations, biking excursions, walking in the forest, play darts, table tennis, badmington, mini basketball, volleyball, boules, mini golf, evening dancings, picnics. Meals are prepared in collaboration with Katedra Żywienia Człowieka SGGW, are of low glycemic index and the total caloric value is in the range of 1800- 2000 kcal per day. One rehabilitation period is scheduled for 20 to 25 participants. Patients are encouraged to lead or be a co-leader of daily physical exercise sessions. Every one may choose from different forms of activity to find the most appealing to him/herself. During cooking workshops which hold 3 to 6 patients per session,

participants prepare afternoon snacks consisting of salad containing seasonal vegetables.

We've prepared a textbook of group activities for the Program. It encloses proposals for 12 meetings regarding healthy diet and daily exercise. This material may be used during rehabilitation periods where it forms the basis of daily work with a group. One may also use the textbook during individual therapy with a patient or talk about individual themes with the participants of a support group. Menu and recipes, both important elements of the program, should be prepared on the basis of local/traditional recipes and local/seasonal ingredients. Meal proposals should also take into account patients' financial abilities. The preparation should be as simple as it gets.

A therapist supervising activities within the Program should be familiar with the basics of human alimentation, a certain therapeutic experience and ability to work with a group. It also seems important that he/she collaborates with other members of the treatment team to support patient's efforts, praise his/her achievements and help overcome obstacles. Physical exercise should be run in a simple and easy way, and the level of difficulty should be adapted to the least fit of the participants. The experience of physical activity should be perceived by every patient as pleasant and satisfactory.

Medical register is the element of the program enabling the therapist as well as the patient to evaluate effectiveness of their mutual work towards improving medical parameters of the patient. If there are no strict medical indications to perform other tests, most important measurement during work with the patient is waist circumference.

	AT BASELINE	AT EVERY VISIT	IF MEDICALLY JUSTIFIED	EVERY 6 MTHS
Weight	+			+
BMI	+			+
Waist circumference	+	+		
RR	+		+	+
accidental glucose from capillary blood	+			+
ECG	+		+	
fasting glucose			+	
HbA1			+	
lipid profile	+		+	

MY HEALTH – I CARE

I WISELY CHOOSE WHAT I EAT AND I'M ACTIVE EVERY DAY

TEXTBOOK FOR PARTICIPANT

Outpatient Treatment Team; IPIN, Warsaw

First Name:

Name:

MY HEALTH – I CARE

I WISELY CHOOSE WHAT I EAT AND I'M ACTIVE EVERY DAY

MEETING I

1. Introduction, getting to know each other
2. Presentation of the rules of group functioning
3. Why change dietary habits
4. Planning meals / why eat 5 times daily
5. Self-observation diary
6. Questions

MATERIALS AND METHODS:

- Rules of group functioning
- Let's plan 5 meals (a letter from a dietician)
- Self-observation diary *MY DAILY NOTES*

HOMEWORK:

- Each day till the next meeting write down all you eat and drink in the *MY DAILY NOTES* table. If you'd like to comment how did you feel just before and while eating, please do.

PARTICIPANT'S NOTES FROM THE MEETING:

MY HEALTH – I CARE

I WISELY CHOOSE WHAT I EAT AND I'M ACTIVE EVERY DAY

GROUP WORKING RULES

- Meetings take place once weekly (each)*/every day for 14 days*, from to hour.
- The group is of open character, which means that new persons may join in different time (it's however suggested that patients participate from the beginning of the group formation)
- The whole Program encompasses a series of 12 weekly* meetings
- It's important that You participate in all the meetings
- We observe the rule of HERE AND NOW, which means that no information regarding other participants may be propagated elsewhere, apart from the time and place of the meetings
- We talk about ourselves, we don't criticize others, if we want to make a suggestion, we try to take our successes as an example. The self-observation diaries can be the source of success stories for all participants
- Both our own and others' failures or transient mishaps are to be regarded with respect
- We talk openly about our difficulties, but to an extent that we feel like at a particular moment/meeting. It'll help us all in mutual pursuit for the best solution
- Each group meeting lasts an hour. This time is spent on learning the rules of rational diet, checking homework and solving together current problems linked with the topic of the meetings
- Exercise workshops, where we will together learn dances in a circle are to last for 30 minutes; it will bring us satisfaction from physical activity and from being a part of the group
- There's one, 10-minute break scheduled during every meeting
- Each participant's work done between the meetings is very important. During the following meeting You can present your observations and successes. Each participant should do his/her homework as best he/she can, so it may benefit him/herself and other members of the group.
- If You can't attend the meeting, please ask Your colleagues what was the topic and what's scheduled for homework, so at the next meeting You can fully participate in the activities

- If for some important reason I cannot attend the meeting, I always try to notify the group in advance and I bring homework for the next scheduled meeting
- During meetings we learn how to change our eating habits wisely, how and what for we should exercise every day. After each meeting participants are given materials summarizing and complementing the meeting's topic, and also homework that is to be completed for the next meeting. Every participant brings his/her completed homework for the next meeting

My daily notes will be with us on every meeting. Your notes are to inspire your own as well as group work. It's important to make them regularly and systematically, only then will they be a good tool for work and study. However if for some reason you'll break the routine, don't give up! You can always go back to writing down what and when you eat.

MY DAILY NOTES

DATE

HOURL	WHAT I EAT; amount, home measures	SWEETS & CAKES	FLUIDS	HOW DO I FEEL
			女	☺ ↔ ☹
			女	☺ ↔ ☹
			女	☺ ↔ ☹
			女	☺ ↔ ☹
			女	☺ ↔ ☹
			女	☺ ↔ ☹
			女	☺ ↔ ☹

女- a glass of unsweetened liquid, ☺ - good mood, ↔ - average mood, ☹ - bad mood

home measures : a slice of bread – size of the palm of hand, 1 cm thick a slice of cheese/cold meats - 6cmx12cm up to 0.3 cm thick; teaspoon – e.g. of butter, sugar, honey ; tablespoon – e.g. of cottage cheese, yoghurt, oil a glass – e.g. of cooked rice, cooked beans, etc.; average piece – e.g. one medium-sized apple

TIPS FOR THE THERAPIST

MEETING I

1. Introduction and getting acquainted
2. Explanation of the guiding rules for the group
3. why change eating habits
4. meal planning / why there should be 5 meals in a day
5. self-observation diary
6. questions

This textbook can be used for work with a group meeting once weekly on an ambulatory basis or when working on a hospital ward / during a fortnightly rehabilitation period. It's important for the group that the meetings are all conducted in similar settings. The room should be neat and adequately spacious. Group members and the leading person are to seat in a semi-circle so as everyone is seen by others and no one takes a particularly prominent or particularly hidden (worse) place. To conduct a meeting it would be convenient to have a whiteboard and colour felt-tips. At best the whiteboard should be placed so as everyone has an easy access to write or read what's being written on it. Each meeting should last about an hour with one 10-minute break. We also suggest physical exercises lasting about 30 minutes, so as each meeting - including break and exercise – lasts no longer than 2 hours. In our program we propose dances in a circle as a form of physical exercise. We feel that this form of physical exercise has an additional therapeutic value for persons experiencing a serious psychiatric illness. Dances in a circle are to integrate members of the group. Coherent musical structure enhances the process of rebuilding patient's personality structure. By taking part in group dancing an individual strengthens his/her social competence. After a while, gradual acquisition of new dancing abilities also improves patients' self-esteem. Music creates a safe space for interpersonal relations. Rhythm, dynamics, melody and tone of compositions enhance the will to move and help to relieve feelings. It seems that dances in a circle may be replaced by other form of physical activity and relaxation, depending on the means of a particular center and qualifications of the leading persons.

After a short introduction of the leaders and group members it's worth clarifying the rules and scope of the group according to information in the textbook. In case of questions regarding rules it should be explained and clarified on the spot. To build patients' trust and safety it is important to underline the confidentiality rule of HERE AND NOW. Patients should be shown that the rules are all written in the textbook. Patients may read them again after the meeting and, if anything appears unclear or creates doubts, it's worth going back to at the next meeting.

Why change dietary habits?

It's time to talk about patients' expectations; why they are here and why they want to change. The talk should be about motivation. You can draw on the whiteboard a simple scale of motivation (see par. IX) and ask the participants to mark their motivation for today. It gives you a picture of group's motivation at a given moment. It's worth underscoring that motivation changes with time and our drive to change isn't the same all the time. Here you can encourage patients to support and motivate each other in a positive way, without criticizing or making fun of anybody. Mutual positive interactions are one of the values of group work. On the whiteboard you may write down patients' reasons for changing dietary habits and starting to exercise.

After a short break we move to discussing a letter from a dietician, a rationale behind making notes and the importance of eating small but frequent meals. It's worth drawing how the basic metabolism changes during the day and night and why meals should be small albeit rather frequent. Not to discourage group members with the size and abruptness of the proposed lifestyle changes, you may underline that these changes should be gradual and that nobody succeeds the first time. It's also important to encourage patients to keep self-observations as this makes them more engaged in the process. Notes are to help them gradually change their dietary habits, they're also a good starting point for discussion etc.

MEETING II

1. Questions regarding last meeting
2. My Daily Notes (successes and failures)
3. Meal planning - quantity, quality, proportions of particular nutrients
Letter from a dietician
4. Questions
5. Homework

MEAL PLANNING – SUGGESTIONS (QUANTITY/QUALITY/PROPORTIONS)

Letter from a dietician

How many meals a day?

We should aim at 5 meals a day. This allows to maintain adequate glucose levels for the whole day, what in turn lessens the evening hunger pangs and allows us to eat smaller portions. It's wise to split a two course lunch in two and make a two-three hour break between first and second course. Ideally you should eat soup around 1 PM and second course around 4 PM.

Meal size

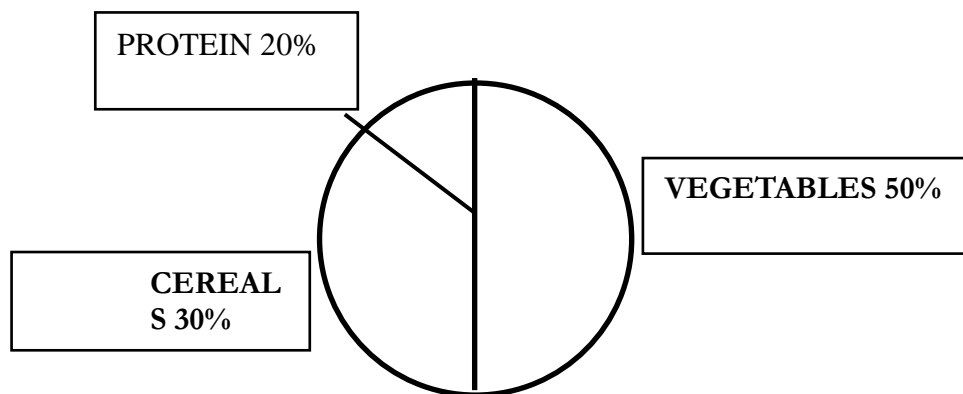
It's important to place the most caloric meals as 3rd and 4th during the day. Breakfast doesn't have to be big but YOU HAVE TO HAVE IT!!! It may consist e.g. of plain oatmeal taken with milk or water. For a second breakfast you can have fruit or a sandwich. If you choose sandwich, it has to (!) have some vegetables in. You may choose from lettuce, tomatoes, cucumbers, radishes, sweet peppers or even plain cabbage put on bread. If eating veggies with every meal is too difficult, you can start by washing meal down with a glass of vegetable juice (e.g. carrot or tomato juice; REMEMBER!: no sugar added!!). Third meal may consist of a vegetable soup, as a last resort even an instant "hot mug" type will do, but remember to drink it warm. You may also choose a home-made or ready-made salad as long as it's without sauce. Better add a spoonful of vegetable oil yourself. 4th meal should resemble a typical second course, but pay attention to keep the right proportion of nutrients (see below). Last meals shouldn't be a repeat of the fourth. At best it should mainly consist of vegetables, and not necessarily contain animal protein. We should aim at eating the fifth, i.e. last meal no later than 2-3 hours before sleep. If after 5 meals a day you still feel

hungry, eat fruit or drink some vegetable juice, alternatively a portion of bread with no add-ons.

Product proportions in meals

According to the Food Pyramid Guide prepared by Polish National Food and Nutrition Institute, each 5 portions of carbohydrates (preferably complex and non-purified) should be accompanied by 4 portions of vegetables, 3 portions of fruit, 2 portions of milk and milk products (including cheese) and 1 portion of meat. You should remember these proportions planning meals for a whole day.

MY LUNCH PLATE



MY LUNCH

These meals are to be composed by yourself according to the following rules:

- 50% of the plate should be occupied by vegetables (raw, blanched, boiled) with a spoonful of vegetable oil; we exclude boiled carrots, beetroots and potatoes, as well as corn
- 30% of the plate goes to cereals (groats/rice/ boiled potatoes / pasta made of durum wheat (!) no eggs added/ dark bread)
- 20% of the plate should be dedicated to proteins (meat (!) no breadcrumbs, fish, cheese, natural yoghurt, kefir, eggs)

NOTES

HOMEWORK

You've probably already managed to make some notes in your DAILY NOTES diary. Each day of accurate noting strengthens new, healthy eating habits. Try to introduce some changes in your usual alimentation, based on the rules presented during this meeting. Maybe you'll manage to introduce your favorite vegetables into most of meals. If you weren't particularly fond of veggies, try each day to introduce a new one into your menu. You might also ask other members of the group about simple recipes for tasty vegetables. Since today till the next meeting try to write down everything you eat and drink, including quantities, at best stating also the hour of every meal. It's important that by the next meeting you already included in your notes all changes you've managed to implement. If making notes is a strain for you, if you have problems keeping them up to date or think some things are too vague, do not give up, keep making notes and talk about your problems on the next meeting. Together we will certainly find a good solution.

My Daily Notes will accompany us on every meeting. Notes from each week will become an inspiration for group work. That's why regularity is so important. Only then are the notes good tool for work and for future improvement. They also should be clear, readable, systematic and true.

On the next meeting we will together make an exemplary lunch plate. You should try to prepare and present one proposition for a well-balanced second course. It will be easier if during this week you prepare such ideal meal for yourself at least once.

If you manage to plan your daily lunch so that vegetables make half of such lunch plate – it's your great success. If you fulfill this plan and write down what you've eaten, on the next meeting you'll be able to help others with the task. If you're not sure whether you kept the right proportions of the lunch, nevertheless don't skip your notes. Together we'll see what can be done to improve your meals so that during next weeks they'll be planned according to the rules of healthy eating. It's important that all meals composed according to rules of healthy and balanced eating were tasty, you should eat them slowly and savor every bite. These meals can be very simple. Just add vegetables to make them more colorful and healthier.

TIPS FOR THE THERAPIST

MEETING II

1. Questions regarding last meeting
2. My Daily Notes (successes and failures)
3. Meal planning - quantity, quality, proportions of particular nutrients
Letter from a dietician
4. Questions
5. Homework

At the beginning of his meeting we should remind the group working rules, especially the rule of confidentiality and of mutual support. You should encourage group members to ask questions, share thoughts about the first meeting and experiences with introducing dietary changes into participants' daily life. It's a very important component of the second meeting. The role of the therapist is also to fish for and praise every little success of the patients.

Next topic should be discussion about problems and doubts that unavoidably accompany a change. You should allow patients to give each other advice and support. The therapist should only summarize this part of the meeting and discreetly correct patients when their advice seems inconsistent with the rules of healthy eating.

When discussing quantity, quality and proportions of the meals it's worth using the whiteboard and write down together with the patients, which products contain protein and which are mostly carbohydrates. A good idea would be to also write down all vegetables mentioned by patients, and maybe ask whether someone has a good idea how to serve them.

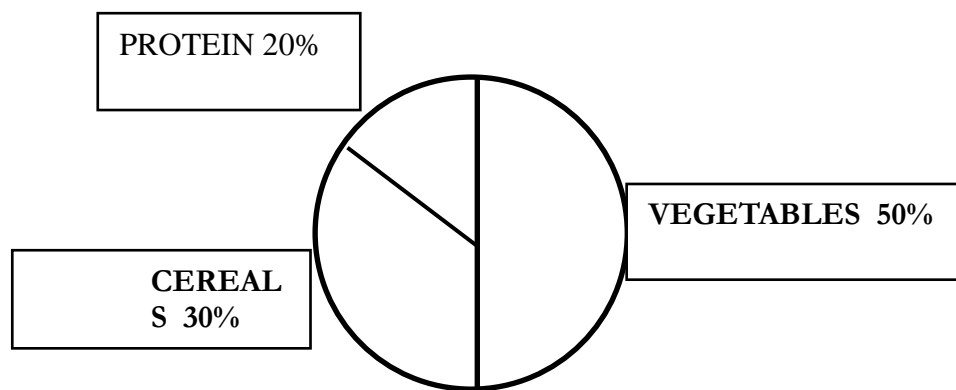
Knowledge of alimentary products groups and how to tell the difference between each of them is worth systematizing.

Subsequently we should go on to group planning of an exemplary lunch which would be perceived by the group as tasty and easy to prepare at home. It's also important to reveal the cost of such exemplary meal and to stress that healthy

eating can be both tasty and cheap.

Group planning of a few exemplary lunch plates according to the above mentioned rules is a good start to discussing homework. Each idea mentioned by participants is to be written down on the whiteboard as an exemplary

MY LUNCH PLATE



MY LUNCH PLATE

After a short break we discuss homework, its scope and mode of implementation. Here it's worth stressing that most important is patient's individual idea for the meal, which he/she should invent, prepare (him/herself or with the help of the family) and ate with gusto.

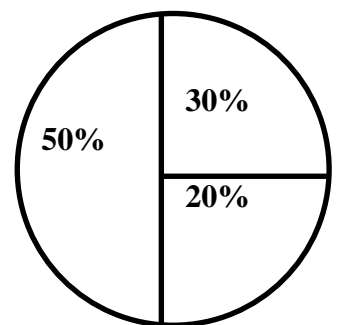
MEETING III

1. Example lunch menus
2. My Daily Notes (successes and difficulties)
3. Meal planning
4. „Life belts“
5. Questions
6. Homework

EXEMPLARY LUNCH MENUS

Write down as many lunch menus as you can, try to obey the golden rule:

- 50% of the plate for vegetables
- 30% of the plate for cereals
- 20% of the plate for protein



MEAL PLANNING

	MON	TUE	WED	THU	FRI	SAT	SUN
VEGETABLES 50% OF THE PLATE							
CEREALS 30% OF THE PLATE							
PROTEIN 20% OF THE PLATE							

„LIFE BELTS“

The most important rule of healthy eating is to plan your meals. It may seem difficult at first, but gets easier with time and finally becomes an integral part of your daily routine. Meal planning should be a part of planning the whole day. If we manage to implement even part of it, it's already a success. Besides, we gain experience and confidence that our plans are feasible and serve our health. By eating small but frequent meals you keep the blood glucose level in check throughout the day. You feel full without gaining weight. Sometimes even if we plan everything well in advance, something may "pop out". Here are some "life belts" that help maintaining rules of healthy eating. „Life belts“ are meals or snacks that are easy to keep at hand. If we can't eat a planned meal on a planned hour, we can resort to such "life belt". It saves us from getting too hungry and at the same time is healthy and low-risk of putting on weight. A good "life belt" can be for example a banana or an apple, plain piece of bread, a handful of sunflower or pumpkin seeds, or 5 almonds. Eating a banana or plain bread BEFORE you get really hungry helps you survive till the next planned meal.

EXAMPLES OF „LIFE BELTS“

Simple, easy to obtain products that can be kept at hand or purchased on the way

	my life belt	price	where to buy	where to keep
e.g.	an average banana	2 zł	at the nearest shop	eat right after you buy it
e.g.	a handful of pumpkin seeds	3 zł per pack	in a "healthy food" shop	carry in a pocket, in a rug sack or in a bag
1.				
2.				
3.				
4.				
5.				

NOTES

HOMEWORK

Planning your meals, prepare at least two simple “life belts”. By now you should have a lot of notes in your My daily notes diary. Each day you keep your notes helps you learn about eating healthy. Since today till the next meeting try to write down everything you eat and drink, at best you should also state an approximate hour of every meal. If making notes is posing problems or if anything looks unclear, do not give up. Share your problems on the next meeting. We might work out a good solution together. Write down if on any occasion you couldn’t eat a planned meal and had to resort to a “life belt”. It might help you in the future and can be a starting point for discussion on the next meeting.

My Daily Notes will accompany us on every meeting. Notes from each week will become an inspiration for group work (without saying whose are they). That’s why regularity is so important. Only then are the notes good tool for work and for future improvement. They also should be clear, readable, systematic and true.

This time fill in also a table from the previous page, to have at least 7 lunch servings planned according to the healthy eating rules. Try also to think, what “life belts” can you always have with you. Write down what’s your solution to eating at least 5 small meals a day. Perhaps your “life belt” will help other group members. Write down what “life belts” do you have with you. You may also bring one to the next meeting.

TIPS FOR THE THERAPIST

MEETING III

1. Lunch plate proposals
2. My Daily Notes (successes and failures)
3. Meal planning
4. „life belts“
5. Questions
6. Homework

Last meeting's homework was about planning, preparing and describing a lunch conforming with the drawing, so it's worth starting with gathering information from the patients, how did they manage. Every idea should be met with interest. Using the table prepared for MEETING III you should fill in, together with the patients, their ideas for lunch. Even if some propositions lack some of the components or if the proportions are not met, you shouldn't criticize the author not to diminish other participants' will to cooperate in the future. If you are to correct patient's project, you should do it in a positive way, e.g.: it's an interesting idea, it's good you've put in carbohydrates as a portion of rice and protein as a piece of meat. Now let's think what in your opinion is lacking from the plate so as it would conform with our exemplary plate? Here we show the circular drawing *My lunch plate* so the patients could easily see that it's vegetable what's lacking. If the patient himself cannot grasp the conclusion, you may ask the group to "fill in" the plate. It's always worth checking, whether the patient presenting a meal plan accepts the suggestions of the group and perceives such meal as tasty, feasible to try and eat at home in the near future. Before the break the group should together plan exemplary lunches for 7 days. It's helpful to draw a table "*meal planning*" from page 11 and fill it in together with patients. It's also time for discussing notes and difficulties in planning meals. Particularly important is praising patients for every success they make in changing their dietary habits. After a short break it's time to discuss the idea of "life belts". You can read with patients text from page 12. The point is to make the participants think out and write down examples of "life belts". If patients bring out sweets or calorie-dense snacks (such as potato chips) you should explain, why healthy eating doesn't encompass sweets or chips. You should also mention here, that you will go back to talk about sugar and sweets as well as salty and fatty snacks

on the next meetings. The more ideas for healthy snacks (or “life belts”) the patients have, the better. At the end of a meeting you should encourage patients to implement at least a few ideas from this meeting. It’s also time to remind and encourage the group to make notes.

MEETING IV

1. sugar in diet – facts and myths
2. fat in diet – facts and myths
3. exemplary list of alimentary products
 - a. to choose
 - b. to avoid
4. homework

Refined sugar, crystal sugar, candied sugar, caramel, sucrose, grape sugar, brown sugar, fructose, glucose, glucose syrup, milk sugar, lactose, maltose, rafinade, molasses etc. these are all different kinds of sugar you can find in different alimentary products. Know how to avoid them!

Sugar in its pure, refined form has been introduced quite recently. Its consumption grows steadily since the industrialization of the refinement methods and fast price drop. The increase in sugar consumption correlates well with the worldwide increasing obesity epidemics. We add sugar to almost everything, starting with fruit juices and ending with mustard and ketchup. But believe us: the necessity of adding sugar is a myth! Our body does well with the sugar we get from starches, cereals, fruit and vegetables. To maintain fairly stable blood glucose levels we should eat frequently, but in small amounts. This keeps hunger at bay while at the same time preventing excess of calories from being stored as fat. Another myth is that brown sugar or pure glucose are healthier and do not make us fat. Fattening potential is even in honey, which is a mixture of glucose and fructose. Even „low sugar” jams and marmalade are fattening. Believe or not: it contains 40% of sugar! Despite several similar common beliefs there's no sugar that wouldn't make us fat. Do not delude yourselves. Eating wisely means also applying a simple rule: DON'T EXCEED 10 G OF SUGAR DAILY. If you manage to eat less – that's good, but you shouldn't assume that next day you may eat more. Try to keep the amount of sugar below 10 g daily. As for fat – it's a myth that we can do without it. It's needed for transporting vitamins, making hormones and cell walls. Fat is indispensable, but we should use it wisely, i.e. in limited amounts. An excellent source of fat are vegetable oils, among them – the olive oil. All vegetable oils with high content of the so-called omega-3 fatty acids are good for you. In Poland we have a very good rapeseed oil.

This simple „fat rule“ will help you keep a healthy weight.

$$\text{daily amount of sugar (in grams)} = \frac{\text{height in cm} - 100}{2}$$

It means that a person 170 cm tall should eat no more than 35 grams of fat daily.

There are many alimentary products high in fat, and many that make your blood sugar levels rise, what facilitates gaining weight. That's why there are also many lists allowing us to choose less fattening products. Below is one of them.

FOOD TO CHOOSE

STARCHES AND CEREALS

Dark, wholemeal bread
pasta *al dente*
soy noodles
basmati rice
buckwheat (different sorts)
oatmeal

VEGETABLES

raw: carrots, celery, lettuce, cabbage,
radishes, spring onions, leeks, beans,
soy, lentils, chickpea, cauliflower (but
no fried breadcrumbs with it), broad
bean, pumpkin, eggplant, marrow,
cucumber, sorrel, spinach and others

FRUIT

apples, pears (limited amounts), prunes,
cherries, peaches, apricots, nectarines,
gooseberries, currants, sweet cherries,
raspberries, oranges,

DAIRY

low fat milk
yoghurt cream
hard cheeses (limited amounts)
flavored cheese (paprika, herbs etc.)
natural yoghurts

MEATS AND SAUSAGES

lean meat and sausages
baked and smoked fish,
pork loin - baked, beef rashers
poultry without skin!!!
!!!meats without breadcrumbs coat

BEVERAGES

tea, coffee, fruit juices (freshly squeezed)
mineral waters
fruit teas

ADD-ONS AND SPICES

FOOD TO AVOID

STARCHES AND CEREALS

white bread
sweet rolls, croissants, buns etc.
overcooked pasta, noodles,
dumplings, pierogis etc.
long-grain rice, semolina, kuskus
cornflakes, pancakes, pasta,
crepes, wheat and corn meal

VEGETABLES

cooked beetroots, cooked carrots,
potatoes in every form, corn

FRUIT

watermelon, melon, kiwi,
grapes, pineapple, canned or
candied fruits strawberries,
grapefruits

DAIRY

full fat milk
full fat cream
fruit yoghurts and buckwheat,
homogenized quarks
flavored quarks

MEATS AND SAUSAGES

fat meat and sausages, frankfurters
pâté, blood sausage, minced meat,
pork chops coated in breadcrumbs

BEVERAGES

sweetened, ready-made juices,
coca-cola, fanta, Pepsi, sprite, etc.
alcohol, including wine and beer

ADD-ONS AND SPICES

fruit jams with fructose
sarepska mustard
horseradish
fructose
artificial sweeteners

SWEETS&CANDIES
bitter dark chocolate
hazelnuts and walnuts
popsicles
sunflower seeds,
jellies, almonds

traditional jams
honey
honey mustard
ketchup
sugar

SWEETS&CANDIES
all confectionery, including:
chocolate bars, cakes, candies,

milk chocolate,
milk puddings, honey-coated nuts

TIPS FOR THE THERAPIST

MEETING IV

1. sugar in diet – facts and myths
2. sugar in diet – facts and myths
3. hypothetical list of alimentary products
 - a. to choose
 - b. to avoid
4. homework

The topic of this meeting is extremely important for the whole process of change. You should make patients talk about as many food myths about fat and sugar as they can think of, and then debunk them one by one. We've only written down a couple of them in the materials. It's important to „customize“ food myths according to local environment and typical dietary mistakes. For some patients giving up sweets will seem impossible at first. That's why it's so important to remind and discuss the „no sweets“ rule as often as possible and to teach how to recognize foods with low glycemic index (GI). This helps strengthen proper dietary habits. If you manage to curb patient's sugar consumption, there's a good chance he/she will lose a lot of weight and/or improve his/her blood test results. It's worth spending some extra meetings – if possible – on discussing with patients sugar overload in their daily diet. A good idea is to search together for „hidden sugar“. E.g. a patient puts 3 tablespoons of sugar into a cup of coffee and he/she drinks 3-5 coffees a day. Try to put all this sugar into a glass jar, then multiply it by 7 (weekly amount), and then by 4. It may turn out that only by sweetening his/her tea/coffee a patient uses up over 2 kg of sugar per month. The more examples from the real life/real patients you can get, the better

outcome for the whole group. Each time it's worth making the patient give another try and curb his/her sugar consumption. The step-by-step method is worth recommending, but some patients when realizing how much sugar do they use, decide to completely lay it off as they would do with e.g. alcohol or tobacco. When talking about fats you should check and methodize patients' knowledge; in which products we can find fat and where do they think is a lot of it. Methodized information should be written down on the whiteboard, so as every participant could copy it to his/her textbook. If time permits you can discuss the role of protein in diet and how much is enough, as in most patients daily amount of protein shouldn't exceed 1g per 1 kg of ideal body weight. By stating this you can go back to the right proportions of every meal and remind that eating healthy means eating a lot of vegetables with every meal.

MEETING V

1. Stress at a glance
2. How to relieve tension
3. When do I eat, while not being hungry

Stress is our body's natural reaction, an agitated state of body and mind, experienced both in joyful and in mournful situations. Stress mobilizes physiological and psychical forces to deal with the stressor. Agitation causes tension which can be relieved by acting. When our life is full of stressors and we can't or – even more often – don't know how to relieve tension, it slowly builds up causing frustration, exasperation and exhaustion. Natural defense behavior is to release tension in a quick, „safe“ and „painless“ way. If people haven't found effective ways of relieving tension, they often mistakenly resort to food. Frequently repeated schemes:

stress → eating → relieving tension

give way to unhealthy habits. We start to think (mistakenly) that eating is the only way to relieve tension. It's a myth not a fact!

The facts are:

1. stress will go away even without eating to relieve tension
2. there are many other ways to relieve tension apart from eating

The tension building up as a result of chronic stress is always temporary. Whether we react this or that way or remain passive, after a while tension gradually subsides and finally goes away. It's also a fact, that you may relieve tension in many different ways.

WHAT'S FOR STRESS

Relaxation is a range of techniques allowing to relieve tension. It works by relaxing muscles, stabilizing breathing rate, calming the „raging thoughts“.

Relaxed muscles allow the energy to flow freely through the body, speeding regeneration, generating feeling of comfort and internal peace.

Breathing exercises

There's nothing more natural than breathing. It's the simplest, always feasible form of exercising. It quickly relaxes, calms and regenerates us.

Breathing exercises can be practiced everywhere: at work, at home, on the walk. Their effectiveness can be further strengthened by previous short relaxation and systematic physical exercises, even short ones, lasting only for a couple of minutes.

Affirmation means bringing forth positive thoughts about ourselves. It's worth combining relaxation with breathing exercises and affirmation. It might be one of the effective and not linked with eating ways to relieve tension.

Physical activity

Another way to deal with tension is physical activity. Daily activity is indispensable for your well-being and effective weight loss. Every 20 minutes of walk or 15 minutes of dance help losing weight and at the same time may become a new way of relieving tension.

when do I eat while not feeling hungry table to be filled during meeting

WHEN I'M:	HOW OFTEN DOES IT HAPPEN	WHAT DO I EAT THEN	HOW MUCH DO I EAT AT ONE GO
IN THE EVENING AT NIGHT			
CURIOUS PROMOTION			
ANGRY			
NERVOUS			
STRESSED			
SAD			
LONELY			
TIRED			
BORED			
OTHER (e.g. TV, cinema)			

HOW IS WEEKEND EATING DIFFERENT?

HOW IS HOLIDAY EATING DIFFERENT?

TIPS FOR THE THERAPIST

MEETING V

1. Stress at a glance
2. How to relieve tension
3. When do I eat, while not being hungry

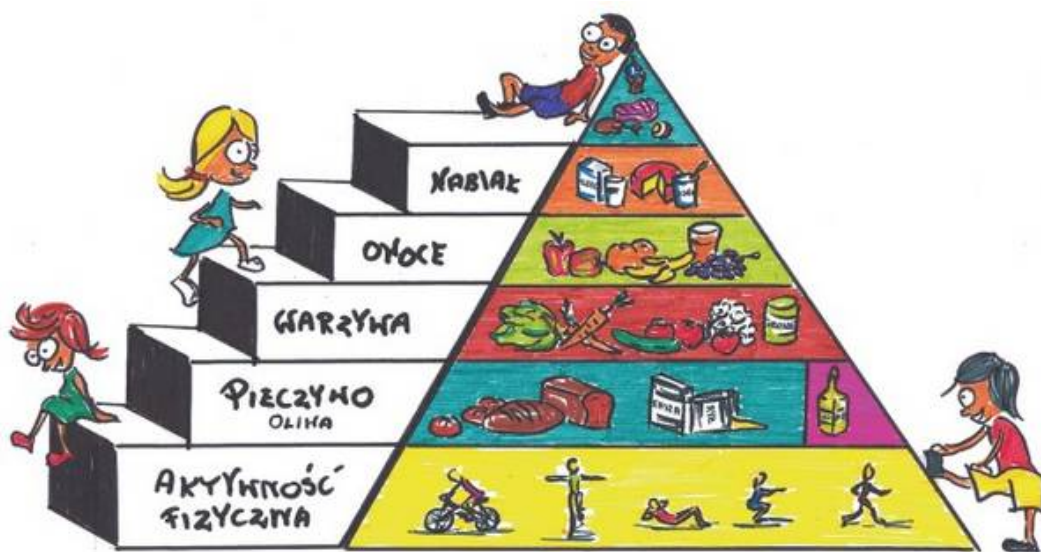
We start the discussion about relieving tension by eating from asking patients what are their experiences in this topic. We try to define together differences between eating while hungry and eating on another occasions. Apart from examples of eating to relieve stress you can bring others, e.g. concerning some food rituals, eating because of guilt or obligation. After recognizing and naming different circumstances that make participants resort to eating, you should direct the talk towards emotions that facilitate overeating.

The table in our textbook may be of help if we draw it on the whiteboard before the meeting. During the first part of the meeting we help patients filling it in according to their actual behaviors. You might ask the group about other [apart from eating] ways of relieving tension they practiced to date. You might also pose questions about theoretical knowledge they have on the subject. The more own examples participants give, the better. Summarizing this part you can not only describe several techniques of relieving tension but also demonstrate at least a couple of them on a volunteer. There's nothing better than experience. After ending e.g. a short relaxation session you should discuss in a group how did the tension of each participant change with time. It's most probable that not all participants experience tension relief afterward. Sometimes it might even

build up. It might be a good point to encourage such patients to seek their own way of relieving stress as long as that way has nothing to do with eating. If time permits you may also mention here how to tell hunger from appetite. With group's permission various relaxation techniques can be introduced as a permanent element of each subsequent meeting.

MEETING VI

1. Indispensable dietary fiber
2. Food Pyramid
3. Constipation
 - Frequent causes
 - Helpful tips
4. Homework



Food Pyramid has been created so everyone could easily see which foods should be eaten frequently and which only occasionally. This pyramid also reminds us that physical activity is an integral part of a healthy lifestyle.

MY NOTES

INDISPENSABLE DIETARY FIBER

Contemporary mechanization of food processing has a negative impact on the functioning of our alimentary tract and our body as a whole. As a result of industrial processing our food frequently becomes less nutritious because it has almost nothing of the dietary fiber which is important for our body. By eating highly processed foods our alimentary tract gets lazy. Fruit-flavored quarks, sweetened yoghurts, bottled or canned juices, frankfurters, hot-dogs, pates and other products of liquid or semi-liquid consistency that doesn't even require proper chewing, are easily digested and all the fat and sugar they contain are absorbed effortlessly. This makes us gain weight and rises the risk of many so called diseases of civilization. Today we know that unhealthy diet is responsible for obesity, type 2 diabetes, colon cancer and many other ailments. When we eat something hard, it's digested more slowly, and that's good for us. Our alimentary tract serves not only digestion. It's also a part of the immune system. A diet high in fiber apart from mobilizing peristalsis mobilizes also the immune system within. Longer chewing and slower digestion keep unwanted kilograms at bay. At the same time mobilized immune cells in the intestines increase our resistance to various pathogens. Chewing increases the production of saliva which acts as antibacterial mouthwash protecting teeth from tartar and decay. In the intestine fiber permanently binds bile acids what lowers the total cholesterol levels in the blood. By "catching" sodium ions fiber helps maintaining physiological blood pressure. Being almost insoluble, fiber decreases absorption of sugar from the intestinal lumen – a very useful feature for everybody who is trying to lose weight. Eating products high in fiber we care for our health in many aspects at once. That's why our diet should be full of high-fiber, hard foods requiring chewing. Good sources of dietary fiber which is not digested (at least not by us – humans) are e.g. cereals, vegetables, fruit. There are two types of fiber: insoluble – found in whole-grain cereals, large-grain buckwheat, wheat or rye flakes, seeds; and soluble (also called pectin) – present in fruit and vegetables. Diet high in fiber mobilizes the whole alimentary tract and increases activity of many internal organs. Such diet strengthens our teeth by making them chew and by increasing the production of saliva. It also makes us feel full as fiber expands in the stomach. This in turn lessens hunger and decreases binge eating episodes. Eating fiber also helps strengthening healthy eating habits, as it makes us chew every bite and by this we are eating more slowly and have a chance of

catching the moment when we start feeling full, satiated. A good idea is to start every meal from a portion of vegetables. Remember: veggies are to make at least half of each of your meals. Every day your diet should include 25-40 g of fiber. Breakfast – cereals (try oatmeal). During the day – fruit (unpeeled), wholemeal bread, brown (unpolished) rice *al dente*, a lot of raw vegetables. Perhaps you will need time to get used to high-fiber diet. Try introducing hard foods in your daily diet step by step. If your teeth prevent you from proper chewing, you can eat raw vegetables minced or blanched (thrown for a minute into boiling water). A good way of increasing the amount of fiber in your diet are vegetable or fruit-vegetable juices, providing they're unsweetened and non-cleared. If eating high-fiber meals gives you winds, do not give up. Try to eat more slowly, chew longer to mix the food with saliva. If your mouth is dry, drink vegetable juice diluted with water. Diet high in fiber decreases the risk of constipation.

	ALIMENTARY PRODUCTS	THE AMOUNT OF FIBER PER 100G OF PRODUCT	REMARKS
VEGETABLES	white cabbage, tomatoes, cucumbers, lettuce	3 – 6 g	contain a lot of water
	carrot, celery, cauliflower, parsley, fresh broad beans	1 – 2,5 g	excellent in salads
	dried beans, peas, chickpea	9 – 15 g	good source of vegetable protein
FRUIT	apples, prunes, pears, citrus fruits, bananas	1 – 2 g	ideal for snacks
	currants, strawberries, raspberries	6 – 7 g	good source of vitamin C, sometimes they may cause allergy
	dried fruit: figs, dates, apricots	10 – 13 g	Warning!!! they contain significant amount of sugar (and calories!!!)
SEEDS, CEREALS	buckwheats	ca. 6 g	great as a base for lunch plate
	oatmeal	ca. 7 g	excellent for breakfast
	Wheat bran	ca. 44 g	together with linen seeds help relieving constipation
	wholemeal bread, pumpernickel	ca. 6 g	excellent choice as a base for sandwiches
	nuts	6 – 13 g	contain quite a lot of PUFA but also a lot of calories

Where will you find dietary fiber

IDEAS FOR HIGH-FIBER MEALS:

1.....
.....

2.....
.....

Constipation is unpleasant but usually can be managed without resorting to pharmaceuticals. We talk about constipation when we don't pass stool for more than 3 days in a row. It causes abdominal discomfort, and we may be sluggish or irritated. The defecation itself often is painful and difficult. It happens that increased tension in the last part of the alimentary tract causes or worsens haemorrhoids. Constipation also increases the risk of inflammation what in turn increases discomfort of defecation. Constipation can be caused by several factors, including low-fiber diet, drinking too little fluids and inactivity. The risk rises also when you're taking some drugs. In sick people often several of these factors are present and they sum up causing frequent and painful episodes of constipation. To effectively lower the risk of constipation you should:

- drink at least 2 liters of unsweetened fluids daily
- eat foods high in fiber
- exercise at least an hour a day (e.g. take a long walk)

Obeying these rules is helpful also if you don't suffer from constipation – it helps shedding kilograms and maintaining good figure.

HOMEWORK

Review your notes and check whether your meals contained enough hard foods – high in fiber. Think, where could you add some more of these. Prepare 3 propositions of high-fiber meals. Find out if such meal is easy to prepare and tasty. You may take suggestions from other members of the group. Maybe your high-fiber dish turns out an interesting recipe also for others. You may also prepare a list of high-fiber snacks, so as every day you can try one of them, find out if they suit you, have accessible price and are easy to prepare.

IDEAS FOR HIGH-FIBER DISHES:

1.....

2.....

3.....

MY LIST OF LOW-CALORIE, HIGH-FIBER SNACKS

- 1.....
- 2.....
- 3.....

TIPS FOR THE THERAPIST

MEETING VI

1. Indispensable dietary fiber
2. Food Pyramid
3. Constipation
4. Frequent causes
5. Helpful tips
6. Homework

Before the meeting draw the exemplary Food Pyramid on the whiteboard. When the meeting starts, discuss it with patients. Check whether they can confront written suggestions with their eating habits. You can also ask the participants to check their notes and together find out if they are consistent with the Food Pyramid. If it turns out not to be the case, you may correct them together with the patient, checking whether your suggestions are welcomed. You should also emphasize that physical activity as the basis of the Food Pyramid will be discussed on the next meeting. Some groups may need more time to discuss problems with constipation than others. You should adapt the time-frame to the needs of the particular group. After a short break we move on to the fiber issue. You can ask patients to write all high-fiber foods they know on the whiteboard. You should widen and modify the list in the textbook according to patients' knowledge and local particularities. You should guide the discussion away from low-fiber foods that may be mentioned by patients. It's important to end with a long list of „good“, high-fiber foods. Then all may elaborate on some dishes high in fiber, or even try to compose a whole day menu for a person who has problems with constipation. Such exemplary menu must encompass unsweetened liquids and propositions of physical activity. Ultimate conclusion from the meeting should be that everybody can benefit from eating high-fiber alimentary products.

MEETING VII

1. why is it necessary to exercise daily
2. my idea for daily exercise
3. in front of a TV – what happens
4. homework

Daily physical activity

Thanks to the industrial progress our muscles have still less and less occasions for work. We drive instead of walking, take a lift or escalator instead of stairs, we don't even have to get up to change TV channels! Unfortunately all these amenities make us getting fatter and sicker. The idea of daily exercise tries to match the form of physical activity to our state of body and mind. It can be long walks, climbing stairs, cycling, dancing or any other form of movement that we perceive as pleasant and which can be increased in intensity. Whichever form of activity you choose, important is to do it regularly. Best if you start with small changes in your daily routine.

Start by thinking what forms of exercise are „at hand“, e.g. on the way to work, mall or at home. Then choose one of the possibilities and start acting! It's important to take your own resolution seriously and act consistently. That's why the first scope should not be too ambitious; e.g. if you live on the 5th floor, say to yourself: since today I'll be climbing one set of stairs and getting in the elevator only on the first floor. It can be done even if you are a dedicated couch potato. By climbing up one floor you gradually build up your stamina and after a couple of weeks even two floors won't be too much for you. Step by step [literally] you will become more fit and healthy.

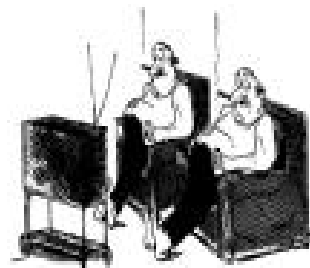
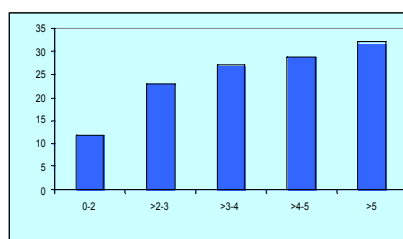
It's the same with dancing. Initially half an hour of dance might seem too much. Gradually we're however getting more fit and may even want such exercise every day. If you feel like dancing for half an hour a day, just turn on some music at home and move to it; get to „feel the beat“. It's a good form of physical exercise, you should aim at prolonging your daily dancing sessions up to an hour.

When choosing the form of exercise it's worth remembering that the exertion shouldn't exceed your present fitness level. Excessive training might even be

counterproductive. Firstly, when exercises are too difficult, you get frustrated and demotivated. Secondly, exceeding your limits you might get injured. Thirdly, lack of preparation might dangerously lower your blood glucose levels causing hunger pangs and leading to overeating. That's why it's important to discover what kind of physical activity suits you best; just follow the rule of doing it every day.

My idea of daily set of exercises:

- 1.....
- 2.....
- 3.....



Sitting in front of a TV for long hours every day we often aren't even aware how destructive it is in a long way. The data show that watching TV or sitting at the computer for more than 3-5 hours a day increases the risk of depression. At the same time more or less motionless sitting facilitates gaining weight. Moreover, while watching we're inclined to snack uncontrollably or smoke cigarettes one by one. By shortening the time we spend in front of a TV we can gain precious hours „missing“ for a daily walk. Believe me, it's worth trying. And with time you will see the effects for yourself.

HOMEWORK

1. Think, what form of physical activity you found attractive in the past. Try to go back practicing it. Make a schedule allowing for lengthening the time dedicated to exercise since today, every day. At the end you should achieve at least an hour of physical activity every day. If you can't remember any exercises that previously made you feel good or if your health doesn't permit you to go back to the activities you used to do in the past, try to plan a safe and achievable for today form of activity together with the therapist. Example:

FORM OF ACTIVITY	PLAN FOR TODAY	AIM
<i>Walk the dog</i>	<i>Today I'm going for a walk with my dog for 15 minutes</i>	<i>Walking the dog for half an hour 3x daily</i>
<i>Climb stairs</i>	<i>I'll climb one floor</i>	<i>Climbing 2 sets of stairs twice daily</i>

2. Find out how many hours a day you spend watching TV or sitting at the computer (outside working hours). Try to spend half of this time going for a walk or practicing another form of physical activity (not too difficult and giving you pleasure).

TIPS FOR THE THERAPIST

MEETING VII

1. why is it necessary to exercise daily
2. my idea for daily exercise
3. in front of a TV – what happens
4. homework

Meeting should start with a talk about activity; what are the advantages of being active and what are patients' experiences on this field. It's worth encouraging patients to give examples of activities that give them pleasure and to tell what additional benefits might stem from exercising. The more virtues of practicing sport participants can list, the better. It makes it easier for the therapist to summarize this part of the meeting by saying: daily activity makes sense. Before break you can suggest reading together the piece from the textbook and ask the group to comment on spending time in front of a TV or a computer, in a ward as well as at home. After a short break or even during this break you can propose an easy form of activity to all participants to evoke joy and relaxation. It may be in the form of a game or play lasting no longer than 5 minutes. Afterward you should still have time to ask patients how did they feel beforehand, during and after the exercise; did anyone find it difficult, didn't want to exercise here or at all. Then it's time to start looking together for the best form of physical activity for each of the participants. You may try to steer the conversation so that some of the patients feel like e.g. going for a walk together after the meeting. Try to

use the power of the group to seek the best form of activity even for those patients who doubt they can start exercising right away. Every idea of daily exercising (even if in your opinion it lacks ambition) is to be encouraged and you should support it as long as the patient promises to do it every day. It might be possible to plan together in a group a gradual intensification of physical activity for consecutive group members. You should also in a delicate but firm way mitigate too ambitious plans made by some of the patients for their future training. Instead try to present other values of being active apart from building up fitness level or burning more and more calories. It's best to support your talk with examples given previously by patients themselves. If conditions permit it in a particular center you may at this point of the meeting propose some forms of activity available „on the spot“. Sometimes patients themselves readily advertise their favourite fitness club or swimming pool with discount for disabled. A statement by another patient „I go here and here and feel good there“ is usually best recommendation for others.

MEETING VIII

Recapitulation

- right number of meals per day
- right proportions of products in each meal
- my ideas for healthy snacks
- my motivation to change eating habits
- my daily activity

Homework

RECAPITULATION

From the past meetings we know that the basis for changing dietary habits is our own motivation. Aside from motivation described earlier on, important are also our FAITH and BELIEF in success. Finding motivation has been perhaps easier than really and firmly believe in ourselves and give ourselves a chance to change eating habits for good. To start believe in yourself and faithfully pursue the ultimate goal you should pose yourself intermediate goals. aiming at 5 meals a day at regular intervals you should start with approximations: if not 5, then

maybe 4 meals are a realistic target for tomorrow. If your meals are not ideal, maybe you can put at least approximately 50% of vegetables, 30% of carbohydrates and 20% of proteins in each or most of them. Every day give yourself a chance. Only then you can firmly believe that each day it will be easier for you to obey new eating rules, prepare healthy snacks that help you „survive“ from meal to meal. Having good motivation for change and noticing even small successes you should also more easily convince yourself into even short exercising sessions and squeeze them into daily routines. Most importantly you should believe that even if today you don't believe much in ultimate success and your motivation is low, tomorrow it may change. If you have a bad day, when for psychological reasons it's more difficult for you to take care of your physical health, don't force yourself, be good to yourself. Just go back to your notes from the day when this motivation was really high and think, what can you do for yourself today. After a while you'll surely feel better and go back to caring for your health. To learn how to eat wisely, it's worth reading also past chapters of the textbook and your own notes. They will make it easier for you to check, what can you improve in your meals to lose weight more effectively or to maintain a healthy weight. Remember to increase the amount of physical activity in parallel to dietary changes. Small, but frequent (every 2-3 hours) meals will spare you hunger pangs after exercising.

HOMEWORK

After reviewing previous chapters of the textbook and your own notes answer the following questions:

How many meals a day should I eat to lose weight?

.....

What are the proportions of vegetables, carbohydrates and protein ideal for losing weight?

.....

What are my ideas for healthy snacks that'll help me lose weight?

.....

What is my motivation to lose weight?

.....

What form of exercise have I chosen to shed kilograms more effectively? When and where exercising makes me feel good?

.....

TIPS FOR THE THERAPIST

MEETING VIII

Recapitulation

- right number of meals per day
- right proportions of products in each meal
- my ideas for healthy snacks
- my motivation to change eating habits
- my daily activity

Homework

You can start by asking the group to „do homework“ together. Questions written down on the whiteboard should facilitate open exchange of ideas between participants. It would be good if you kept yourself from interfering, only watching for the conversation to stick to the main topics of the meeting. A good way to do this is to paraphrase or systematize patients' opinions. Depending on the individual needs the group may focus on different topics mentioned in the questions on the whiteboard. If the discussion turns out to be sluggish and uninventive, you can always propose a questions session with the expert.

Next thing is to write down on the board all the questions posed by the group. It is important to let the participants answer most of them; they may use the textbook, own notes or discuss answers among themselves. Discussion about the topics mentioned earlier on is to strengthen the acquired knowledge. An important issue is to end it by saying that every member of the group has already become for himself a kind of an expert on the topic of healthy diet. If time permits, after the break you may go back to patients' notes and homework on any topic chosen by the group and once again, together, do such homework. Sometimes it's good to go back to the issue of group and individual motivation by drawing a unified graph of motivation for today.

MEETING IX

1. motivation for a change
2. a steady-state or loss of balance, i.e. „a plateau period“ or a „yo-yo effect“
3. reading labels
4. homework

Motivation to change the way you eat and to get physically active

Your motivation level changes with time. For sure you experience occasional drops in motivation and days when you feel more like changing your life. Often it's hard to say why your motivation has dropped significantly. Sometimes it's linked with worsening of your psychic health and sometimes it isn't. On our first meeting we talked about the reasons why you wanted to eat wisely and be in good physical condition. Can you recall what they were? Has something changed since then regarding your motivation? Check whether the reason why you stepped on the difficult path to change is still worth your hard work. From time to time you should remind yourself "why am I doing this"?

How strong is my motivation

(please, mark by X, what's your motivation today)

- 0 - others want me to lose weight and to exercise more
1 - I would like to lose weight/remain slim and be fit
2 - I can do something not to gain weight, to improve my fitness etc.
3 - I can do a lot to lose weight, take care of my physical health etc.
4 - I do whatever it takes to lose weight/maintain healthy weight and good figure etc.



If you succeed in losing weight, your motivation usually rises, but sometimes after shedding a few kilograms you stop caring. You stop watching yourself and return to old, bad habits. On the other hand you may get discouraged and demotivated when at first you don't see any positive effects of your hard work. You should check your level of motivation from time to time and when this level

starts hovering between 1 and 2, lower your expectations a bit. E.g. instead of a 2-hour walk every day, say you'll walk for 20 minutes, but DO IT! If you can't manage to eat regularly, at least try not to add sugar to any meal or drink. It increases your chances to go back to higher standards of a healthy lifestyle later on, when you get better.

DYNAMIC MODEL OF ALTERNATE GAINING AND LOSING WEIGHT – A YO-YO EFFECT, A PLATEAU PERIOD

You can avoid a yo-yo effect

It's almost certain that at some point during the process of losing weight your weight stops and further kilograms don't go away no matter what you do. You keep a balanced diet, you exercise and your weight... simply doesn't notice your efforts. Some experts call this state „a plateau period“. You can cheer up – it's inevitable, but it passes. You just have to know that such time will come. A lot of people give up at this point (because their efforts seem fruitless) and start gaining weight. It's frustrating. Often it means returning to old dietary habits and forgo exercising. Result? – the weight goes way up and a person ends with more kilograms than before starting the diet. It's called a yo-yo effect. Remember! You can avoid it! Just when the plateau comes don't give up diet and try to intensify daily exercising regime. And wait patiently. You'll see – the weight will start to go down, but in every individual it takes different amount of time. Knowing about the inevitable „plateau period“ you can prepare for this difficult time, remind yourself why you want to lose weight and keep extra kilograms at bay.

Physical activity and healthy diet will bring on the desired effects. With time.

A „yo-yo effect“ is an unpleasant consequence of many fad diets. In a few words: a yo-yo effect means gaining more weight than you managed to lose while on a diet. It has two main reasons:

Firstly: obeying a very low-calorie diet (VLCD) slows your basal metabolic rate (BMR), your body starts thinking „we're starving!“. So when you go back to normal, balanced diet, it starts accumulating fat „just in case“. This leads to weight gain even though you don't eat much. Moreover, because physiological hunger signals are strongly repressed during VLCD, you learn to ignore this

physiological „talk“ of your body what in turn leads to irregular, too large meals eaten „when time permits“, often with long intervals between them. Such eating pattern rises your chance of gaining weight again.

Secondly: visible short-term results of a VLC diet frequently lure into allowing yourself „a small prize“ usually in the form of food you had to avoid. One „small prize“ leads to another, and yet another, and without noticing you find yourself again in the grip of all old, bad habits. And they make us fat.

To avoid the „yo-yo effect“ you shouldn't follow any short-term fad diets. Instead, just eat healthy and be active every day.

Read the labels!

While we know that food packagings usually are inedible, do we also know for sure that what's inside them is edible? They say: you are what you eat, so do you know what you eat? Today's meeting is to encourage you to watch closely the food you buy. You have the right to know whether the yoghurt you buy is sweetened, what flour was used to make the «light» bread and is the «fruit juice» a real thing or just the mix of water, sugar and some fruit juice concentrate.

We strongly encourage you to ask in a restaurant or in a bar: how was your ordered meal prepared. It's normal to be curious whether someone has added too much of a fatty sauce to your salad. By eating wrong foods we are getting fat. So if you order a fresh-fruit dessert in a café, go ahead and ask the waitress to bring it without sweet, whipped cream. Ordering a salad ask for leaving mayonnaise or – if it's grated carrots - sugar out of it.

The ingredients of different alimentary products are usually written in a very small print so don't forget to take your glasses for shopping. You may also ask someone from the personnel to read the label for you. Remember: it's your right to know what you pay for and what you eat! Even if in large print it says «light» or «low-fat» on the label, it doesn't mean that it doesn't have a lot of sugar in. It's important to know your rights because they help you to care for your health and well-being.

HOMEWORK

Your homework for now is to read labels on all foods you buy/eat every day. Start today, but don't end at the next meeting! Reading labels on alimentary products should become your «second nature» or at least a good part of daily routine. If you're eating out, get to know whether in your food there's not too much sugar or fat. If possible choose meals «with no sugar added».

TIPS FOR THE THERAPIST

MEETING IX

- motivation for a change
- a steady-state or loss of balance, i.e. „a plateau period“ or a „yo-yo effect“
- reading labels

This meeting consists of three linked parts that can be discussed in any order. The simplest way is to start with reading labels. Bring a few food packages of items popular with the patients. Alternatively you can ask the group on the previous meeting to bring 2 food packages per person. The aim is to read the labels together and find out, which foods have too much sugar or fat.

Here it's time to emphasize that everyone should read food labels and do it regularly, because we all aim at changing dietary habits for the rest of our life and not only for the sake of another short-term, fad diet. You should check how strong is the motivation of individual group members to keep caring for health. It's a natural way of smoothly passing to analyzing how the motivation changes in time. You can mark on the whiteboard current motivation level of each of the patients and elaborate on them. E.g. what does it mean «I will do something to keep from gaining weight and to improve my fitness».

After a short break, on the basis of the textbook try to draw on the whiteboard the dynamic model of the yo-yo effect and the plateau period. Explain different stages of losing and gaining weight as you draw. To activate the patients you can try to inspire a common discussion about what to do when you experience a plateau period. It's worth emphasizing that this period is just another step in the process and cannot be bypassed. You may go back to patients' motivation and try to make each of them convince him/herself why eating wisely and being active every day should become a permanent element of his/her life.

MEETING X

1. My daily notes – successes and failures, discoveries and comments
2. Reading food labels – discoveries and comments
3. Can healthy food be inexpensive?
4. Important questions

Making daily notes is an important step towards permanent change in your eating habits. Only analyzing these notes you are able to judge what you've already mastered quite well and where is still room for improvement. Sometimes a healthy diet and regular physical activity lead to weight loss. However we consider it a success if a patient changes his/her lifestyle for a more pro-healthy one and weight loss or even curbing weight gain is only a welcome by-product of this change. Some participants don't lose weight but the longer they stick to a healthy lifestyle, the better their blood tests get (e.g. their glucose and cholesterol levels go back to normal). Making notes helps to correct dietary habits for healthier, wiser diet. Moreover these notes teach us to think about ourselves and to care for our health as the most precious thing in our lives. They may also help evaluating the cost of a new diet, proving that healthy food doesn't have to be expensive and tasteless. With the help of notes it's easier to plan meals for the coming weeks. Invented and prepared, then eaten and described, a tasty salad can become a stable feature in your menu. It can also be a welcomed example for other members of the group. After some time your notes may become a collection of excellent recipes you will use every day. **We** encourage you to look at your notes as a source of knowledge about yourself, your bigger and smaller successes in your quest for a better health!!! Look at someone else's dish and/or the one you've prepared yourself in a way suggested in the table below

	PRODUCTS	PRICE	ACTIONS	TIME TO PREPARE
VEGETABLES 50% OF THE PLATE				
CEREALS 30% OF THE PLATE				
PROTEIN 20% OF THE PLATE				
		TOTAL COST OF THE DISH		TOTAL TIME OF PREPARING THE DISH

HOMEWORK

Making notes try to analyze one of the meals you've prepared according to the points suggested in the above table. Buying food pay attention to the price and choose these free of added sugar. Preparing a meal by yourself or with the help of someone close to you, find out how much time you need for each action. Try to preserve the proportions of products in the meal following the rule of „50%, 30%, 20%“. If you find the meal tasty and healthy at the same time – write the data in the table below. Maybe before next meeting you'll exchange ideas for tasty, healthy and inexpensive dishes with other members of the group.

	PRODUCTS	PRICE	ACTIONS	TIME TO PREPARE
VEGETABLES 50% OF THE PLATE				
CEREALS 30% OF THE PLATE				
PROTEIN 20% OF THE PLATE				
		TOTAL COST OF THE DISH		TOTAL TIME OF PREPARING THE DISH

TIPS FOR THE THERAPIST MEETING X

1. My daily notes – successes and failures, discoveries and comments
2. Reading food labels – discoveries and comments
3. Can healthy food be inexpensive?
4. Important questions

This meeting is the time to gather and systematize knowledge learned during previous ones. While discussing Daily Notes with patients, you check which rules of healthy diet they have managed to implement. You pick up and praise successes and try to find at least one for each participant. Don't value them. Even small change serves the purpose if only is permanent. You also should show understanding when hearing about failures. Try to find the solution with the help of the group. Check which of the presented propositions patient is willing to try and implement. Then spark the discussion about food composition trying to make

everybody interested in it. A good way may be to initiate a game „find harmful sugar“, which might encourage patients to do shopping and eat in a more conscious way. You should have next portion of food packages at hand. Examining each of them allows not only to explain nutritional value, but also to describe taste and compare prices. At this point it's good to activate the group so that everybody gives examples of inexpensive, tasty and healthy dishes, then write it down on the whiteboard. Remember to put food into context, i.e. it should be economically sound, adapted to the season and local particularities of the center. The more examples you hear from participants, the better the meeting results are. You may even name every idea with inventor's name: e.g. *Miss Black's dinner* or *fast snack according to John*.

After a short break you take time for open questions regarding the topic of the meeting. Because the cycle of meetings approaches the end, it's also a good occasion to recapitulate gained knowledge and correct possible misconceptions. The group may want to talk about the future. You should be prepared to talk about this subject. Here it is time to give clear information about other forms of support offered by the center. If the course has been the only way of teaching patients about healthy eating and getting active, you may encourage them to form informal support groups or even to further individual work for their health and well-being.

Important is to arrange the discussion in a way that participants answer all or most of the questions about healthy eating and being active. Therapist's role is just to supervise their answers so that they'll be true and accurate. If someone gets it wrong, you should correct this part of his speech and add necessary particulars but refrain from criticizing the speaker, so as not to discourage him from taking active part in future discussions.

MEETING XI

(Materials for this meeting are taken from Judi Hollis's work)

1. practicing assertiveness i.e. how to say „NO“ firmly but without feeling guilty about it and without hurting others
2. other effective strategies connected with healthy eating
 - a. during holidays/parties
 - b. while hiking or going away from home
 - c. during hospital stay, during relapses
 - d. at other times
3. Homework

Let's start with a story

Dorothy had been invited for her sister's birthday. An important point of the party was cutting and eating a birthday cake. The cake was standing on the table from the very beginning, tempting everyone with its look and smell. For sure mother had bought it at a good patisserie as a birthday gift for her daughter. Now imagine it's you being invited to this party. What about the cake? It seems nobody except you has the problem. Only you start imagining what will happen if you deny a piece. How would Dorothy's sister react? Would her mother think you're rude if you say no to the cake? And now let's face it: NOBODY EXCEPT YOU CARES WHETHER YOU EAT IT OR NOT. It's your old habit of eating a lot of sweets that makes you ruminate the idea. You start thinking whether you would gain weight after just one piece, convincing yourself that such a small piece won't do any harm. You cheat yourself that by eating the cake you'll please Dorothy, her sister and her mother. „Just one piece“. When somebody passes you a plate with the cake you feel „absolved“, even „forced“ to eat it. But after the first you reach for another sweets and overeat for the rest of the party. Only afterward you start feeling bad about yourself, maybe sad or angry for this unnecessary binge.

- IT DOESN'T HAVE TO BE THIS WAY!

- YOU SPEND EXACTLY THE SAME AMOUNT OF ENERGY REFRAINING YOURSELF FROM A CAKE AND DECIDING TO EAT IT.

Refrain might be a better reward than a piece of cake.

See what did Dorothy do, maybe it'll help you to say „no“ next time;

Dorothy gave herself a gift of refrain and she got much more – a sense of dignity and strength, satisfaction from making a right choice and experience that you can feel good without eating cake. She discovered that by saying „no“ to a piece of cake she didn't offend or harm anyone.

mother: Here, Dorothy, have a piece of cake; please your sister.

Dorothy: Thanks Mom. I don't want a cake.

mother: Oh, come on, Dorothy, this is not the time for dieting. *(notice that Dorothy didn't say anything about dieting. If you don't want to eat something you don't have to give reasons for it!)*

Dorothy: No, thanks. I just don't feel like eating cake right now. *(Dorothy keeps saying „no“ to make her mother hear and to reinforce her resolution. She says „not right now“, sometimes it is enough for the offerer. It's worth trying to show that it's you who decide when and if you will e.g. eat the cake!)*

mother: What is it about, Dorothy? Are you envying your sister? Or maybe you're crossed with her? *(Here are brought some completely unfounded accusations. As if not wanting to eat the cake at the moment meant she didn't love her sister enough or didn't want to wish her all the best on her birthday. Maybe you've noticed that mother doesn't care whether Dorothy wishes her sister well; she stubbornly just wants to force this piece of cake into Dorothy. Dorothy could of course shy, blush and eat this b...y cake to make her sister happy. But eating everything what's offered, even if prepared especially for us, is not the way to show our loved ones our affection. If you're not hungry – DON'T EAT!!! Love and respect can be expressed in many ways unrelated to eating.)*

Dorothy: I wish my sister all the best. I'm not angry or crossed with her. I just don't feel like eating cake right now. *(Dorothy refuted her mother's unfounded accusations. She said she loved her sister and once again emphasized, that she wasn't going to eat the cake! Notice: she just states facts, doesn't explain, doesn't quarrel with her mother. You have the right to voice your opinion without feeling guilty and without rebuking others. You have the right to deny certain foods and this has absolutely nothing to do with your feelings towards other people)*

mother: If I were you, I'd have taken the cake *(Mom is stubborn, but she can't force anyone to do sth that someone doesn't want to). She's not Dorothy. She may eat all the cake she wants but she has no right to force her daughter. Luckily she's not Dorothy! But observe: mom's nagging is getting weaker. It's*

because Dorothy very consistently and without explanations says „no“ to the cake. You can also act like this. It works!!!).

Dorothy: Mom, I thank you for your concern, and for the cake. *(This last phrase Dorothy said very calmly but firmly. She wasn't angry or sad. She was ASSERTIVE. Dorothy won without making excuses and what's even more important – without eating cake. She was so proud of herself that rest of the evening she spent dancing and she didn't eat anything. She just wasn't hungry. Earlier on she ate a healthy meal with a lot of vegetables. She was pleased with herself, she took care of her without hurting anyone. Saying „no“ to sweets she said „yes“ to good fun, joy and contentment. You also can say „no“ to sweets, calmly but consistently if you're not hungry or if you don't want to eat sth you are served.)*

WHAT IS ASSERTIVENESS?

- judging what's most important for me and acting accordingly
- self-respect, valuing myself and my health
- doing what's good for ME and not necessarily acting according to the wishes of others
- taking responsibility for myself and my actions
- showing that I don't want to argue, that I respect others' opinions, but only as much as I respect my own
- self-confidence without guilt
- accepting opinions of others, but not necessarily agree with them
- calm acceptance of criticism as well as compliments

Remember:

when learning to say „NO“, you may not be perfect right from the start.

Stick to the plan, remember your goal!

Refuse with a smile and without feeling guilty!

You don't hurt anyone else by taking care of yourself!

The more times you'll try, the easier saying „no“ will become for you!!!

OTHER STRATEGIES HELPING YOU TO AVOID UNHEALTHY OVEREATING

Let's ponder when during last year it was hardest for you to stick to a healthy diet.

Try to recall as many situations as you can. It'll help you prepare better for the future. Enter these situations in the table below as in the example:

<i>February - March</i>	<i>I was at the hospital, I was lying down a lot and they change my drugs often</i>	<i>I wasn't particularly hungry, but my family was bringing me sweets, chocolate and pastry, as well as sweetened drinks. That's why I gained weight</i>
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Month of the year	Description of the situation	What was the issue that led to overeating/gaining weight

Now consider, whether you can find a solution allowing you in such situations to eat wisely, take care of your health, your figure and your fitness level.

Probably you can not only think out a solution but also have good experiences from the past. If you don't, you can always ask another members of the group for help. Together it's always easier to find a good solution.

Share your own experiences with others and learn from their examples. It pays off.

Situation and encountered difficulties	Ideas for preserving healthy diet and maintain good physical condition under these circumstances

HOMEWORK

If it happens that you don't manage to fill in the table below, you can treat it as a part of your homework.

Your other task is to practice alimentary assertiveness. If somebody offers you something fattening or simply you don't feel like eating at the moment, try to calmly deny this offer. You can ask your close ones for help and practice together until you decide that saying „no“ is now a lot easier for you than before.

Good luck. This skill is worth learning.

TIPS FOR THE THERAPIST

MEETING XI

1. practicing assertiveness i.e. how to say „NO“ firmly but without feeling guilty about it and without hurting others
2. other effective strategies connected with healthy eating
 - a. during holidays/parties
 - b. while hiking or going away from home
 - c. during hospital stay, during relapses
 - d. at other times
3. Homework

Before you start to practice assertiveness with the group, you may propose a short warm-up, when you ask the group about their experiences in saying „no“ to others or talking others into something. It's important to steer the conversation so that afterward you can ask the participants how did they feel when they had said „no“ and how when it had been them who was denied sth. You should find out in what circumstances it's most difficult to deny offered sweets.

After such warm-up you move on to explaining what assertiveness really is.

Activate the group and together with them try to consider how assertive behavior may help in maintaining a healthy diet.

First ask three participants to read aloud the dialog from the textbook. One person plays Dorothy, another – her mother, and yet another is a tale-teller. It's

important that the tale-teller sits among other patients and reads his/her part slowly, loudly and clearly. Dorothy and her mother sit on an improvised stage. Everybody reads from the script but he/she might also improvise a bit.

At the end you discuss the scene with all patients. What do they think they could implement in their own life? Maybe someone from the group would like to try and practice saying „no“ without hurting others' feelings.

After a short break you move on to discussing other strategies useful in difficult situations. All the time we e talking about strategies facilitating maintenance of healthy eating and physical fitness in strenuous circumstances that patients might encounter.

It's worth drawing the table from the textbook on the whiteboard and fill it in together with the patients. Most of the time should be dedicated to exemplary solutions used by patients in the past with good results.

You should take particular care of these patients, who you know are the least assertive in the group. It would be perfect if people who find refusing most easy could help and be supportive to others.

MEETING XII

FINAL SUMMARY

1. Program evaluation
2. Reinforcing new dietary and exercising habits

Today's meeting ends the 12-meeting cycle during which we've learned together how to take care of our own health through balanced diet and daily physical activity. We hope that these meetings have systematized your knowledge about healthy eating and about the importance of regular physical exercise. Some of the information might have been totally new for you, and have changed your way of eating and your perception of physical activity. Our meetings have come to an end, but this doesn't mean you should go back to your old lifestyle habits. To make this new way of eating and of finding joy in physical activity really a part of your life needs a lot more time and determination on your side. Notes you were making on each meeting and as homework are a perfect tool helping you to take care of your physical health in terms of diet as well as exercising. We encourage

you to use your own notes and our textbook as a way to improve your lifestyle. Your experience in making changes in your diet and your joy from participating in various forms of physical activity may also be helpful to others. Healthy lifestyle is worth propagating. Since today it's you, participants of our program can be role models for others. Maybe someone around you: a friend, an acquaintance, next of kin makes unnecessary alimentary mistakes or forgets about staying active. Your example and friendly talks may be helpful. Mutual motivating and support produce extremely good results. It's definitely worth trying!

While strengthening your healthy habits (balanced eating and daily activity) it's worth seeking help from other members of our group. Maybe you'll manage to meet others on long walks, biking trips or arrange a trip to the swimming pool. Exchanging recipes for healthy meals, salads etc. is also a very good idea.

To summarize:

now it's your turn to say:

My health – I care; I wisely choose what I eat and I'm active every day

Please, fill in the questionnaire regarding the program

„My health – I care; I wisely choose what I eat and I'm active every day“

1. How do You evaluate the program in general (from 0 to 5) ?



2. What are the advantages of the program?

.....
.....

3. What was definitely disturbing? What would You propose to eliminate from the program in the future?

.....
.....

4. What would You change in the style and form of the meetings?

.....
.....

5. What does our program lacks in Your opinion?

.....
.....

New, healthy way of eating and daily exercise.

What changes will I implement in my daily routine?

Please, state what changes in Your eating habits and daily exercising have You implemented

	DIET	ACTIVITY
<i>I managed to implement during meetings</i>		
I'm implementing since today		
I plan to implement this month		
I will implement within six months		
To avoid a yo-yo effect I want also		
When do I plan to implement these last changes		

FINAL REMARKS FOR THE THERAPIST

MEETING XII

1. program evaluation
2. choice of physical activities
3. consolidation of new, acquired eating and exercising patterns

Program evaluation

Half of the last meeting should be dedicated to evaluation of the program. It's important to let the patients express their expectations, disappointments,

surprises. If a patient have had unrealistic expectations (e.g. he/she was hoping to lose 15 kg during the twelve-meetings period or he/she expected someone to give him/her a recipe for stopping binge eating at night without hard work or introducing lifestyle changes) it's worth elaborating on this. It should be the role of therapist to encourage the group to help that patient making his/her expectations more realistic. The discussion should lead to creating necessary support for the person who haven't achieved his/her unrealistic goals. Support should help the patient build more realistic plans as well as show him/her that participation in the program made him/her also achieve something. If it turns out that the patient didn't make any lasting changes in his/her eating pattern nor activity pattern, maybe on some occasion he/she gave a recipe for a good meal or even during meetings he/she participated in physical activities so he/she got to know that he/she is able to exercise.

During last meetings patients often ask about something that had been already told earlier in the course of the program. This is a good moment to mobilize the group into discussion when all participants answer each other's questions. The trainer's role is to monitor the content of discussion, encourage participants to give as many examples from their own experience as possible, and to mitigate any possible criticism of the others.

There might be questions about the possibility of continuing meetings in the future.

The answer depends largely on the means of the particular center It is however worth mentioning that a set of 12 meetings does not exhaust the topic of physical health care. Such set of meetings cannot replace daily care for someone's well-being; regular exercise and healthy eating. One may also suggest the participants to continue their meetings on an informal basis, to join collective exercising, organize hiking or biking trips etc. It's worth emphasizing that even if someone didn't achieve everything he/she had planned, there's still time and necessity to improve in the future, even after the set of meetings ends.

Choice of physical activity

During program choosing the form physical activities one should take into consideration the abilities of the weakest participant in the group. Intensity and

degree of complication may be gradually increased. Important is that the participants enjoy the activity, that it makes them happy and brings satisfaction. If some of the group members for medical reasons cannot participate in a certain exercise, the trainer should find him/her another, not contraindicated activity. E.g. if a patient cannot participate in dances in a circle because of a high anxiety level, he may be made „responsible“ to bring the CD player and/or run the music for the dancing group; if the reason is some motor disability, he/she may seat outside the circle and tap the rhythm or clap hands with the music.

Some patients may take more time than the others to join the dancing group. That's why it's always good to open the dancing room also for those participants who don't dance (yet). If at a certain moment patient expresses his/her will to join the circle, he/she should be encouraged to do so, even for a short time. It's worth asking him/her afterward what had helped him to join, how did he/she feel, what was pleasant about the exercise etc. It also gives the patient him/herself an opportunity to express his/her motivation and afterward satisfaction from undertaking physical activity.

A person leading the physical activity class has to conceal his/her physical fitness, much better than that of the participants. Solo shows are strictly forbidden. The aim of these activity is to familiarize patients with physical exercise and not to discourage them from further workout by showing them the unattainable physical skills of the trainer.

From time to time, according to group dynamics, it's worth giving patients the opportunity to conduct physical exercise on their own accord. Volunteers may be asked to lead the warmup or to remind others the already known dance steps. The trainer should then only take care to ensure that proposed exercises aren't too difficult for the rest or too monotonous. Ideally the propositions of physical exercises should be very varied. According to actual possibilities of a given center it's worth introducing several alternative forms of physical activity. It's also worth trying to demonstrate patients 2 to 4 different forms of physical activity during the cycle of 12 meetings. One should only remember that given examples shouldn't deviate too much from the daily possibilities of a given group of patients.

Planning for the future; strengthening new eating and exercising habits

After a short break we move on to further summaries.

In this part of the last meeting we draw a table on the whiteboard, entitled: *My new, healthy diet and my daily exercise.*

What changes will I implement every day? See page

It enables us to fill the table with all the patients and at the same time to discuss ideas for future changes. Sometime there's a person particularly active, who already made a lot of changes and has a lot of ideas for the future. At that point the trainer should stress, that slow introduction of small changes works best, at the same time not criticizing such person for too much enthusiasm, only warning that too great expectations may end in failure. This meeting is a time for another wave of support from the therapist. They should show that all the work the patients have done participating in the meetings is an important step in preserving good health and well-being. The trainer should recall beforehand the activity level of individual participants and mention at least one success for every patient. Every success may be of different importance in our eyes, but the last meeting is no time for valuating the achievements. It's time for appreciation and encouragement of every participant. It would be nice to propose the participants a sort of recall meeting in the near future (2-3 months after program termination) to facilitate strengthening of all good habits. Of course it can be done within the capabilities of particular centers.

Intervention Measure

Motivational Interviewing

with people with severe mental illness

- Adapted to the field of nutrition
(MI – Nutrition)
- Adapted to the field of physical activity
(MI – Physical Activity)
- Adapted to the field of smoking cessation
(MI – Smoking)
- Adapted to the field of oral health and oral hygiene practice
(MI – Oral Health)

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Motivational Interviewing adapted for people with mental disorder

People with a mental disorder could have several disabilities that possibly interfere with the motivational interviewing style. For example, people with depression or schizophrenia often have significant cognitive deficits that may influence their ability to fully participate in motivational interviewing sessions.

Several mental disorders, particularly “depression” and “schizophrenia” are characterized by deficits in a variety of neurobiological, cognitive, and behavioural capacities that may limit the applicability of the motivational interviewing style in this target population. For example, the MI approach deals with change in intentional behaviour, but patients with schizophrenia have significant difficulty sustaining intentional behaviour. MI posits that change entails ongoing judgments about the pros and cons of a specific behaviour and one’s ability to make changes, but schizophrenia is marked by cognitive deficits that interfere with both introspection and complex problem solving. And MI also leads – across the process of change - to personal goals for which a set of coping skills are necessary but that may not be in the repertoire of many individuals with schizophrenia.

Moreover, several factors can be expected to diminish motivation among patients with a mental disorder. People with mental disorder often do not seem to be motivated by common reinforcers. Some patients with a mental disorder demonstrate significant anergia and lack of interest in usually motivating (social) events. These individuals might show significant difficulty in identifying the costs and benefits of special goals. In addition, many patients suffer from some degree of generalized avolition and anergia as a function of hypodopaminergia in the frontal cortex, medication side effects, or other social, psychological, and biological factors that contribute to negative symptoms. Thus they may lack the “internal drive” to initiate the complex behavioural routines required for behaviour change. Another negative symptom, anhedonia, may compromise the experience of positive affect, thereby limiting patients’ ability to experience pleasure and positive reinforcement in an aimed change behaviour goal and restricting patients’ appraisal of the advantages of a new performance.

Research indicates that critical factors in change behaviour include intrinsic motivation, the ability to exert self-control in the face of temptation or urges, cognitive and behavioural coping skills, and social support. Unfortunately, an individual with a mental disorder often has limitations in each of these areas.

A second factor that might compromise the applicability of the transtheoretical model for people with mental disorder is the profound and pervasive **cognitive impairment** that often goes along with the disorder. Patients with enduring and severe mental illness, e.g., such as schizophrenia, have prominent deficits in attention, memory, and higher-level cognitive processes such as abstract reasoning.

They also have deficits in maintenance of set, which is the ability to sustain focus on a strategy or goals, and in the ability to integrate situational context or previous experience into ongoing processing— that is, to use previous experience to direct current behaviour—as well as in other executive functions.

The higher-level **cognitive deficits** would make it very difficult for patients with schizophrenia to engage in the complex processes thought to be central to intentional change in behaviour. They may have difficulty engaging in self-reflection or evaluating previous experiences to formulate realistic appraisals of self-efficacy. Deficits in the ability to draw connections between past experience and current stimuli may impede the ability to relate their current behaviour and unhealthy lifestyle to negative consequences over time and to modify their decisional balance accordingly. Deficits in problem-solving ability and abstract reasoning may impede the ability to evaluate the pros and cons of their unhealthy behaviour or formulate realistic goals. Motivation to change vary over time for anyone coping with an unhealthy habit, but often mentally ill people have the added burden of being unable to reliably recall their intentions and commitments to change. Frontal temporal impairments are associated with a phenomenon referred to as “forgetting to remember,” which may make it difficult for patients to recall commitments to change or to use coping skills.

Another constraint on change is related to the marked **social impairment** that also often goes along with a mental disorder. People with schizophrenia are often unable to fulfill basic social roles, they have difficulty initiating and maintaining conversations, and they frequently are unable to achieve goals or have their needs met in situations requiring social interaction.

However, existing treatment models do not adequately account for the specific learning and performance deficits that are characteristic of mentally ill people. HELPS has developed a treatment approach that takes into account the unique deficits in motivation, cognitive ability, and social skills associated with mental disorder.

MI therapists would do well to remember, however, that motivational interviews are only the first step in helping people actualize their goals. Because the patient determines that pursuing a specific goal would yield far more benefits than costs does not mean that the goal will be achieved. The person may suffer several disabilities related to the psychiatric disorder that impede achieving this goal. Once motivated to accomplish a specific goal, the person may need to avail himself/herself of several other psychosocial interventions, including education and skills training for example.

Based on experiences adapting Motivational Interviewing (MI) for people with a mental disorder, we offer the following recommendations for MI-therapists:

- We recommend using the collaborative, respectful, and evocative style of MI to guide interactions intended to improve therapeutic engagement and adherence. This approach is consistent with

trends supporting empowerment and self-determination in the treatment of persons with severe and persistent mental illness.

- MI group sessions should be done in a small-group format, with six to eight participants, to ensure sufficient individual attention and opportunities to rehearse skills within the session. The 40 to 60-minute sessions are held first once a week, later with longer distance (“booster sessions”), for approximately six months. This treatment duration allows time for participants to develop motivation to change and work toward their goals.
- Several steps are taken in consideration of cognitive deficits. Sessions should be highly structured, and there is a strong emphasis on behavioural rehearsal. The didactic material should be broken down into small units. Complex social repertoires, such as making friends or refusing poor nutrition (fast food), are divided into component elements, such as maintaining eye contact and being able to say no. Patients are first taught to perform the elements, and then gradually learn to combine them. The optimal degree of structure versus client-centred approach in sessions will vary depending on the intrusiveness of symptoms of mental disorder or thought disorder. Cognitive and communication deficits may require that an MI intervention be adapted to the abilities of the patient.
- Often patients with a mental disorder have considerable difficulty with abstract concepts and in generalizing principles of action across situations. Rather than teaching generic problem solving skills and coping strategies that can be adapted to a variety of situations, we focus on specific skills that are effective for handling a few key high-risk situations.
- Use is made of learning aides, such as handouts, flip charts or whiteboards, worksheets, and memo cards for example, to reduce the requirements on memory and attention.
- We recommend to not pressure patients to set any goals about a specific unhealthy behaviour when they enter the program. Rather, we recommend first attempt to engage them in the program. Reason for that is that a factor that deters many patients from committing in changing behaviour is low self-efficacy based on a long history of failure in achieving any goals. Consequently, first attempt to enhance a sense of efficacy by building the experience of success into the program. Patients achieve success in learning skills that are directed at starting conversations and refusing unreasonable requests. Only then is the focus shifted to social situations involving the patients’ unhealthy behaviour. Hence, when we do help them to set goals, they have already had some success in practicing some of the skills needed to achieve their goals. The content of the sessions on coping skills and relapse prevention based on social learning theory.
- The presence of psychotic symptoms should not automatically preclude consideration of MI with residents. Therapists can selectively reflect upon the relevant aspects of patient speech and redirect tangential statements back to the topic of changing a specific unhealthy behaviour. Although it is tempting to forgo efforts to use MI with patients who are very concrete or display

long response latencies, experiences of one's own shows that slowing the pace to wait for patient input is often rewarded. Similarly, soliciting patient input (even if it is limited) and providing some degree of choice (even if the options are provided by the MI-therapist) can occur even when a fairly structured therapy is dictated by clinical considerations.

- An important condition for using MI is the ability to establish rapport and a shared clinical focus. When this does not emerge out of the initial exercises, then use general MI style in the context of brief, unstructured flex sessions with the aim of uncovering topics of interest to the patient to facilitate future conversations.
- MI as described here is designed to improve physical health, and we encourage clinicians to consider the use of MI to advance these goals. MI would not be appropriate for clinical situations such as crisis management.
- Patients with co-morbid disorders may talk about recovery efforts using language that has been learned from previous courses of, e.g., alcohol treatment. When aphorisms such as "Just take it a day at a time" or "People, places, and things" emerge, MI techniques are quite useful to encourage elaboration and to ensure that the patient personalizes the meanings of such statements. Asking for a patient to explain what an "Alcoholics Anonymous-slogan" means or how it applies to him or her may reveal only a surface understanding of the concept; this presents an opportunity to help the patient make the link between the general principle and specific ways to apply it in his or her life.
- Assessment feedback and structured exercises are useful for initiating discussion about an unhealthy behaviour. These tools provide some structure around which to organize sessions and effectively trigger associations that can be explored in a less structured manner. Patients with schizophrenia or other major mental illnesses will vary in how comfortable they are in unstructured discussion about difficult aspects of their lives. When efforts to engage a person using only MI-style interviewing techniques (open-ended questions, reflections) result in limited success, we find that introducing a structured exercise often leads to productive conversation. Patients often specify the decisional balance and personal goals exercises as particularly helpful to them, and request copies of the worksheets to serve as concrete reminders.
- We have also learned that it is relatively easy to elicit change talk from patients with mental disorders and multiple life problems. However, it is harder to achieve behavioural follow-through. Patients with severe and persistent mental illnesses may have particular difficulties translating motivation into behaviour change. Statements of verbal intentions to change may not generalize to behaviour change if patients have skills deficits and/or low levels of self-efficacy. Thus, we recommend using motivational enhancement techniques in concert with behavioural contracting and skills training when a patient shows deficits in this area.

MI - NUTRITION



Motivational Interviewing – Adapted to the field of nutrition

Research manual drafted for the HELPS Project

This Manual is based on the Motivational Enhancement Therapy Manual (1995) by William Miller, Allen Zweben, Carlo DiClemente, and Roberto Rychtarik. NIH Publication No. 943723

PREFACE

Mi Nutrition is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change regarding healthy nutrition. This treatment strategy employs motivational strategies to mobilize the patient's own change resources. It may be delivered as an intervention in itself, may be used as a prelude or in addition to further treatment.

The Mi Nutrition manual is provided to the public to permit replication of the treatment procedures and approaches developed in the HELPS project. It is a research guide for clinical staff in applying an adapted Motivational Interviewing Style (MIS) people with problems concerning nutrition. This manual was prepared as part of the HELPS project funded by the European Commission (DG Sanco, Contract No 2006224).

Mi Nutrition is grounded in the clinical approach known as motivational interviewing (Miller, 1983; Miller & Rollnick, 1991). This document is an adaptation and extension of the Project MATCH MET therapist manual. Large portions of the basic text have been adopted and adapted directly from that public domain manual. New examples have been inserted to illustrate applications in the field of unhealthy nutrition behaviour habits.

This Mi Nutrition manual was prepared for MI offered in an inpatient and outpatient setting, although its application in residential settings for people with a mental disorder is also feasible. No claims are made regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MI are well-grounded in clinical and experimental research, the specific efficacy of Mi Nutrition as outlined in this manual remains to be tested.

The Mi Nutrition manual begins with an overview of Motivational Interviewing Style and a description of the general principles to be applied. Specific guidelines are provided for how to structure the MI sessions. Finally, recommendations are made for dealing with special problems that can arise in conducting MI.

INTRODUCTION

Motivational Interviewing - Adaption for Nutrition

Motivational Interviewing for changing poor diet habits include the fact that this behaviour generally involves modification rather than elimination, and reshaping rather than abstaining. Whereas there is generally no “quit day”, there may be concrete behavioural targets such as eating five servings of fruits and vegetables per day or reaching a daily caloric limit.

Changes in the field of nutrition must be long-term, if not for a life time, so that they are effective on the physical health status of a patient (e.g. reducing saturated-fat intake for a hyperlipidemic individual). Thus, ambivalence may centre on the long-term burden of change.

Motivational Interviewing for this target group should focus on helping them come to grips with the chronic nature of their condition, as well as identify ways to reduce what can be perceived as an overwhelming burden. Moreover, giving up or reducing the intake of favourite foods (fast food, sweets, cookies, and cakes) or reducing preferred tastes (salty meals) is often perceived as unpleasurable or a sacrifice, and such change can manifest similar to withdrawal. Thus, a key goal for a motivational interviewing counsellor may be to help an individual reframe their change in positive terms – for example, what is gained versus what is lost – as well as to conceptualize their change in other than hedonic terms: for example, the effect on or the reduced anxiety about their health risk rather than focusing on the taste of broccoli.

Motivation for Change

There are six core elements which are active ingredients of the relatively brief interventions that have been shown by research to induce change, summarized by the acronym **FRAMES**:

FEEDBACK of personal risk or impairment

Emphasis on personal **RESPONSIBILITY** for change

Clear **ADVICE** to change

A **MENU** of alternative change options

Therapist **EMPATHY**

Facilitation of patient **SELF-EFFICACY** or optimism

These therapeutic elements are consistent with a larger review of research on what motivates change (Miller, 1985; Miller & Rollnick, 1991).

Stages of Change

Prochaska and DiClemente (1982, 1984, 1985, 1986) have described a transtheoretical model of how people change behaviours, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviours. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages have been identified in this model (Prochaska & DiClemente, 1984, 1986).

Individuals who are not considering change in their problem behaviour are described as being in **PRECONTEMPLATION**. The **CONTEMPLATION** stage entails the person's beginning to consider both the existence of a problem and the feasibility and costs of changing the problem behaviour. As this individual progresses, he or she moves on to the **DETERMINATION** stage where the decision is made to take action and change. Once the individual begins to modify the problem behaviour, he or she enters the **ACTION** stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to **MAINTENANCE** or sustained change. If these efforts fail, a **RELAPSE** occurs, and the individual begins another cycle. The ideal path is progress directly from one stage to the next until maintenance is achieved. For most people with specific unhealthy nutrition behaviour patterns, however, the process to healthy nutrition habits involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process. Several revolutions through this cycle of change are common before the individual maintains change successfully.

From a stages-of-change perspective, the Mi approach addresses where the patient is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the MI therapist, the contemplation and determination stages are most critical. The objective is to help patients consider seriously two basic issues. The first is, how much of a diet problem poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of unhealthy diet habits toward change is essential for movement from contemplation to determination. Secondly, the patient in contemplation assesses the possibility and the costs/benefits of changing the unhealthy nutrition behaviour patterns.

Patients consider whether they will be able to make a change, and how that change will impact their lives.

In the determination stage, patients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their nutrition style in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the MI therapist to empathize with the patient, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

MI is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in unhealthy diet behaviours. It draws on motivational principles that have been derived from both experimental and clinical research. The motivational approach is well supported by clinical trials: its overall effectiveness compares favourably with outcomes of alternative treatments, and when cost-effectiveness is considered, the MI strategy fares well indeed in comparison with other approaches (Holder et al., 1991).

CLINICAL CONSIDERATIONS

Rationale and Basic Principles

The MI approach begins with the assumption that the responsibility and capability for change lie within the patient. The therapist's task is to create a set of conditions that will enhance the patient's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the patient's inner resources. MI seeks to support *intrinsic* motivation for change, which will lead the patient to initiate, persist in, and comply with behaviour change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self-Efficacy

Express Empathy

The MI therapist seeks to communicate great respect for the patient. Communications that imply a superior/inferior relationship between therapist and patient are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The patient's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the patient who can decide to change and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MI is listening rather than telling. Persuasion is gentle, subtle, always with the assumption that change is up to the patient. The power of such gentle, non-aggressive persuasion has been widely recognized in clinical writings. Reflective listening (accurate empathy) is a key skill in motivational interviewing. It communicates an acceptance of patients as they are, while also supporting them in the process of change.

Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The MI approach seeks to enhance and focus the patient's attention on such discrepancies with regard to unhealthy nutrition habits. In certain cases (e.g., the "precontemplators" in Prochaska and DiClemente's model) it may be necessary first to develop such discrepancy by raising the patient's awareness of the adverse personal consequences of his or her poor diet habits. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy and regain emotional equilibrium. In other cases, the patient enters treatment in a later "contemplation" stage, and it takes less time and effort to move the patient along to the point of determination for change.

Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the patient's discomfort but do not alter unhealthy food intake and nutritional habits and related risks. An unrealistic (from the patient's perspective) attack on his or her unhealthy nutritional behaviour patterns tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand. The MI style explicitly avoids direct argumentation, which tends to evoke resistance. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the patient to see accurately the consequences of unhealthy nutritional behaviour habits, and to begin devaluing the perceived positive aspects of unhealthy food intake. When MI is conducted properly, it is the patient and not the therapist who voices the arguments for change (Miller & Rollnick, 1991).

Roll with Resistance

How the therapist handles patients "resistance" is a crucial and defining characteristic of the MI approach. MI strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting patient perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the patient rather than provided by the therapist. This approach for dealing with resistance will be described in more detail later.

Support Self-efficacy

A person who is persuaded that he or she has a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described *self efficacy* as a critical determinant of behaviour change. Self-efficacy is, in essence, the belief that one *can* perform a particular behaviour or accomplish a particular task. In this case, the patient must be persuaded that it is possible to change his or her own unhealthy diet habits and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an overall optimistic nature that is crucial here. Rather, it is the patient's specific belief that he or she can change the poor diet problem. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort, without changing behaviour. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

MI emphasizes the patient's personal choice regarding future eating and nutritional behaviour patterns. As the MI approach views ambivalence as a normal stage of change, an MI therapist meets resistance with reflection rather than argumentation and emphasizes the patient's ability to change (self-efficacy). The MI therapist builds motivation and elicits ideas from the patient as to how change might occur.

Whereas skill training strategies implicitly assume readiness to change, MI focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature. Once such a motivational shift has occurred, however, the ordinary resources of the individual may well suffice. For many individuals a skill training approach may be inefficacious precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller & Brown, 1991). However, MI is not incompatible with skills trainings.

PRACTICAL STRATEGIES

Phase 1: Building Motivation for Change

Motivational counselling can be divided into two major phases: (1) building motivation for change, and (2) strengthening commitment to change (Miller & Rollnick, 1991). The early phase of MI focuses on developing the patient's motivation to make a change in his or her nutritional behaviour habits. Patients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family or legal authorities. Most patients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

This may be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989). One side of the seesaw favours status quo (e.g., continued poor diet as before), whereas the other favours change. The former side of the decisional balance is weighed down by perceived positive benefits from unhealthy nutritional habits and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's diet style, and feared consequences of continuing unchanged. Your task is to shift the balance of weight in favour of change. Eight strategies toward this end (Miller & Rollnick, 1991) are outlined in this section.

1. Eliciting Self-Motivational Statements

The positive side of the coin here is that the MI therapist seeks to elicit from the patients certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983). These include statements of:

- being open to input about poor diet behaviour patterns and effects
- acknowledging real or potential problems related to unhealthy nutrition
- expressing a need, desire, or willingness to change
- expressing optimism about the possibility of change.

There are several ways to elicit such statements from patients. One is to ask for them directly, via open-ended questions. Some examples: I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your nutritional behaviour patterns. Tell me about these. Tell me a little about your food intake and

eating habits. What do you like most about the foods you eat? What is positive about these foods for you? And what is the other side? What are your worries about eating these foods and your eating habits? Tell me what you've noticed about your eating habits. How have they changed over time? What things have you noticed that concern you, that you think could be problems, or might become problems? What have other people told you about your food choices and eating habits? What are other people worried about? What makes you think that you may need to make a change in your diet behaviour?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?", etc. If it gets bogged down, you can inventory general areas such as those contained in the Worksheet "What is your nutrition style?". This sheet can be used as a structured inquiry. Here are some areas you should include:

Amount and tolerance - Is the patient's food intake increasing? Does the patient seem to need larger portion sizes to experience the same effect as before (e.g. decreasing emotional distress), or to tolerate larger portion sizes without showing much effect?

Behaviour - Has the unhealthy diet behaviour caused trouble with the social environment (e.g. taking away foods out of the residents' refrigerator which belong others; problems with friends and family due to the increase in weight?), neglect of responsibilities, inconveniences like having to move, financial problems, or embarrassing behaviour (e.g. eating extremely fast)?

Coping - Is the patient using foods to cope with problems and day to day difficulties? How well does it work in reducing (versus escaping) problems?

Dependence - How dependent is the patient on foods and eating? Is there a feeling of pressure to have to eat or a daily greed for sweets?

Emotional Health - How does it affect the patient's emotions? Does the person feel ashamed, guilty, out of control because of his or her diet habits?

Family - What effects does poor diet behaviour patterns have on the patient's family?

Feeling Good About Self (Self-Esteem) - How does the unhealthy nutrition style and its consequences affect the patient's self-concept?

Physical Health - Have the poor eating habits contributed to illness or physical problems (e.g. diabetes, increased blood pressure, pain in the knees)?

Important Relationships - How do poor diet habits affect the patient's relationships with loved ones and friends?

Job - How does the unhealthy nutritional style and its consequences affect the patient's employment?

Key People - What do key people in the patient's life think about his or her unhealthy nutritional style?

Loving Relationships and Sexuality - How do the poor diet habits impact the patient's physical attractiveness, sexual drive, and sexual relationships?

Mental Abilities - Have the eating habits affected the person's ability to concentrate?

2. Listening with Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to patients' statements. The therapeutic skill of accurate empathy (active listening, reflection, understanding) is an optimal response within the MI strategy.

In popular conceptions, empathy is thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the patient is saying, then reflects it back to the patient, often in a slightly modified or reframed form. Acknowledgment of the patient's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke patient resistance; (2) it encourages the patient to keep talking and exploring the topic; (3) it communicates respect and caring, and builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the patient means; and (5) it can be used to reinforce ideas expressed by the patient.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the patient has said, and passing over others. In this way, patients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the patient to elaborate the reflected statement.

Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favour of continued exploration of the patient's own processes. It may be of further help to contrast reflective with other kinds of possible therapist responses to some patient statements:

PATIENT: I guess I do eat too much sometimes, but I don't think I have a *problem* with nutrition and my body weight, and I do not feel fat.

CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .

QUESTION: Why do you think you don't have a problem?

REFLECTION: So on the one hand you can see some reasons for concern, *and* you really don't want to be labeled as "having a problem."

PATIENT: My friend is always telling me that I am eating too much and always wrong things.

JUDGING: What's wrong with that? She probably has some good reasons for thinking so.

QUESTION: Why does she think that?

REFLECTION: And that really annoys you.

PATIENT: If I stop eating sweets and cakes, what am I supposed to do for friends?

ADVICE: I guess you'll have to get yourself some new ones.

SUGGESTION: Well, you could just tell your friends that you don't eat anymore sweets and cakes together with them, but you still want to see them.

REFLECTION: It's hard for you to imagine living without cakes and cookies.

This style of reflective listening is to be used throughout MI. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to patient statements. As the following sections indicate, however, the MI therapist also uses a variety of other strategies.

Finally, it should be noted here that selective reflection *can* backfire. For a patient who is ambivalent, reflection of one side of the dilemma ("So you can see that your unhealthy diet habits are causing you some physical health problems.") may evoke the other side from the patient ("Well, I don't think I have a *problem* really."). If this occurs, the

therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the patient's discrepancy. These may be joined in the middle by the conjunction "but" or "and", though we favour the latter to highlight the ambivalence:

Double-sided Reflection

You don't think that your unhealthy eating and nutrition habits (e.g. too much sugar, salt, and fat intake; gobbling down the food) are harming you seriously now, and at the same time you *are* concerned that your poor diet could affect your physical health later.

You really enjoy eating sweets and salty snacks and would hate to give that up, and you can also see that they are causing serious problems for your physical health, e.g. high blood pressure.

3. Questioning

The MI style does include some purposeful questioning as an important therapist response. Rather than *telling* the patient how he/she should feel, or what to do, the therapist *asks* the patient about his/her own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing.

4. Presenting Personal Feedback

The first MI session should always include feedback to the patient from the pre-treatment assessment. This is done in a structured way, providing patients with a written report of their results (Worksheet "What is your nutrition style?"), and comparing these with normative ranges. To initiate this phase, give the patient the worksheet "What is your nutrition style?", retaining a copy for your own reference and the patient's file. Go through the worksheet step by step, explaining each item of information, pointing out the patient's score, and comparing it with the normative data provided. A very important part of this process is your own monitoring of and responding to the patient during the feedback. Observe the patient as you provide personal feedback. Allow time spaces for the patient to respond verbally. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

5. Affirming the Patient

You should also seek opportunities to affirm, compliment, and reinforce the patient sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting patient self-esteem.

Statements for example:

- I appreciate your hanging in there through this feedback, which must be pretty rough for you.
- I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
- You really have some good ideas for how you might change.
- You have taken a big step today and I really respect you for it.

6. Handling Resistance

Patient resistance is a legitimate concern. Failure to comply with a therapist's instructions, and resistant behaviours within treatment sessions (e.g., arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some patient behaviours that have been found to be predictive of poor treatment outcome:

Interrupting : cutting off or talking over the therapist

Arguing: challenging the therapist, discounting the therapist's views, disagreeing, hostility

Sidetracking : changing the subject, not responding, not paying attention

Defensiveness: minimizing or denying the problem, excusing one's own behaviour, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

An important goal in MI style is to *avoid* evoking patient resistance (anti-motivational statements). How you *respond* to resistant behaviours is one of the defining characteristics of MI.

A first rule of thumb is never meet resistance head-on. Certain kinds of reactions are likely to exacerbate resistance, back the patient further into a corner, and elicit anti-motivational statements from the patient.

These therapist responses include:

- Arguing, disagreeing, challenging
- Judging, criticizing, blaming
- Warning of negative consequences
- Seeking to persuade with logic or evidence
- Interpreting or analyzing the "reasons" for resistance
- Confronting with authority
- Using sarcasm or incredulity

Even direct questions as to *why* the patient is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the patient further defence of the anti motivational position, and leave you in the logical position of counter argument. If you find yourself in the position of arguing with the patient to acknowledge a problem and the need for change, then shift your strategies.

Remember that you want the *patient* to make self-motivational statements (basically, "I have a problem" and "I need to do something about it"), and if you defend these positions yourself it may evoke the opposite from the patient. Here are several strategies for deflecting resistance:

- **Simple reflection.** One strategy is simply to reflect what the patient is saying. This sometimes has the effect of eliciting the opposite, and balancing the picture.
- **Reflection with amplification.** A modification is to reflect, but exaggerate or amplify what the patient is saying to the point where the patient is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.
- **Double-sided reflection.** The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a patient offers a

resistant statement, reflect it back with the other side (based on previous statements in the session).

PATIENT: But I can't just stop eating cakes and cookies. I mean, all of my friends eat sweet things in our tea time meetings!

THERAPIST: You cannot imagine not eating unhealthy food like cakes and biscuits while your friends do so, and at the same time you're worried about how it's affecting your physical health.

- **Shifting focus.** Another strategy is to defuse resistance by shifting attention away from the problematic issue.

PATIENT: But I can't just stop eating cakes and cookies. I mean, all of my friends eat sweet things in our tea time meetings!

THERAPIST: You're getting way ahead of things. I'm not talking about your quitting here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing right now - going through your feedback - and later on we can worry about what, if anything, you want to do about it.

- **Rolling with resistance.** Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the patient back to a balanced or opposite perspective. This strategy can be particularly useful with patients who present in a highly oppositional manner, and who seem to reject every idea or suggestion.

PATIENT: But I can't just stop eating cakes and cookies. I mean, all of my friends eat sweet things in our tea time meetings!

THERAPIST: And it may very well be that when we're through, you'll decide that it's worth it to further eat sweets like cakes and cookies as you have been at the tea time meetings. It may be too difficult to make a change. That will be up to you.

7. Reframing

Reframing is a strategy whereby the therapist invites the patient to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said.

When a patient is receiving feedback that confirms the poor diet problems, a friend's reaction of "That's what I've been trying to tell you" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

Reframing can be used to help motivate the patient and so to deal with unhealthy nutritional behaviour habits. In placing current problems in a more positive or optimistic frame, the MI therapist hopes to communicate that the problem is solvable and changeable. In developing the reframe it is important to use the patient's own views, words, and perceptions about poor diet habits.

Some examples of interpretive reframes that can be utilized with patients are:

- **Food as reward.** "You may have a need to reward yourself on the evenings and the weekends for successfully handling stressful and difficult tasks during a day or the week."
→ The implication here is that there are alternative ways of rewarding oneself without consuming unhealthy food.
- **Food as a protective function.** "You don't want to impose additional stress on your family and friends by openly sharing concerns or difficulties in your life [give examples]. As a result, you carry all this yourself, and absorb tension and stress by eating too much and unhealthy food, as a way of trying not to burden your family."
→ The implication here is that the user has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides the emotional and unhealthy eating habits.
- **Food as an adaptive function.** "Your nutritional behaviour patterns can be viewed as a means of avoiding conflict or tension in your relationships. Your food intake tends to keep the *status quo*, to keep things as they are. It seems like you have been using foods to keep your relationships intact. Yet, you seem uncomfortable with this arrangement."
→ The implication is that the patient cares about the relationship and has been trying to keep it together, but needs to find more effective ways to do this.

The general idea in reframing is to place the problem behaviour in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change the problem*.

8. Summarizing

It is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a longer summary reflection of what the patient has said. It is especially useful to repeat and summarize the patient's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the patient. Such a summary serves the function of allowing the patient to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Along the way during a session, shorter "progress" summaries can be given. Here is an example of how you might offer a summary to a patient at the end of a first session:

Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you to tell me about your unhealthy nutrition behaviour, and you told me several things. You said that your sweets intake has been increasing rapidly, and you notice that you have a high tolerance for it. You've been spending a lot of money on sweets, fast foods and salty snacks, and you're worried that you could get physical problems, like diabetes or a high blood pressure included its consequences like cardiovascular problems for example. There have been some real somatic symptoms, and you're concerned about how all of this is affecting your body and physical health. On the feedback, you were somewhat surprised to learn that your sweets and salty snack consumption in general is very high compared to other residents in the facility. You have seen some signs that your poor diet is starting to damage you physically. I appreciate how open you have been to all this feedback, and I can see you have some real concerns now about your poor diet habits. Is that a pretty good summary? Did I miss anything?

Phase 2: Strengthening Commitment to Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation, and to help tip the patient's decisional balance in favour of change. A second major process in MI is to consolidate the patient's commitment to change, once sufficient motivation is present (Miller & Rollnick, 1991).

Timing is a key issue - knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente-Model,

this is the stage of *DETERMINATION*, when the balance of contemplation has tipped in favour of change, and the patient is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the patient's decision.

There are no universal signs of crossing over into the determination stage. Here are some changes you might observe (Miller & Rollnick, 1991):

- The patient stops resisting and raising objections
- The patient asks fewer questions
- The patient appears more settled, resolved, unburdened, or peaceful
- The patient makes self-motivational statements indicating a decision (or openness) to change ["I guess I need to do something about my food intake." "If I wanted to improve this, what could I do?"]
- The patient begins imagining how life might be after a change.

Here is a checklist of issues to assist you in determining a patient's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment:

- Has the patient missed previous appointments or cancelled prior sessions without rescheduling?
- If the patient was coerced into treatment, has the patient discussed with you his or her reactions to this involuntariness - anger, relief, confusion, acceptance, etc.?
- Does the patient show a certain amount of indecisiveness or hesitancy about scheduling future sessions?
- Is the treatment being offered quite different from what the patient has experienced or expected in the past; and if so, have these differences and the patient's reactions been discussed?
- Does the patient seem to be very guarded during sessions, or otherwise seem to be hesitant or resistant when a suggestion is offered?
- Does the patient perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the patient's uncertainties and ambivalence about diet habits

and change. It is also wise to delay any decision-making or attempts to obtain firm commitment to a plan of action.

For many patients, there may not be a clear point of decision or determination. Often people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a patient appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the patient has decided to change, there is no longer any need for Phase I strategies. Likewise you should proceed carefully with patients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment.

The following strategies are useful once the initial phase has been passed, and the patient is moving toward change.

Asking Key Questions

One useful strategy in making the transition from Phase 1 to Phase 2 is to provide the kind of summary statement described earlier, summing up all of the reasons for change that the person has given, while also acknowledging remaining points of ambivalence. At the end of this summary, ask a *key question* such as:

- What do you make of all this?
- Where does this leave you in terms of diet habits?
- What's your plan? What are you thinking you will do?
- I wonder what you're thinking about your nutrition behaviour at this point.
- Now that you're this far, I wonder what you might do about these concerns.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (Phase 1: building motivation) to strengthening commitment and negotiating a *plan* for change (Phase 2). Patients may initiate this transition by stating a need or desire to change, or by asking what he or she could do. Alternatively, you may trigger this transition with a key question.

Your goal during Phase 2 is to elicit from the patient some ideas and ultimately a plan for what to do about the patient's drug use. It is not your task at this point to prescribe a plan for *how* the patient should change, or to teach specific skills for doing so. The overall message is: "Only *you* can change your poor diet habits, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?"

Communicating Free Choice

An important and consistent message throughout MI is the patient's responsibility and freedom of choice. Reminders of this theme should be included during the commitment strengthening process:

Examples:

- It's up to you what you do about this.
- No one can decide this for you.
- No one can change your poor diet habits for you. Only you can do it.
- You can decide to continue with your unhealthy nutrition habits, or to make a change.

Consequences of Action and Inaction

A useful strategy is to ask the patient to anticipate what the result would be if the patient continued using as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the patient.

For a more complete picture, you could also discuss what the patient *fears* about changing. What might be the negative consequences of giving up the previous behaviour patterns, for example? What are the advantages of continuing to eat as before? Reflection, summarizing, and reframing are appropriate therapist responses. One possibility here is to construct a formal "decisional balance" sheet, by having the patient generate (and writing down) the pros and cons of change options. What are the positive

and negative aspects of continuing to eat as before? What are the possible benefits and costs of making a change?

Information and Advice

Often patients will ask for key information, as important input for their decisional process. In general, however, you should feel free to provide accurate, specific information that is requested by patients. It is often helpful to ask for the patient's response to any information that you provide: Does it make sense to you? Does that surprise you? What do *you* think about it?

Patients may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree.

For example:

- If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.
- I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

- I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life.
- I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

When it comes to "how to do," it is often best not to prescribe specific strategies or attempt to train specific skills at the outset. Instead try turning the challenge back to the patient:

- How do you think you might be able to do that?

- What might stand in your way?
- You'd have to be pretty creative [strong, clever, and resourceful] to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a pill that you can take once a day and it keeps you from overeating. How does it work?"). Accurate and specific information can be provided in such cases.

A patient may well ask for information that you do not have. Do not feel obliged to know all the answers. It is okay to say that you do not know it, but will find out. You can offer to research a question and get back to the patient at the next session.

The goal of change behaviour

The goal of change is, in fact, a choice that each patient must and does make for him/herself. Within the MI style, it is not up to you to "permit" or "let" or "allow" patients to make choices. The choice is theirs to make, and you cannot make it for them.

At the same time many patients, at least initially, find a suggested goal unacceptable, or view it as unattainable. Therapist insistence in such cases may only increase resistance and risk of drop-out. It is helpful here to keep in mind the emerging "harm reduction" perspective: basically, that any step in the right direction is a step in the right direction. What goals, then, can be considered as harm reduction? The more specific question here is: What kind of change(s) is the patient willing to pursue?

It is important to be clear, here, that you are not *advocating* continued unhealthy nutrition behaviour. Your overall goal in counselling is to help the patient move away from harmful poor diet and eating habits. In certain cases, you may feel particular responsibility to encourage a specific diet habit, if the patient appears to be leaning in a different direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MI. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . .").

Dealing with Resistance

The same principles used for defusing resistance in the first phase of MI therapy also apply here. Reluctance and ambivalence are not challenged directly, but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MI. One form of such statements is permission to continue unchanged:

- Maybe you'll decide that it's worth it to you to keep on using the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

- I wonder if it's really possible for you to continue your poor diet habits and still maintain your physical attractiveness, too.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2, to help in specifying the patient's action plan. You can use it as a format for taking notes as the patient's plan emerges. Do not start Phase 2 by filling out the CPW. Rather the information needed for the CPW should emerge through the motivational dialogue described above. This information can then be used as a basis for your recapitulation (see below).

Use the CPW as a guide, to ensure that you have covered these aspects of the patient's plan:

The changes I want to make are...

In what ways or areas does the patient want to make a change? Be specific. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviours).

The most important reasons why I want to make these changes are...

What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the patient?

The steps I plan to take in changing are...

How does the patient plan to achieve his/her goals? How could the desired change be accomplished? Within the general plan and strategies described, what are some specific, concrete first steps that the patient can take? When, where, and how will these steps be taken?

I will know that my plan is working if...

What does the patient hope will happen as a result of this change plan? What benefits could be expected from this change?

Some things that could interfere with my plan are...

Help the patient to anticipate situations or changes that could undermine the plan. What could go wrong? How could the patient stick with the plan despite these problems or setbacks?

Recapitulating

Toward the end of the commitment process, as you sense that the patient is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired. This may include a repetition of the reasons for concern uncovered in the Phase 1 (see "Summarizing"), as well as new information developed during Phase 2. Emphasis should be given to the patient's self-motivational statements, the patient's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

Let me see if I understand where you are. Last time we reviewed the reasons why you have been concerned about your poor diet habits. There were a number of these. You were concerned that your unhealthy food intake has contributed to somatic complaints and problems in your social environment. You were worried, too, about the amount of the money you have been spending on food, and the fact that your food intake and your overeating seem to be getting out of control. The accident that you had helped you to realize that it was time to do something about your nutrition behaviour habits, but I think you were still surprised when I gave you the feedback, just how much in danger for physical illness you were.

We've talked about what you might do about this, and you had different ideas at first. You thought you'd just change your eating behaviour on your own. We talked about what

the results might be if you tried different approaches. You were concerned that if you didn't make a sharp break or change with your eating habits, you'd probably slip right back into regular behaviour, and forget what we've discussed here. You agreed that that would be a risk. You didn't like the idea of attending a cooking workshop for people with weight problems because you were concerned that people would see you there with your overweight, even though, as we discussed, there is a strong principle of anonymity and presumably several of them are in a similar situation to you.

Where you seem to be heading now is toward trying out a period of a healthy nutrition style, for at least four weeks, to see how it goes and how you feel. You like the idea of spending more time with several other residents who have similar diet problems to you, so you can go and talk together about your experiences with your changed behaviour. You could do things together in the evenings or at weekends so as not to be alone and not to be at increased risk for emotional overeating. You also thought you would get involved again in some of the facility or community activities you used to enjoy during the day, or maybe look for a responsible task or a job to keep you busy. Do I have it right? What have I missed?

If the patient offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the patient's situation, as above, and responded to additional points and concerns raised by the patient, move toward getting a formal commitment to change. In essence, the patient is to commit verbally to take concrete, planned steps to bring about the needed change. The closing question (not necessarily in these words) is:

Are you ready, then, to commit yourself to do this?

As you discuss this commitment, also cover the following points:

- Clarify what, exactly, the patient plans to do. Give the patient the completed Change Plan Worksheet, and discuss it.
- Reinforce what the patient perceives to be likely benefits of making a change, as well as the consequences of inaction.

- Ask what concerns, fears, or doubts the patient may have, which might interfere with carrying out the plan.
- Ask what other obstacles might be encountered, which could divert the patient from the plan. Ask the patient to suggest how they could deal with these.
- Clarify the social environment's role in helping the patient to make the desired change.
- Determine what additional help the patient would like to have from you or from other treatment agencies. If you are terminating your treatment, remind the patient that there will be a follow-up interview to see how they are doing.

If the patient is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the patient the signed original, retaining a copy for your file.

Some patients are unwilling to commit themselves to a change goal or program. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the nutrition problem, you may ask the person to defer the decision until a later time. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing patients the opportunity to postpone such decision-making, is that the motivational processes will act more favourably on them over time. Such flexibility provides patients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the patient may feel coerced into making a commitment before she or he is ready to take action. In this case, a patient may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don't you think about it between now and our next session, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later I'm sure it will become clear to you what you want to do. OK?

It can be helpful in this way to express explicit understanding and acceptance of the patient's ambivalence, as well as confidence in his or her ability to resolve the dilemma.

Phase 3: Follow-Through Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the patient's commitment to change (Phase 2), MI focuses on follow-through. This may occur as early as the second session, depending upon the patient's pace of progress. Three processes are involved in follow-through:

- reviewing progress,
- renewing motivation, and
- redoing commitment.

It is also in Phase 3 that the need for further treatment or referral is assessed.

Reviewing Progress

Begin a follow-through session with a review of what has happened since your last session. Discuss with the patient what commitment and plans were made, and explore what progress the patient has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes ("Building Motivation for Change") can be used again here to renew motivation for change. The extent to which this is done will depend upon your judgment as to the patient's current commitment to change. This may be assessed by asking the patient what he/she remembers as the most important reasons for making a change in diet habits.

Redoing Commitment

The Phase 2 processes ("Consolidating Commitment to Change") can also be continued during follow-through. This may simply be a reaffirmation of the commitment made earlier. If the patient has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the patient's sense of autonomy and self-efficacy, an ability to carry out self-chosen goals and plans.

Further Treatment

Through the motivational enhancement processes described above, the patient may decide that he or she would like specific additional treatment to help in pursuing goals. The important Phase 3 task here is to clarify with the patient what goals are to be achieved through such treatment, and then to determine what type of treatment services are mostly likely to be effective in meeting these goals.

THE STRUCTURE OF MI SESSIONS

The preceding sections outlined the basic flow of MI from Phase 1 through Phase 3. This section will address issues involved in the planning and conduct of the MI sessions.

The Initial Session

Preparing for the First Session

The general intent is to provide the patient with objective feedback regarding his or her poor diet habits and related problems.

Presenting the Rationale and Limits of Treatment

Begin by explaining the nature of this approach. Here is an example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent a lot of time completing the questionnaires that we need, and we appreciate the time you put into that process. We'll make good use of that information today. I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing to be done here, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

After we have worked together for a few sessions you should have a better sense of what you want to do. If you decide that you would like to make some changes and want some consultation with that, I may be able to help, and we could work together. If you need other kinds of help or support, I'll refer you. Do you have any questions about what we'll be doing? After this introduction, start the first session with a brief structuring of the first session.

Tell the patient that you will be giving them feedback from the pre-treatment questionnaires and interviews, but first you want to understand better how they see their (= the patient's) situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening with Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Patient," "Handling Resistance," and "Reframing" are also quite appropriate here. When you sense that you have elicited the major themes of concern from the patient, offer a summary statement (see "Summarizing"). If this seems acceptable to the patient, indicate that the next step is for you to provide feedback from the patient's initial assessment. Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session.

Whenever you do complete the feedback process, ask for the patient's overall response. One possible query would be:

- I've given you quite a bit of information here, and at this point I wonder what you make of all this, and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected, and used as a bridge to the next phase of MI.

After obtaining the patient's responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process, and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MI: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the patient [see "Recognizing Change Readiness"], begin eliciting thoughts, ideas, and plans for what might be done to address the problem [see "Discussing a Plan"]. During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the patient what are perceived to be the possible benefits of action, and the likely negative consequences of inaction [see "Consequences of Action"]. These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to make a change) and given to the patient. The basic patient-centred stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly, is to be maintained throughout this and all MI sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard [see "Asking for Commitment"]. It can be helpful to write down the patient's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the patient. Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a patient may drop out of treatment rather than "go back on" the agreement.

Ending the (First) Session(s)

Always end the (first) session(s) by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the sessions presenting feedback and dealing with concerns or resistance. In other cases, the patient will be well along toward determination, and you may be into Phase II (strengthening commitment) strategies by the end of the session. The speed with which this session proceeds will depend upon the patient's current stage of change. Where possible, it is desirable to elicit some patient self motivational statements about change within the first session, and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the patient will do and what changes will be made (if any) between the first and second sessions. Don't hesitate to move toward commitment to change in the first session if this seems appropriate. On the other hand, don't feel pressed to do so. Premature commitment is ephemeral, and pressuring a patient toward change before he or she is ready will evoke resistance and undermine the MI process.

Missed Appointments

When a patient misses a scheduled appointment, respond immediately and cover the following basic points:

- Clarify the reasons for the missed appointment
- Affirm the patient - reinforce for having come
- Express your eagerness to see the patient again, and encouragement to continue
- Briefly mention serious concerns that emerged, and your appreciation (as appropriate) that the patient is exploring these
- Express your optimism about the prospects for change, and for benefit to the patient
- Ask whether there are any questions that you can answer for the patient
- Reschedule the appointment

If no reasonable explanation is offered for the missed appointment (e.g., illness), explore with the patient whether the missed appointment might reflect any of the following:

- uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)
- ambivalence about making a change
- frustration or anger about having to participate in treatment (particularly with patients coerced into entering the program)

Handle such concerns in a manner consistent with MI (e.g., with reflective listening, reframing).

Indicate that it is not surprising, in the beginning phase of consultation, for a person to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the patient to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any resistance that is encountered. Affirm the patient for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the patient in this regard. Reschedule the appointment. Research indicates that a prompt note and telephone call significantly increases the likelihood that the patient will return.

Follow-Through MI Sessions

The **second session** should not be more than a week later. It should begin with a brief summary of what transpired during the first session. Then proceed with the MI process, picking up where you left off. Continue with the patient's personal feedback from assessment, if this was not completed during the first session. Proceed toward Phase II strategies and commitment to change, if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with follow-through procedures.

Begin each session with a discussion of what has transpired since the last session, and a review of what has been accomplished in previous sessions. Specific use is made in each session of the follow-through strategies outlined earlier: (1) reviewing progress; (2) renewing motivation, and (3) redoing commitment.

Complete each session with a summary of where the patient is at present (e.g., the patient's reasons for concern, the main themes of the feedback, the plan that has been negotiated - see "Recapitulation"), eliciting the patient's perceptions of what steps should be taken next. The plan for change (if previously negotiated) can be reviewed, revised, and (if previously written down) rewritten. During follow-through sessions, be careful not to assume that ambivalence has been resolved, and that commitment is firm. It is safer to assume that the patient is still ambivalent, and to continue using the motivation-building strategies of Phase I, as well as the commitment-strengthening strategies of Phase II.

There should be a clear sense of continuity of care. MI sessions should be presented as progressive consultations, and as continuous with subsequent treatment and (research) follow-up sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions (including the research follow-ups) serve as periodic check-ups of progress toward change. It can be helpful during follow-through sessions to discuss specific situations that have occurred since the last session.

Sessions 3 and 4 are to be scheduled for weeks 3 and 4, respectively. Further sessions can be scheduled as "booster" sessions to reinforce the motivational process.

In case of several weeks lapse between sessions, you could use 5-minutes-talks as boosters and you should telephone the patient a few days before the scheduled appointment. This expresses continued active interest in your patient and serves as a reminder to them. Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where your patient is at present, eliciting the patient's perceptions of what steps should be taken next.

During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the patient is still ambivalent and to continue using the motivation building strategies.

Transition or Referral

When a clear change plan develops, the next step is to determine what, if any, additional treatment or consultation the patient would like to have in support of change (e.g. skills training). If you are personally able to provide some or all of the desired treatment,

proceed. If not, help the patient to identify the appropriate treatment resources and make the referral. (Whenever possible, make the referral call personally from your office while the patient is present, and make a specific appointment for the patient.)

Termination

Formal termination of the MI phase is generally accomplished by a final recapitulation of the patient's situation and progress through the MI sessions. Your final summary should include these elements:

- Reviewing the most important factors motivating the patient for change, and reconfirming these self-motivational themes.
- Summarizing the commitments and changes that have been made thus far.
- Affirming and reinforcing the patient for commitments and changes that have been made.
- Exploring additional areas for change that the patient wants to accomplish in the future.
- Eliciting self-motivational statements for the maintenance of change, and for further changes.
- Supporting patient self-efficacy, emphasizing the patient's ability to change.
- Dealing with any special problems that are evident.
- Reminding the patient of the follow-up interview(s), emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

To consolidate motivation, it may be useful to ask the patient what would be the worst things that could happen if he/she went back to poor diet habits as before. Help the patient look to the immediate future, to anticipate upcoming events or potential obstacles that could contribute to relapse.

MI - NUTRITION



WORKSHEETS

What Is Your Nutrition Style?

How often do you...

(Never, Sometimes, Often)

- talk with your doctor about your nutrition plan?
- bake, barbecue, broil, boil, or steam instead of frying foods?
- choose nonfat, 1% or skim milk dairy products?
- read labels to choose foods low in fat and calories?
- wait until you are hungry before eating?
- stop eating as soon as you are full?
- save a portion of a restaurant meal for later?
- add a new fruit or vegetable to your diet?

If most of your checks are in the "Often" column – *Great!*

If most of your checks are in the "Never" or "Sometimes" columns, you may get a nutritional boost from changing your food habits.

Where would you choose to begin?

What I want to change:

The image displays 18 empty rounded rectangular boxes, organized into three main sections. The top section contains 10 boxes arranged in three rows: two in the first row, two in the second, and six in the third. The middle section contains 5 boxes arranged in two rows: two in the first and three in the second. The bottom section consists of a single horizontal row of 3 boxes. All boxes are identical in size and shape, with rounded corners and a thin black border.

Importance Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how important is it for you to make this change?

1 2 3 4 5 6 7 8 9 10



Not at all important

Extremely important

Confidence Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how confident are you that you could make this change?

1 2 3 4 5 6 7 8 9 10



Not at all confident

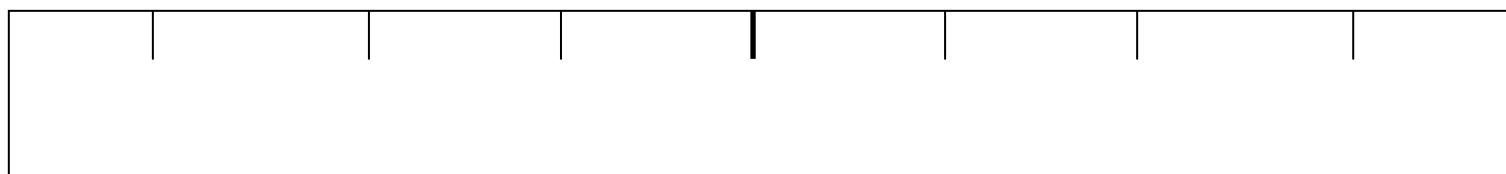
Extremely confident

Readiness Ruler

Name: _____

Date: _____

Change Behaviour:

Healthy Food**I am not ready****I am unsure****I am ready**

Readiness Ruler

Name: _____

Date: _____

Change Behaviour:

Weight Reduction

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

I am not ready**I am unsure****I am ready**

My Change of Behaviour Plan

Name: _____

Date: _____

I want to change the following behaviour:

The most important reason why I want to make this change is:

Further reasons why I want to make this change are:

My main goal for myself in making this change is:

To reach my goal I will do the following things:

The first 3 steps I plan to take in changing are:

I will know that my Change of Behaviour Plan is working when:

WEIGHING DECISIONS

When you weigh decisions, you are looking at the costs and benefits of whatever you are doing.

You may have been eating unhealthy food up to now because you believe the benefits of “delicious meals” outweigh the costs of quitting eating them.

Weighing decisions involves personal choices, your choices.

CONSEQUENCES

Consequences are the results of your nutrition behavioral changes. They can be both negative and positive. For example, in the short-term, sweets may help you feel more quiet in problem situation, but in the long run it could negatively affect your health.

Several people are able to change nutrition behavior on their own, and when they are asked about what made them change, they often say that they just “thought about it.” People often do things as a result of the decisions they make. They evaluate the consequences of their change behavior (decisional balance) before making the final decision to change.

This is exactly what you can do!

Think of a weight scale with the costs (negatives) of your nutrition behavior on one side, and the benefits (positives) on the other side. If the costs and benefits are pretty equal, there is nothing compelling you to change. If you keep adding weights to either side of the scale, an

imbalance will occur. To change, you need to tip the scale. You need to personally evaluate your nutritional behavior patterns so the negatives of your eating habits outweigh the positives.

This process is called decisional balancing.

We do it all the time: weighing the pros and cons of change. For example, people weigh the pros and cons of making changes in their jobs and their relationships. Making decisions about whether to quit eating unhealthy food or not, is the same as making decisions about other areas in your life.

THINKING ABOUT YOUR NUTRITION

In thinking about your eating food habits, ask yourself:

What do I stand to lose and gain by continuing to eating unhealthy food?
What role do nutrition play in my life?

At some point, you may have received real benefits from your nutrition behavior – a sense that you “fit in” among friends who like fast food, stress reduction, relaxation – However, since you are now reading this, you are reconsidering these benefits and focusing on the costs of your behavior.

DECISION TO CHANGE

One of the things that can help you clarify your thoughts about nutrition is to list all the benefits and costs of unhealthy food. This exercise is intended to help you think about what is involved in your decision to change. Remember that it is **your decision** to change! You are the one who must decide what it will take for you to tip the scale in favor of change.

**Good things about your
actual diet behavior**

**Bad things about your
actual diet behavior**

**Good things about eating
more healthy food**

**Bad things about eating
more healthy food**

My Change of Behaviour Plan

- Hooks and Obstacles

Name: _____

Date: _____

I want to change the following behaviour:

These are some possible hooks & obstacles that could impede my change:

How can I handle these hooks & obstacles?

MI – Physical Activity



Motivational Interviewing – Adapted to the field of physical activity

Research manual drafted for the HELPS Project

This Manual is based on the Motivational Enhancement Therapy Manual (1995) by William Miller, Allen Zweben, Carlo DiClemente, and Roberto Rychtarik. NIH Publication No. 943723

PREFACE

“MI - Physical Activity” (MI-PA) is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change regarding physical activity. This treatment strategy employs motivational strategies to mobilize the patient's own change resources. It may be delivered as an intervention in itself, may be used as a prelude or in addition to further treatment.

The “MI-PA manual” is provided to the public to permit replication of the treatment procedures and approaches developed in the HELPS project. It is a research guide for clinical staff in applying an adapted Motivational Interviewing Style (MIS) to people with problems concerning lack of exercise and physical activity. This manual was prepared as part of the HELPS project funded by the European Commission (DG Sanco, Contract No 2006224).

MI-PA is grounded in the clinical approach known as motivational interviewing (Miller, 1983; Miller & Rollnick, 1991). This document is an adaptation and extension of the Project MATCH MET therapist manual. Large portions of the basic text have been adopted and adapted directly from that public domain manual. New examples have been inserted to illustrate applications in the field of lack of exercise and physical activity.

This MI-PA manual was prepared for MI offered in an inpatient and outpatient setting, although its application in residential settings for people with a mental disorder is also feasible. No claims are made regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MI are well-grounded in clinical and experimental research, the specific efficacy of MI-PA as outlined in this manual remains to be tested.

The MI-PA manual begins with an overview of Motivational Interviewing Style and a description of the general principles to be applied. Specific guidelines are provided for how to structure the MI sessions. Finally, recommendations are made for dealing with special problems that can arise in conducting MI.

INTRODUCTION

Motivational Interviewing - Adaption for Physical Activity

Motivational Interviewing for changing physical activity patterns include the fact that this behaviour generally involves modification rather than elimination, and reshaping rather than abstaining. Whereas there is generally no “quit day”, there may be concrete behavioural targets such as exercising a specific number of days per week or minutes per day.

Changes in the field of physical activity must be long-term, if not for a life time, so that they are effective on the physical health status of a patient (e.g. normalized blood pressure or fitness of the cardiovascular system). Thus, ambivalence may centre on the long-term burden of change.

Motivational Interviewing for this target group should focus on helping them come to grips with the chronic nature of their condition, as well as identify ways to reduce what can be perceived as an overwhelming burden. Moreover, giving up or reducing preferred sedentary behaviours are often perceived as unpleasurable or a sacrifice, and such changes can manifest similar to withdrawal. Thus, a key goal for a motivational interviewing counsellor may be to help an individual reframe their change in positive terms – for example, what is gained versus what is lost – as well as to conceptualize their change in other than hedonic terms: for example, the effect on or the reduced anxiety about their health risk rather than focusing on the sweat at sports or difficulty in breathing when jogging.

Motivation for Change

There are six core elements which are active ingredients of the relatively brief interventions that have been shown by research to induce change, summarized by the acronym **FRAMES**:

FEEDBACK of personal risk or impairment

Emphasis on personal **RESPONSIBILITY** for change

Clear **ADVICE** to change

A **MENU** of alternative change options

Therapist **EMPATHY**

Facilitation of patient **SELF-EFFICACY** or optimism

These therapeutic elements are consistent with a larger review of research on what motivates change (Miller, 1985; Miller & Rollnick, 1991).

Stages of Change

Prochaska and DiClemente (1982, 1984, 1985, 1986) have described a transtheoretical model of how people change behaviours, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviours. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages have been identified in this model (Prochaska & DiClemente, 1984, 1986).

Individuals who are not considering change in their problem behaviour are described as being in **PRECONTEMPLATION**. The **CONTEMPLATION** stage entails the person's beginning to consider both the existence of a problem and the feasibility and costs of changing the problem behaviour. As this individual progresses, he or she moves on to the **DETERMINATION** stage where the decision is made to take action and change. Once the individual begins to modify the problem behaviour, he or she enters the **ACTION** stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to **MAINTENANCE** or sustained change. If these efforts fail, a **RELAPSE** occurs, and the individual begins another cycle. The ideal path is progress directly from one stage to the next until maintenance is achieved. For most people with specific sedentary behaviour patterns, however, the process to physical activity involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process. Several revolutions through this cycle of change are common before the individual maintains change successfully.

From a stages-of-change perspective, the MI approach addresses where the patient is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the MI therapist, the contemplation and determination stages are most critical. The objective is to help patients consider seriously two basic issues. The first is, how much of a problem "lack of exercise" poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of lack of exercise toward change is essential for movement from contemplation to determination. Secondly, the patient in contemplation assesses the possibility and the costs/benefits of changing preferred sedentary behaviour. Patients

consider whether they will be able to make a change, and how that change will impact their lives.

In the determination stage, patients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to modify their physical activity behaviour in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the MI therapist to empathize with the patient, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

MI is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in sedentary and lack of exercise behaviours. It draws on motivational principles that have been derived from both experimental and clinical research. The motivational approach is well supported by clinical trials: its overall effectiveness compares favourably with outcomes of alternative treatments, and when cost-effectiveness is considered, the MI strategy fares well indeed in comparison with other approaches (Holder et al., 1991).

CLINICAL CONSIDERATIONS

Rationale and Basic Principles

The MI approach begins with the assumption that the responsibility and capability for change lie within the patient. The therapist's task is to create a set of conditions that will enhance the patient's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the patient's inner resources. MI seeks to support *intrinsic* motivation for change, which will lead the patient to initiate, persist in, and comply with behaviour change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self-Efficacy

Express Empathy

The MI therapist seeks to communicate great respect for the patient. Communications that imply a superior/inferior relationship between therapist and patient are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The patient's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the patient who can decide to change and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MI is listening rather than telling. Persuasion is gentle, subtle, always with the assumption that change is up to the patient. The power of such gentle, non-aggressive persuasion has been widely recognized in clinical writings. Reflective listening (accurate empathy) is a key skill in motivational interviewing. It communicates an acceptance of patients as they are, while also supporting them in the process of change.

Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The MI approach seeks to enhance and focus the patient's attention on such discrepancies with regard to physical activity behaviour. In certain cases (e.g., the "precontemplators" in Prochaska and DiClemente's model) it may be necessary first to develop such discrepancy by raising the patient's awareness of the adverse personal consequences of his or her preferred sedentary behaviour. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy and regain emotional equilibrium. In other cases, the patient enters treatment in a later "contemplation" stage, and it takes less time and effort to move the patient along to the point of determination for change.

Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the patient's discomfort but do not alter sedentary habits and physical activity behaviour and related risks. An unrealistic (from the patient's perspective) attack on his or her unhealthy sedentary behaviour patterns tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand. The MI style explicitly avoids direct argumentation, which tends to evoke resistance. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the patient to see accurately the consequences of unhealthy sedentary behaviour and a lack-of-exercise-lifestyle, and to begin devaluing the perceived positive aspects of a preferred sedentary behaviour. When

MI is conducted properly, it is the patient and not the therapist who voices the arguments for change (Miller & Rollnick, 1991).

Roll with Resistance

How the therapist handles patients "resistance" is a crucial and defining characteristic of the MI approach. MI strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting patient perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the patient rather than provided by the therapist. This approach for dealing with resistance will be described in more detail later.

Support Self-efficacy

A person who is persuaded that he or she has a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described *self efficacy* as a critical determinant of behaviour change. Self-efficacy is, in essence, the belief that one *can* perform a particular behaviour or accomplish a particular task. In this case, the patient must be persuaded that it is possible to change his or her own unhealthy sedentary behaviour and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an overall optimistic nature that is crucial here. Rather, it is the patient's specific belief that he or she can modify the physical activity behaviour. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort, without changing behaviour. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

MI emphasizes the patient's personal choice regarding future physical activity patterns. As the MI approach views ambivalence as a normal stage of change, consequently an MI therapist meets resistance with reflection rather than argumentation and emphasizes the patient's ability to change (self-efficacy). The MI therapist builds motivation and elicits ideas from the patient as to how change might occur.

Whereas skill training strategies implicitly assume readiness to change, MI focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature. Once such a motivational shift has occurred, however, the ordinary resources of the individual may well suffice. For many individuals a skill training approach may be inefficacious

precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller & Brown, 1991). However, MI is not incompatible with skills trainings.

PRACTICAL STRATEGIES

Phase 1: Building Motivation for Change

Motivational counselling can be divided into two major phases: (1) building motivation for change, and (2) strengthening commitment to change (Miller & Rollnick, 1991). The early phase of MI focuses on developing the patient's motivation to make a change in his or her preferred sedentary behaviour. Patients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family or legal authorities. Most patients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

This may be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989). One side of the seesaw favours status quo (e.g., continued sedentary behaviour and lack of exercise lifestyle as before), whereas the other favours change. The former side of the decisional balance is weighed down by perceived positive benefits from unhealthy sedentary behaviour and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's exercise style, and feared consequences of continuing unchanged. Your task is to shift the balance of weight in favour of change. Eight strategies toward this end (Miller & Rollnick, 1991) are outlined in this section.

1. Eliciting Self-Motivational Statements

The positive side of the coin here is that the MI therapist seeks to elicit from the patients certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983). These include statements of:

- being open to input about "sedentary behaviour" and "lack of exercise" and effects

- acknowledging real or potential problems related to lack of exercise
- expressing a need, desire, or willingness to change
- expressing optimism about the possibility of change.

There are several ways to elicit such statements from patients. One is to ask for them directly, via open-ended questions. Some examples: I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your sedentary behaviour. Tell me about those. Tell me a little about your physical fitness and lack of exercise. What do you like most about the sedentary behaviour? What is positive about this lifestyle without physical activity for you? And what is the other side? What are your worries about doing no exercises and your sedentary behaviour? Tell me what you've noticed about your physical activity behaviour. How has it modified and changed over time? What things have you noticed that concern you, that you think could be problems, or might become problems? What have other people told you about your lack of exercise lifestyle? What are other people worried about? What makes you think that you may need to make a change in your physical activity behaviour?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?", etc. If it bogs down, you can inventory general areas such as those contained in the worksheet "What is your physical activity style?"

2. Listening with Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to patients' statements. The therapeutic skill of accurate empathy (active listening, reflection, understanding) is an optimal response within the MI strategy.

In popular conceptions, empathy is thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the patient is saying, then reflects it back to the patient, often in a slightly modified or reframed form. Acknowledgment of the patient's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke patient resistance; (2) it encourages the patient to keep talking and exploring

the topic; (3) it communicates respect and caring, and builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the patient means; and (5) it can be used to reinforce ideas expressed by the patient.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the patient has said, and passing over others. In this way, patients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the patient to elaborate the reflected statement.

Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favour of continued exploration of the patient's own processes. It may be of further help to contrast reflective with other kinds of possible therapist responses to some patient statements:

PATIENT: I guess I am quite lazy and don't do enough exercise, but I don't think I have a *problem* with my body and physical health, and I do not feel unhealthy.

CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .

QUESTION: Why do you think you don't have a problem?

REFLECTION: So on the one hand you can see some reasons for concern, *and* you really don't want to be labeled as "having a problem."

PATIENT: My friend is always telling me that I am too inactive and that my lack of exercise and lazy lifestyle will harm me physically one day.

JUDGING: What's wrong with that? She probably has some good reasons for thinking so.

QUESTION: Why does she think that?

REFLECTION: And that really annoys you.

This style of reflective listening is to be used throughout MI. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to patient statements. As the following sections indicate, however, the MI therapist also uses a variety of other strategies.

Finally, it should be noted here that selective reflection *can* backfire. For a patient who is ambivalent, reflection of one side of the dilemma ("So you can see that your lack of exercise and poor physical activity lifestyle are causing you some physical health problems.") may evoke the other side from the patient ("Well, I don't think I have a *problem* really."). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the patient's discrepancy. These may be joined in the middle by the conjunction "but" or "and", though we favour the latter to highlight the ambivalence:

Example for Double-sided Reflection

You don't think that your lack of physical activity behaviour is harming you seriously now, and at the same time you *are* concerned that your sedentary behaviour and lack of physical activity could affect your physical health later.

3. Questioning

The MI style does include some purposeful questioning as an important therapist response. Rather than *telling* the patient how he/she should feel, or what to do, the therapist *asks* the patient about his/her own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing.

4. Presenting Personal Feedback

The first MI session should always include feedback to the patient from the pre-treatment assessment. This is done in a structured way, providing patients with a written report of their results (Worksheet "What is your physical activity style?"), and comparing these with normative ranges. To initiate this phase, give the patient the worksheet "What is your physical activity style?", retaining a copy for your own reference and the patient's file. Go through the worksheet step by step, explaining each item, pointing out the patient's score, and comparing it with the normative data. A very important part of this process is your own monitoring of and responding to the patient during the feedback. Observe the patient as you provide personal feedback. Allow time spaces for the patient to respond verbally. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

5. Affirming the Patient

You should also seek opportunities to affirm, compliment, and reinforce the patient sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting patient self-esteem.

Statements for example:

- I appreciate your hanging in there through this feedback, which must be pretty rough for you.
- I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
- You really have some good ideas for how you might change.
- You have taken a big step today and I really respect you for it.

6. Handling Resistance

Patient resistance is a legitimate concern. Failure to comply with a therapist's instructions, and resistant behaviours within treatment sessions (e.g. arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some patient behaviours that have been found to be predictive of poor treatment outcome:

Interrupting : cutting off or talking over the therapist

Arguing: challenging the therapist, discounting the therapist's views, disagreeing, hostility

Sidetracking : changing the subject, not responding, not paying attention

Defensiveness: minimizing or denying the problem, excusing one's own behaviour, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

An important goal in MI style is to *avoid* evoking patient resistance (anti-motivational statements). How you *respond* to resistant behaviours is one of the defining characteristics of MI.

A first rule of thumb is never meet resistance head-on. Certain kinds of reactions are likely to exacerbate resistance, back the patient further into a corner, and elicit anti-motivational statements from the patient.

These therapist responses include:

- Arguing, disagreeing, challenging
- Judging, criticizing, blaming
- Warning of negative consequences
- Seeking to persuade with logic or evidence
- Interpreting or analyzing the "reasons" for resistance
- Confronting with authority
- Using sarcasm or incredulity

Even direct questions as to *why* the patient is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the patient further defence of the anti motivational position, and leave you in the logical position of counter argument. If you find yourself in the position of arguing with the patient to acknowledge a problem and the need for change, then shift your strategies.

Remember that you want the *patient* to make self-motivational statements (basically, "I have a problem" and "I need to do something about it"), and if you defend these positions yourself it may evoke the opposite from the patient. Here are several strategies for deflecting resistance:

- **Simple reflection.** One strategy is simply to reflect what the patient is saying. This sometimes has the effect of eliciting the opposite, and balancing the picture.
- **Reflection with amplification.** A modification is to reflect, but exaggerate or amplify what the patient is saying to the point where the patient is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.
- **Double-sided reflection.** The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a patient offers a

resistant statement, reflect it back with the other side (based on previous statements in the session).

PATIENT: But I can't start with physical activities. I simply have no time to go walking or jogging through the park in the middle of the day.

THERAPIST: You cannot imagine becoming physical active because of a lot of work or tasks during the day and therefore a lack of time, and at the same time you're worried about how it's affecting your physical health.

- **Shifting focus.** Another strategy is to defuse resistance by shifting attention away from the problematic issue.

PATIENT: But I can't start with physical activities. I simply have no time to go walking or jogging through the park in the middle of the day.

THERAPIST: You're getting way ahead of things. I'm not talking about your modifying here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing right now - going through your feedback - and later on we can worry about what, if anything, you want to do about it.

- **Rolling with resistance.** Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the patient back to a balanced or opposite perspective. This strategy can be particularly useful with patients who present in a highly oppositional manner, and who seem to reject every idea or suggestion.

PATIENT: But I can't start with physical activities. I simply have no time to go walking or jogging through the park in the middle of the day.

THERAPIST: And it may very well be that when we're through, you'll decide that it's worth it to further maintain your sedentary behaviour. It may be too difficult to make a change. That will be up to you.

7. Reframing

Reframing is a strategy whereby the therapist invites the patient to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said.

When a patient is receiving feedback that confirms the problems of sedentary behaviour and a "lack-of-exercise-lifestyle", a friend's reaction of "That's what I've been trying to tell you" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

Reframing can be used to help motivate the patient and so to deal with physical activity and exercise habits. In placing current problems in a more positive or optimistic frame, the MI therapist hopes to communicate that the problem is solvable and changeable. In developing the reframe it is important to use the patient's own views, words, and perceptions about poor physical activity behaviour and lack of exercise.

Some examples of interpretive reframes that can be utilized with patients are:

- **Sedentary behaviour as reward**

"You may need to reward yourself during the evenings or at weekends for successfully handling stressful and difficult tasks during the day or the week."

→ The implication here is that there are alternative ways of rewarding oneself (not only by sitting in front of the television).

- **Sedentary behaviour as an adaptive function**

"Your sedentary behaviour can be viewed as a means of avoiding conflict or tension in your relationships. Your sedentary behaviour tends to keep the *status quo*, to keep things as they are. It seems like you have been using inactivity to keep your relationships intact. Yet, you seem uncomfortable with this arrangement."

→ The implication is that the patient cares about the relationship and has been trying to keep it together, but needs to find more effective ways to do this.

The general idea in reframing is to place the problem behaviour in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change the problem*.

8. Summarizing

It is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a longer summary reflection of what the patient has said. It is especially useful to repeat and summarize the patient's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the patient. Such a summary serves the function of allowing the

patient to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Along the way during a session, shorter "progress" summaries can be given. Here is an example of how you might offer a summary to a patient at the end of a first session:

Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you to tell me about your physical activity behaviour and your lack of exercise, and you told me several things. You said that your physical inactivity has been increasing rapidly, and you notice that you enjoy doing nothing. You've been spending a lot of money on computer games and bus tickets, and you're worried that you could get physical problems, like breathlessness, diabetes or a high blood pressure including its consequences like cardiovascular problems for example. There have been some real somatic symptoms, and you're concerned about how all of this is affecting your body and physical health. On the feedback, you were somewhat surprised to learn that your sedentary behaviour in general is very extreme compared to the general population. You have seen some signs that your lack of exercise is starting to damage you physically. I appreciate how open you have been to all this feedback, and I can see you have some real concerns now about your lack of exercise behaviour. Is that a pretty good summary? Did I miss anything?

Phase 2: Strengthening Commitment to Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation, and to help tip the patient's decisional balance in favour of change. A second major process in MI is to consolidate the patient's commitment to change, once sufficient motivation is present (Miller & Rollnick, 1991).

Timing is a key issue - knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente-Model, this is the stage of *DETERMINATION*, when the balance of contemplation has tipped in favour of change, and the patient is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the patient's decision.

There are no universal signs of crossing over into the determination stage. Here are some changes you might observe (Miller & Rollnick, 1991):

- The patient stops resisting and raising objections
- The patient asks fewer questions
- The patient appears more settled, resolved, unburdened, or peaceful
- The patient makes self-motivational statements indicating a decision (or openness) to change ["I guess I have to do something against my sedentary behaviour." "If I wanted to improve my physical activity, what could I do?"]
- The patient begins imagining how life might be after a change.

Here is a checklist of issues to assist you in determining a patient's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment:

- Has the patient missed previous appointments or cancelled prior sessions without rescheduling?
- If the patient was coerced into treatment, has the patient discussed with you his or her reactions to this involuntariness - anger, relief, confusion, acceptance, etc.?
- Does the patient show a certain amount of indecisiveness or hesitancy about scheduling future sessions?
- Is the treatment being offered quite different from what the patient has experienced or expected in the past; and if so, have these differences and the patient's reactions been discussed?
- Does the patient seem to be very guarded during sessions, or otherwise seem to be hesitant or resistant when a suggestion is offered?
- Does the patient perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the patient's uncertainties and ambivalence about physical activity, lack of exercise, and change. It is also wise to delay any decision-making or attempts to obtain firm commitment to a plan of action.

For many patients, there may not be a clear point of decision or determination. Often people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part

upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a patient appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the patient has decided to change, there is no longer any need for Phase I strategies. Likewise you should proceed carefully with patients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment.

The following strategies are useful once the initial phase has been passed, and the patient is moving toward change.

Asking Key Questions

One useful strategy in making the transition from Phase 1 to Phase 2 is to provide the kind of summary statement described earlier, summing up all of the reasons for change that the person has given, while also acknowledging remaining points of ambivalence. At the end of this summary, ask a *key question* such as:

- What do you make of all this?
- Where does this leave you in terms of physical activity?
- What's your plan? What are you thinking you will do?
- I wonder what you're thinking about your sedentary behaviour at this point.
- Now that you're this far, I wonder what you might do about these concerns.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (Phase 1: building motivation) to strengthening commitment and negotiating a *plan* for change (Phase 2). Patients may initiate this transition by stating a need or desire to change, or by asking what he or she could do. Alternatively, you may trigger this transition with a key question.

Your goal during Phase 2 is to elicit from the patient some ideas and ultimately a plan for what to do about the patient's drug use. It is not your task at this point to prescribe a plan for *how* the patient should change, or to teach specific skills for doing so. The overall message is: "Only *you* can change your lack of exercise behaviour, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?"

Communicating Free Choice

An important and consistent message throughout MI is the patient's responsibility and freedom of choice. Reminders of this theme should be included during the commitment strengthening process:

Examples:

- It's up to you what you do about this.
- No one can decide this for you.
- No one can change your lack of exercise behaviour for you. Only you can do it.
- You can decide to continue with your sedentary behaviour, or to make a change.

Consequences of Action and Inaction

A useful strategy is to ask the patient to anticipate what the result would be if the patient continued as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the patient.

For a more complete picture, you could also discuss what the patient *fears* about changing. What might be the negative consequences of giving up the previous behaviour patterns, for example? What are the advantages of continuing to be physical inactive as before? Reflection, summarizing, and reframing are appropriate therapist responses. One possibility here is to construct a formal "decisional balance" sheet, by having the patient generate (and writing down) the pros and cons of change options. What are the positive and negative aspects of continuing as before? What are the possible benefits and costs of making a change?

Information and Advice

Often patients will ask for key information, as important input for their decisional process. In general, however, you should feel free to provide accurate, specific information that is requested by patients. It is often helpful to ask for the patient's

response to any information that you provide: Does it make sense to you? Does that surprise you? What do *you* think about it?

Patients may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree.

For example:

- If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.
- I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

- I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life.
- I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

When it comes to "how to do," it is often best not to prescribe specific strategies or attempt to train specific skills at the outset. Instead try turning the challenge back to the patient:

- How do you think you might be able to do that?
- What might stand in your way?
- You'd have to be pretty creative [strong, clever, and resourceful] to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a pill that you can take once a day and it keeps you physical fit. How does it work?"). Accurate and specific information can be provided in such cases.

A patient may well ask for information that you do not have. Do not feel obliged to know all the answers. It is okay to say that you do not know it, but will find out. You can offer to research a question and get back to the patient at the next session.

The goal of change behaviour

The goal of change is, in fact, a choice that each patient must and does make for him/herself. Within the MI style, it is not up to you to "permit" or "let" or "allow" patients to make choices. The choice is theirs to make, and you cannot make it for them.

At the same time many patients, at least initially, find a suggested goal unacceptable, or view it as unattainable. Therapist insistence in such cases may only increase resistance and risk of drop-out. It is helpful here to keep in mind the emerging "harm reduction" perspective: basically, that any step in the right direction is a step in the right direction. What goals, then, can be considered as harm reduction? The more specific question here is: What kind of change(s) is the patient willing to pursue?

It is important to be clear, here, that you are not *advocating* continued lack of exercise and sedentary behaviour. Your overall goal in counselling is to help the patient move away from harmful sedentary behaviour and lack of exercise habits. In certain cases, you may feel particular responsibility to encourage a specific physical exercise habit, if the patient appears to be leaning in a different direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MI. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . .").

Dealing with Resistance

The same principles used for defusing resistance in the first phase of MI therapy also apply here. Reluctance and ambivalence are not challenged directly, but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MI. One form of such statements is permission to continue unchanged:

- Maybe you'll decide that it's worth it to you to keep on using the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

- I wonder if it's really possible for you to continue sedentary behaviour and still maintain your physical fitness and attractiveness.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2, to help in specifying the patient's action plan. You can use it as a format for taking notes as the patient's plan emerges. Do not start Phase 2 by filling out the CPW. Rather the information needed for the CPW should emerge through the motivational dialogue described above. This information can then be used as a basis for your recapitulation (see below). Use the CPW as a guide, to ensure that you have covered these aspects of the patient's plan:

The changes I want to make are...

In what ways or areas does the patient want to make a change? Be specific. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviours).

The most important reasons why I want to make these changes are...

What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the patient?

The steps I plan to take in changing are...

How does the patient plan to achieve his/her goals? How could the desired change be accomplished? Within the general plan and strategies described, what are some specific, concrete first steps that the patient can take? When, where, and how will these steps be taken?

I will know that my plan is working if...

What does the patient hope will happen as a result of this change plan? What benefits could be expected from this change?

Some things that could interfere with my plan are...

Help the patient to anticipate situations or changes that could undermine the plan. What could go wrong? How could the patient stick with the plan despite these problems or setbacks?

Recapitulating

Toward the end of the commitment process, as you sense that the patient is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired. This may include a repetition of the reasons for concern uncovered in the Phase 1 (see "Summarizing"), as well as new information developed during Phase 2. Emphasis should be given to the patient's self-motivational statements, the patient's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

Let me see if I understand where you are. Last time we reviewed the reasons why you have been concerned about your sedentary behaviour, your physical inactivity and lack of exercise. There were a number of these. You were concerned that your sedentary lifestyle has contributed to somatic complaints. You were worried, too, about the amount of the money you have been spending on computer games and bus tickets, and about the general bad feeling with regard to your body. These had helped you to realize that it was time to do something about your physical activity, but I think you were still surprised when I gave you the feedback, about just how much danger for physical illness you were in.

We've talked about what you might do about this, and you had different ideas at first. You thought you'd just change your sedentary behaviour on your own. We talked about what the results might be if you tried different approaches. You were concerned that if you didn't make a sharp break or change, you'd probably slip right back into your "regular" sedentary behaviour, and forget what we've discussed here. You agreed that would be a risk. You didn't like the idea of attending a walking group outside your facility because you were concerned that you do not have appropriate communication and social skills, even though, as we discussed, there is a possibility to learn these skills.

Where you seem to be headed now is toward trying out a "period of physical activity", for four weeks at least, to see how it goes and how you feel. You like the idea of spending more time with several other residents with similar lack of exercise problems as you, so you can go and talk together about your experiences with your changed behaviour. You could do things together in the evenings or on weekends so as not to be alone and not to be at increased risk for inactivity and sedentary behaviour. You also thought you would get involved again in some of the facility or community activities you used to enjoy during the afternoon. Do I have it right? What have I missed?

If the patient offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the patient's situation, as above, and responded to additional points and concerns raised by the patient, move toward getting a formal commitment to change. In essence, the patient is to commit verbally to take concrete, planned steps to bring about the needed change. The closing question (not necessarily in these words) is:

Are you ready, then, to commit yourself to do this?

As you discuss this commitment, also cover the following points:

- Clarify what, exactly, the patient plans to do. Give the patient the completed Change Plan Worksheet, and discuss it.
- Reinforce what the patient perceives to be likely benefits of making a change, as well as the consequences of inaction.
- Ask what concerns, fears, or doubts the patient may have, which might interfere with carrying out the plan.
- Ask what other obstacles might be encountered, which could divert the patient from the plan. Ask the patient to suggest how they could deal with these.
- Clarify the social environment's role in helping the patient to make the desired change.
- Determine what additional help the patient would like to have from you or from other treatment agencies. If you are terminating your treatment, remind the patient that there will be a follow-up interview to see how they are doing.

If the patient is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the patient the signed original, retaining a copy for your file.

Some patients are unwilling to commit themselves to a change goal or program. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the “physical inactivity problem”, you may ask the person to defer the decision until a later time. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing patients the opportunity to postpone such decision-making, is that the motivational processes will act more favourably on them over time. Such flexibility provides patients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the patient may feel coerced into making a commitment before she or he is ready to take action. In this case, a patient may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don't you think about it between now and our next session, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later I'm sure it will become clear to you what you want to do. OK?

It can be helpful in this way to express explicit understanding and acceptance of the patient's ambivalence, as well as confidence in his or her ability to resolve the dilemma.

Phase 3: Follow-Through Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the patient's commitment to change (Phase 2), MI focuses on follow-through. This may occur as early as the second session, depending upon the patient's pace of progress. Three processes are involved in follow-through:

- reviewing progress,
- renewing motivation, and
- redoing commitment.

It is also in Phase 3 that the need for further treatment or referral is assessed.

Reviewing Progress

Begin a follow-through session with a review of what has happened since your last session. Discuss with the patient what commitment and plans were made, and explore what progress the patient has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes ("Building Motivation for Change") can be used again here to renew motivation for change. The extent to which this is done will depend upon your judgment as to the patient's current commitment to change. This may be assessed by asking the patient what he/she remembers as the most important reasons for making a change in sedentary behaviour.

Redoing Commitment

The Phase 2 processes ("Consolidating Commitment to Change") can also be continued during follow-through. This may simply be a reaffirmation of the commitment made earlier. If the patient has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the patient's sense of autonomy and self-efficacy, an ability to carry out self-chosen goals and plans.

Further Treatment

Through the motivational enhancement processes described above, the patient may decide that he or she would like specific additional treatment to help in pursuing goals. The important Phase 3 task here is to clarify with the patient what goals are to be achieved through such treatment, and then to determine what type of treatment services are mostly likely to be effective in meeting these goals.

THE STRUCTURE OF MI SESSIONS

The preceding sections outlined the basic flow of MI from Phase 1 through Phase 3. This section will address issues involved in the planning and conduct of the MI sessions.

The Initial Session

Preparing for the First Session

The general intent is to provide the patient with objective feedback regarding his or her sedentary behaviour and lack of physical activity and related problems.

Presenting the Rationale and Limits of Treatment

Begin by explaining the nature of this approach. Here is an example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent a lot of time completing the questionnaires that we need, and we appreciate the time you put into that process. We'll make good use of that information today. I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing to be done here, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

After we have worked together for a few sessions you should have a better sense of what you want to do. If you decide that you would like to make some changes and want some consultation with that, I may be able to help, and we could work together. If you need other kinds of help or support, I'll refer you. Do you have any questions about what we'll be doing?

After this introduction, start the first session with a brief structuring of the first session. Tell the patient that you will be giving them feedback from the pretreatment questionnaires and interviews, but first you want to understand better how they see their (= the patient's) situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening with Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Patient," "Handling Resistance," and "Reframing" are also quite appropriate here. When you sense that you have elicited the major themes of concern from the patient, offer a summary statement

(see "Summarizing"). If this seems acceptable to the patient, indicate that the next step is for you to provide feedback from the patient's initial assessment. Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session.

Whenever you do complete the feedback process, ask for the patient's overall response. One possible query would be:

- I've given you quite a bit of information here, and at this point I wonder what you make of all this, and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected, and used as a bridge to the next phase of MI.

After obtaining the patient's responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process, and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MI: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the patient [see "Recognizing Change Readiness"], begin eliciting thoughts, ideas, and plans for what might be done to address the problem [see "Discussing a Plan"]. During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the patient what are perceived to be the possible benefits of action, and the likely negative consequences of inaction [see "Consequences of Action"]. These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to make a change) and given to the patient. The basic patient-centred stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly, is to be maintained throughout this and all MI sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard [see "Asking for Commitment"]. It can be helpful to write down the patient's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the patient. Be careful, however, not to press prematurely for a commitment. If a plan is signed before

commitment is firm, a patient may drop out of treatment rather than "go back on" the agreement.

Ending the (First) Session(s)

Always end the (first) session(s) by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the sessions presenting feedback and dealing with concerns or resistance. In other cases, the patient will be well along toward determination, and you may be into Phase II (strengthening commitment) strategies by the end of the session. The speed with which this session proceeds will depend upon the patient's current stage of change. Where possible, it is desirable to elicit some patient self motivational statements about change within the first session, and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the patient will do and what changes will be made (if any) between the first and second sessions. Don't hesitate to move toward commitment to change in the first session if this seems appropriate. On the other hand, don't feel pressed to do so. Premature commitment is ephemeral, and pressuring a patient toward change before he or she is ready will evoke resistance and undermine the MI process.

Missed Appointments

When a patient misses a scheduled appointment, respond immediately and cover the following basic points:

- Clarify the reasons for the missed appointment
- Affirm the patient - reinforce for having come
- Express your eagerness to see the patient again, and encouragement to continue
- Briefly mention serious concerns that emerged, and your appreciation (as appropriate) that the patient is exploring these
- Express your optimism about the prospects for change, and for benefit to the patient
- Ask whether there are any questions that you can answer for the patient
- Reschedule the appointment

If no reasonable explanation is offered for the missed appointment (e.g., illness), explore with the patient whether the missed appointment might reflect any of the following:

- uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)
- ambivalence about making a change
- frustration or anger about having to participate in treatment (particularly with patients coerced into entering the program)

Handle such concerns in a manner consistent with MI (e.g., with reflective listening, reframing).

Indicate that it is not surprising, in the beginning phase of consultation, for a person to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the patient to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any resistance that is encountered. Affirm the patient for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the patient in this regard. Reschedule the appointment. Research indicates that a prompt note and telephone call significantly increases the likelihood that the patient will return.

Follow-Through MI Sessions

The **second session** should not be more than a week later. It should begin with a brief summary of what transpired during the first session. Then proceed with the MI process, picking up where you left off. Continue with the patient's personal feedback from assessment, if this was not completed during the first session. Proceed toward Phase II strategies and commitment to change, if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with follow-through procedures.

Begin each session with a discussion of what has transpired since the last session, and a review of what has been accomplished in previous sessions. Specific use is made in each session of the follow-through strategies outlined earlier: (1) reviewing progress; (2) renewing motivation, and (3) redoing commitment.

Complete each session with a summary of where the patient is at present (e.g., the patient's reasons for concern, the main themes of the feedback, the plan that has been negotiated - see "Recapitulation"), eliciting the patient's perceptions of what steps should be taken next. The plan for change (if previously negotiated) can be reviewed, revised, and (if previously written down) rewritten. During follow-through sessions, be careful not to assume that ambivalence has been resolved, and that commitment is firm. It is safer to assume that the patient is still ambivalent, and to continue using the motivation-building strategies of Phase I, as well as the commitment-strengthening strategies of Phase II.

There should be a clear sense of continuity of care.

MI sessions should be presented as progressive consultations, and as continuous with subsequent treatment and (research) follow-up sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions (including the research follow-ups) serve as periodic check-ups of progress toward change. It can be helpful during follow-through sessions to discuss specific situations that have occurred since the last session.

Sessions 3 and 4 are to be scheduled for weeks 3 and 4, respectively. Further sessions can be scheduled as "booster" sessions to reinforce the motivational process.

In case of several weeks lapse between sessions, you could use 5-minutes-talks as boosters and you should telephone the patient a few days before the scheduled appointment. This expresses continued active interest in your patient and serves as a reminder to them. Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where your patient is at present, eliciting the patient's perceptions of what steps should be taken next.

During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the patient is still ambivalent and to continue using the motivation building strategies.

Transition or Referral

When a clear change plan develops, the next step is to determine what, if any, additional treatment or consultation the patient would like to have in support of change (e.g. skills training). If you are personally able to provide some or all of the desired treatment, proceed. If not, help the patient to identify the appropriate treatment resources and

make the referral. (Whenever possible, make the referral call personally from your office while the patient is present, and make a specific appointment for the patient.)

Termination

Formal termination of the MI phase is generally accomplished by a final recapitulation of the patient's situation and progress through the MI sessions. Your final summary should include these elements:

- Reviewing the most important factors motivating the patient for change, and reconfirming these self-motivational themes.
- Summarizing the commitments and changes that have been made thus far.
- Affirming and reinforcing the patient for commitments and changes that have been made.
- Exploring additional areas for change that the patient wants to accomplish in the future.
- Eliciting self-motivational statements for the maintenance of change, and for further changes.
- Supporting patient self-efficacy, emphasizing the patient's ability to change.
- Dealing with any special problems that are evident.
- Reminding the patient of the follow-up interview(s), emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

To consolidate motivation, it may be useful to ask the patient what would be the worst things that could happen if he/she went back to sedentary behaviour and lack of physical activity as before. Help the patient look to the immediate future, to anticipate upcoming events or potential obstacles that could contribute to relapse.

MI – Physical Activity



WORKSHEETS

What Is Your Physical Activity Style?

How often do you...

(Never, Sometimes, Often)

- talk with your doctor about your physical activity plan?
- find ways to add more physical activity to your every day life: using stairs, parking further away from buildings?
- do activities that use your large muscle groups and need steady breathing for a total of at least 20 minutes, 3X/week?
- consider a new reason to be physical active: connecting with others, being inspired, seeing something beautiful?
- try a new physical activity: walking, using stairs, gymnastic, swimming, dancing, yoga, gardening, in-line skating?
- choose activities that respect your body's strengths and limits?
- pay attention to your body, and stop exercising if you feel weak, nauseous, or breathless?

If most of your checks are in the "Often" column – *Great!*

If most of your checks are in the "Never" or "Sometimes" columns, you have an opportunity to boost your healthy activity level.

Where would you choose to begin?

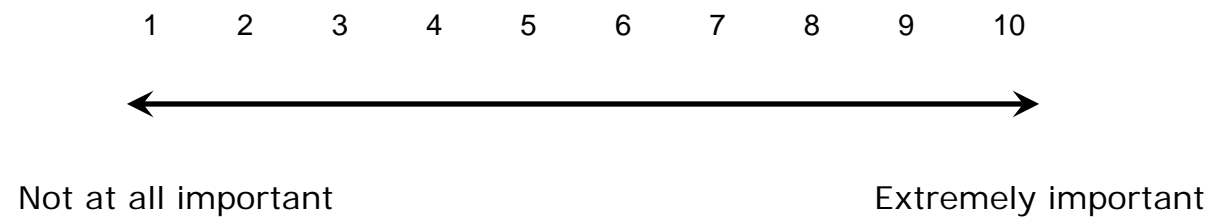
A collection of 10 empty rounded rectangular boxes arranged in a grid-like pattern, intended for labeling. The boxes are arranged in four rows: the first row has two boxes, the second and third rows each have three boxes, and the fourth row has four boxes. All boxes are identical in size and shape, with rounded corners and a thin black border.

Importance Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how important is it for you to make this change?



Confidence Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how confident are you that you could make this change?

1 2 3 4 5 6 7 8 9 10



Not at all confident

Extremely confident

Readiness Ruler

Name: _____

Date: _____

Change Behaviour:

Physical Activity

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

I am not ready**I am unsure****I am ready**

My Change of Behaviour Plan

Name: _____

Date: _____

I want to change the following behaviour:

The most important reason why I want to make this change is:

Further reasons why I want to make this change are:

My main goal for myself in making this change is:

To reach my goal I will do the following things:

The first 3 steps I plan to take in changing are:

I will know that my Change of Behaviour Plan is working when:

WEIGHING DECISIONS

When you weigh decisions, you are looking at the costs and benefits of whatever you are doing.

You may have been up to now physically inactive because you believe the benefits of a sedentary lifestyle outweigh the costs of physical strain by sport or exercise.

Weighing decisions involves personal choices, your choices.

CONSEQUENCES

Consequences are the results of your sedentary behavioral changes. They can be both negative and positive. For example, in the short-term, sedentary lifestyle may help you feel emotional unstressed, but in the long run it could negatively affect your physical health.

Several people are able to change sedentary behaviour on their own, and when they are asked about what made them change, they often say that they just “thought about it.” People often do things as a result of the decisions they make. They evaluate the consequences of their change behavior (decisional balance) before making the final decision to change.

This is exactly what you can do!

Think of a weight scale with the costs (negatives) of your lack of exercise on one side, and the benefits (positives) on the other side. If the costs and benefits are pretty equal, there is nothing compelling you to change. If you keep adding weights to either side of the scale, an imbalance will occur. To

change, you need to tip the scale. You need to personally evaluate your sedentary lifestyle so the negatives of your lack of exercise outweigh the positives.

This process is called decisional balancing.

We do it all the time: weighing the pros and cons of change. For example, people weigh the pros and cons of making changes in their jobs and their relationships. Making decisions about whether to increase physical activity, is the same as making decisions about other areas in your life.

THINKING ABOUT YOUR SEDENTARY LIFESTYLE AND LACK OF EXERCISE

In thinking about your sedentary lifestyle and lack of exercise, ask yourself:

What can I win and lose if I continue my sedentary lifestyle?

What role have physical activity in my life?

At some point, you may have received real benefits from your sedentary lifestyle and lack of exercise – a sense that you “fit in” among friends who dislike physical activity and sport, but preferred relaxation – However, since you are now reading this, you are reconsidering these benefits and focusing on the costs of your behavior.

DECISION TO CHANGE

One of the things that can help you clarify your thoughts about sedentary lifestyle and lack of exercise is to list all the benefits and costs of sedentary lifestyle and lack of exercise. This exercise is intended to help you think about what is involved in your decision to change. Remember that it is **your decision** to change! You are the one who must decide what it will take for you to tip the scale in favor of change.

**Good things about your
actual sedentary lifestyle and
lack of exercise**

**Good things about being more
physical active**

**Bad things about your
actual sedentary lifestyle
and lack of exercise**

**Bad things about being
more physical active**

My Change of Behaviour Plan

- Hooks and Obstacles

Name: _____

Date: _____

I want to change the following behaviour:

These are some possible hooks & obstacles that could impede my change:

How can I handle these hooks & obstacles?

MI – Smoking Cessation



Motivational Interviewing – Adapted to the field of smoking

Research manual drafted for the HELPS Project

This Manual is based on the Motivational Enhancement Therapy Manual (1995) by William Miller, Allen Zweben, Carlo DiClemente, and Roberto Rychtarik. NIH Publication No. 943723

PREFACE

“MI – Smoking Cessation” (MI-SC) is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change regarding nicotine consumption and addiction to smoking. This treatment strategy employs motivational strategies to mobilize the patient's own change resources. It may be delivered as an intervention in itself, may be used as a prelude or in addition to further treatment.

The “MI-SC manual” is provided to the public to permit replication of the treatment procedures and approaches developed in the HELPS project. It is a research guide for clinical staff in applying an adapted Motivational Interviewing Style (MIS) to people with problems concerning nicotine dependence, nicotine consumption and smoking habits. This manual was prepared as part of the HELPS project funded by the European Commission (DG Sanco, Contract No 2006224).

MI-SC is grounded in the clinical approach known as motivational interviewing (Miller, 1983; Miller & Rollnick, 1991). This document is an adaptation and extension of the Project MATCH MET therapist manual. Large portions of the basic text have been adopted and adapted directly from that public domain manual. New examples have been inserted to illustrate applications in the field of nicotine drug dependency and smoking.

This MI-SC manual was prepared for people with a ICD-10 / DSM-IV diagnosis in an outpatient setting, although its application in residential settings for people with a mental disorder is also feasible. No claims are made regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MI are well-grounded in clinical and experimental research, the specific efficacy of MI-SC as outlined in this manual remains to be tested.

The MI-SC manual begins with an overview of Motivational Interviewing Style and a description of the general principles to be applied. Specific guidelines are provided for how to structure the MI sessions. Finally, recommendations are made for dealing with special problems that can arise in conducting MI.

INTRODUCTION

Motivational Interviewing - Adaption for Smoking

Although pharmacological treatments and counselling guidelines have been shown to be effective in helping *motivated* smokers quit, these treatments are less helpful for smokers who are *less motivated* to quit. In psychiatric and social care facilities health care practitioners are more likely to encounter smokers who are unmotivated to quit. Therefore, strategies are needed to help staff members work with unmotivated and ambivalent smokers.

Ziedonis and Williams (2003) have summarized the numerous biological, psychological and social factors that may act to increase the risk of nicotine dependence among people with a mental disorder.

- Biological factors include: enhancement of dopamine transmission with possible reduction in negative symptoms; possibly an influence on stress, anxiety and depression; and genetic influences on the initiation and maintenance of smoking.
- Social factors that increase smoking risks include: limited education; poverty; unemployment ; peer pressure; and the treatment system. That is, as some patients start daily smoking after onset of schizophrenia, there may be influences from the patients and the treatment environment ("smoking psychiatrists") on smoking behaviour.

Despite the high prevalence of smoking, smoking cessation programmes have not in general been part of treatment routines available to people with a mental disorder. This is possibly due to the belief that the cognitive, social and affective deficits, including the unmotivated attitude often found in patients with a diagnosis of depression or schizophrenia present an insurmountable barrier to change in this patient group.

Motivational Interviewing for people with enduring and severe mental illness should focus on helping them come to grips with the nature of their condition, as well as identify ways to reduce what can be perceived as an overwhelming burden. Moreover, giving up smoking habits or reducing nicotine consumption are often perceived as unpleasurable or a sacrifice, and such changes can manifest similar to withdrawal. Thus, a key goal for a motivational interviewing counsellor may be to help an individual reframe their change in positive terms – for example, what is gained versus what is lost – as well as to conceptualize their change in other than hedonic terms: for example, the effect on or the reduced anxiety about their health risk rather than focusing on the difficulty in breathing based on bronchial asthma triggered by smoking.

Motivation for Change

The treatment adopts the assumption of the motivational enhancement therapy approach that the responsibility for change lays within the patient (Miller et al 1995). There are six core elements which are active ingredients of the relatively brief interventions that have been shown by research to induce change, summarized by the acronym **FRAMES**:

FEEDBACK of personal risk or impairment

Emphasis on personal **RESPONSIBILITY** for change

Clear **ADVICE** to change

A **MENU** of alternative change options

Therapist **EMPATHY**

Facilitation of patient **SELF-EFFICACY** or optimism

These therapeutic elements are consistent with a larger review of research on what motivates change (Miller, 1985; Miller & Rollnick, 1991).

Stages of Change

Prochaska and DiClemente have described a transtheoretical model of how people change behaviours, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviours. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages have been identified in this model (Prochaska & DiClemente, 1984, 1986).

Individuals who are not considering change in their problem behaviour are described as being in **PRECONTEMPLATION**. The **CONTEMPLATION** stage entails the person's beginning to consider both the existence of a problem and the feasibility and costs of changing the problem behaviour. As this individual progresses, he or she moves on to the **DETERMINATION** stage where the decision is made to take action and change. Once the individual begins to modify the problem behaviour, he or she enters the **ACTION** stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to **MAINTENANCE** or sustained change. If these efforts fail, a **RELAPSE** occurs, and the individual begins another cycle. The ideal path is progress directly from one stage to the next until maintenance is achieved. For most people with excessive nicotine consumption and smoking habits, however, the process to

quit smoking involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process. Several revolutions through this cycle of change are common before the individual maintains change successfully.

From a stages-of-change perspective, the MI approach addresses where the patient is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the MI therapist, the contemplation and determination stages are most critical. The objective is to help patients consider seriously two basic issues. The first is, how much of a “nicotine consumption and smoking problem” poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of addicted to smoking or smoking behaviour toward change is essential for movement from contemplation to determination. Secondly, the patient in contemplation assesses the possibility and the costs/benefits of changing smoking habits, the costs/benefits of quit smoking. Patients consider whether they will be able to make a change, and how that change will impact their lives.

In the determination stage, patients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to modify their smoking habits in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the MI therapist to empathize with the patient, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

MI is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in behaviour associated with smoking. It draws on motivational principles that have been derived from both experimental and clinical research. The motivational approach is well supported by clinical trials: its overall effectiveness compares favourably with outcomes of alternative treatments, and when cost-effectiveness is considered, the MI strategy fares well indeed in comparison with other approaches (Holder et al., 1991).

CLINICAL CONSIDERATIONS

Rationale and Basic Principles

The MI approach begins with the assumption that the responsibility and capability for change lie within the patient. The therapist's task is to create a set of conditions that will enhance the patient's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the patient's inner resources. MI seeks to support *intrinsic* motivation for change, which will lead the patient to initiate, persist in, and comply with behaviour change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self-Efficacy

Express Empathy

The MI therapist seeks to communicate great respect for the patient. Communications that imply a superior/inferior relationship between therapist and patient are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The patient's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the patient who can decide to change and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MI is listening rather than telling. Persuasion is gentle, subtle, always with the assumption that change is up to the patient. The power of such gentle, non-aggressive persuasion has been widely recognized in clinical writings. Reflective listening (accurate empathy) is a key skill in motivational interviewing. It communicates an acceptance of patients as they are, while also supporting them in the process of change.

Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The MI approach seeks to enhance and focus the patient's attention on such discrepancies with regard to nicotine consumption and smoking behaviour. In certain cases (e.g., the "precontemplators" in Prochaska and DiClemente's model) it may be necessary first to develop such discrepancy by raising the patient's awareness of the adverse personal consequences of his or her nicotine drug dependency or smoking habits. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more

willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy and regain emotional equilibrium. In other cases, the patient enters treatment in a later "contemplation" stage, and it takes less time and effort to move the patient along to the point of determination for change.

Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the patient's discomfort but do not alter nicotine consumption, smoking behaviour and related risks. An unrealistic (from the patient's perspective) attack on his or her nicotine consumption and behaviour associated with smoking tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand. The MI style explicitly avoids direct argumentation, which tends to evoke resistance. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the patient to see accurately the consequences of smoking habits and nicotine consumption, and to begin devaluing the perceived positive aspects of a smoking behaviour. When MI is conducted properly, it is the patient and not the therapist who voices the arguments for change (Miller & Rollnick, 1991).

Roll with Resistance

How the therapist handles patients "resistance" is a crucial and defining characteristic of the MI approach. MI strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting patient perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the patient rather than provided by the therapist. This approach for dealing with resistance will be described in more detail later.

Support Self-efficacy

A person who is persuaded that he or she has a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described *self efficacy* as a critical determinant of behaviour change. Self-efficacy is, in essence, the belief that one *can* perform a particular behaviour or accomplish a particular task. In this case, the patient must be persuaded that it is possible to change his or her own smoking behaviour and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an overall optimistic nature that is crucial here. Rather, it is the patient's specific belief that he or she can modify the nicotine consumption and quit smoking. Unless this element is present, a discrepancy crisis is

likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort, without changing behaviour. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

MI emphasizes the patient's personal choice regarding future (non-)smoking behaviour. Whereas the MI approach views ambivalence as a normal stage of change, consequently an MI therapist meets resistance with reflection rather than argumentation and emphasizes the patient's ability to change (self-efficacy). The MI therapist builds motivation and elicits ideas from the patient as to how change might occur.

Whereas skill training strategies implicitly assume readiness to change, MI focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature. Once such a motivational shift has occurred, however, the ordinary resources of the individual may well suffice. For many individuals a skill training approach may be inefficacious precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller & Brown, 1991). However, MI is not incompatible with skills trainings and in cases of mentally ill people often helpful or even necessary.

PRACTICAL STRATEGIES

Phase 1: Building Motivation for Change

Motivational counselling can be divided into two major phases: (1) building motivation for change, and (2) strengthening commitment to change (Miller & Rollnick, 1991). The early phase of MI focuses on developing the patient's motivation to make a change in his or her nicotine consumption and behaviour associated with smoking. Patients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family or others. Most patients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

This may be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989). One side of the seesaw favours status quo (e.g., continued smoking as before), whereas the other favours change. The former side of the decisional balance is weighed down by perceived positive benefits from smoking habits and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's smoking behaviour, and feared consequences of continuing unchanged. Your task is to shift the balance of weight in favour of change. Eight strategies toward this end (Miller & Rollnick, 1991) are outlined in this section.

1. Eliciting Self-Motivational Statements

The positive side of the coin here is that the MI therapist seeks to elicit from the patients certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983). These include statements of:

- being open to input about “nicotine consumption and behaviour associated with smoking” and effects
- acknowledging real or potential problems related to smoking
- expressing a need, desire, or willingness to change
- expressing optimism about the possibility of change.

There are several ways to elicit such statements from patients. One is to ask for them directly, via open-ended questions. Some examples: I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your nicotine consumption and smoking behaviour. Tell me about those. Tell me a little about your smoking habits and behaviour related to smoking. What do you like most about the smoking behaviour? What is positive about this nicotine consumption for you? And what is the other side? What are your worries about your smoking habits? Tell me what you've noticed about your nicotine consumption and behaviour associated with smoking. How has it modified and changed over time? What things have you noticed that concern you, that you think could be problems, or might become problems? What have other people told you about your nicotine consumption? What are other people worried about? What makes you think that you may need to make a change in your smoking behaviour?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?", etc.

2. Listening with Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to patients' statements. The therapeutic skill of accurate empathy (active listening, reflection, understanding) is an optimal response within the MI strategy.

In popular conceptions, empathy is thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the patient is saying, then reflects it back to the patient, often in a slightly modified or reframed form. Acknowledgment of the patient's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke patient resistance; (2) it encourages the patient to keep talking and exploring the topic; (3) it communicates respect and caring, and builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the patient means; and (5) it can be used to reinforce ideas expressed by the patient.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the patient has said, and passing over others. In this way, patients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the patient to elaborate the reflected statement.

Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favour of continued exploration of the patient's own processes. It may be of further help to contrast reflective with other kinds of possible therapist responses to some patient statements:

PATIENT: I guess I am smoking too much, but I don't think I have a *problem* with my nicotine consumption. Sometimes I have to cough and I am having difficulty with breathing, but I do not feel ill. And I am sure that I am not addicted.

CONFRONTATION: That is nonsense anyway! How can you sit there and tell me you don't have a problem when ...

- QUESTION:* Why do you think you don't have a problem?
- REFLECTION:* So on the one hand you can see some good reasons for concern, *but* you really don't want to be labelled as "addicted".
- PATIENT:* My girl friend is always telling me that I am smoking too much and that my nicotine consumption will harm me physically once a day.
- JUDGING:* What's wrong with that? She probably has some good reasons for thinking so.
- QUESTION:* Why does she think that?
- REFLECTION:* It seems that this really annoys you.

This style of reflective listening is to be used throughout MI. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to patient statements. As the following sections indicate, however, the MI therapist also uses a variety of other strategies.

Finally, it should be noted here that selective reflection *can* backfire. For a patient who is ambivalent, reflection of one side of the dilemma ("So you can see that your smoking behaviour and nicotine consumption is causing you some physical health problems.") may evoke the other side from the patient ("Well, I don't think I have a *problem* really."). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the patient's discrepancy. These may be joined in the middle by the conjunction "but" or "and", though we favour the latter to highlight the ambivalence:

Example for Double-sided Reflection

You don't think that your smoking behaviour is harming you seriously now, and at the same time you *are* concerned that your nicotine consumption could affect your physical health later.

3. Questioning

The MI style does include some purposeful questioning as an important therapist response. Rather than *telling* the patient how he/she should feel, or what to do, the therapist *asks* the patient about his/her own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing.

4. Presenting Personal Feedback

The first MI session should always include feedback to the patient from the pre-treatment assessment. This is done in a structured way, providing patients with a written report of their results (Worksheet "Your smoking behaviour"), and comparing these with normative ranges. To initiate this phase, give the patient the worksheet "Your smoking behaviour", retaining a copy for your own reference and the patient's file. Go through the worksheet step by step. A very important part of this process is your own monitoring of and responding to the patient during the feedback. Observe the patient as you provide personal feedback. Allow time spaces for the patient to respond verbally. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

5. Affirming the Patient

You should also seek opportunities to affirm, compliment, and reinforce the patient sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting patient self-esteem.

Statements for example:

- I appreciate your hanging in there through this feedback, which must be pretty rough for you.
- I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
- You really have some good ideas for how you might change.
- You have taken a big step today and I really respect you for it.

6. Handling Resistance

Patient resistance is a legitimate concern. Failure to comply with a therapist's instructions, and resistant behaviours within treatment sessions (e.g. arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some patient behaviour that have been found to be predictive of poor treatment outcome:

Interrupting : cutting off or talking over the therapist

Arguing: challenging the therapist, discounting the therapist's views, disagreeing, hostility

Sidetracking : changing the subject, not responding, not paying attention

Defensiveness: minimizing or denying the problem, excusing one's own behaviour, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

An important goal in MI style is to *avoid* evoking patient resistance (anti-motivational statements). How you *respond* to resistant behaviours is one of the defining characteristics of MI.

A first rule of thumb is never meet resistance head-on. Certain kinds of reactions are likely to exacerbate resistance, back the patient further into a corner, and elicit anti-motivational statements from the patient.

These therapist responses include:

- Arguing, disagreeing, challenging
- Judging, criticizing, blaming
- Warning of negative consequences
- Seeking to persuade with logic or evidence
- Interpreting or analyzing the "reasons" for resistance
- Confronting with authority
- Using sarcasm or incredulity

Even direct questions as to *why* the patient is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the patient further defence of the anti-motivational position, and leave you in the logical position of counter argument. If you find yourself in the position of arguing with the patient to acknowledge a problem and the need for change, then shift your strategies.

Remember that you want the *patient* to make self-motivational statements (basically, "I have a problem" and "I need to do something about it"), and if you defend these positions yourself it may evoke the opposite from the patient. Here are several strategies for deflecting resistance:

- **Simple reflection.** One strategy is simply to reflect what the patient is saying. This sometimes has the effect of eliciting the opposite, and balancing the picture.
- **Reflection with amplification.** A modification is to reflect, but exaggerate or amplify what the patient is saying to the point where the patient is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.
- **Double-sided reflection.** The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a patient offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

PATIENT: But I can't stop smoking! Yes you're right, smoking is bad for the body and I have several somatic complaints due to smoking, and I am afraid they will become worse over time. But if I stop smoking, I will gain weight and then I am unattractive. And beyond that, for me smoking is psychologically calming.

THERAPIST: You cannot imagine stopping smoking because of concerns regarding your body weight and of the positive effect of psychological calming. But at the same time you're worried about how it's affecting your physical health.

- **Shifting focus.** Another strategy is to defuse resistance by shifting attention away from the problematic issue.

PATIENT: But I can't stop smoking! Yes you're right, smoking is bad for the body and I have several somatic complaints due to smoking and I am afraid they will become worse over time. But if I stop smoking, I will gain weight and then I am unattractive. And beyond that, for me smoking is psychologically calming.

THERAPIST: You're getting way ahead of things. I'm not talking about your modifying behaviour associated with smoking here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing right now - going through your "smoking history" - and later on we can worry about what, if anything, you want to do about it.

- **Rolling with resistance.** Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the patient back to a balanced or opposite perspective. This strategy can be particularly useful with patients who present in a highly oppositional manner, and who seem to reject every idea or suggestion.

PATIENT: But I can't stop smoking! Yes you're right, smoking is bad for the body and I have several somatic complaints due to smoking and I am afraid they will become worse over time. But if I stop smoking, I will gain weight and then I am unattractive. And beyond that, for me smoking is psychologically calming.

THERAPIST: And it may very well be that when we're through, you'll decide that it's worth it to further maintain your nicotine consumption and smoking behaviour. It may be too difficult to make a change. That will be up to you.

7. Reframing

Reframing is a strategy whereby the therapist invites the patient to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said.

When a patient is receiving feedback that confirms the problems of nicotine consumption and smoking behaviour, a friend's reaction of "That's what I've been trying to tell you" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

Reframing can be used to help motivate the patient and so to deal with smoking habits. In placing current problems in a more positive or optimistic frame, the MI therapist hopes to communicate that the problem is solvable and changeable. In developing the reframe it is important to use the patient's own views, words, and perceptions about nicotine consumption and smoking behaviour.

Some examples of interpretive reframes that can be utilized with patients are:

- **Smoking as reward**

"You may have a need to reward yourself on the evenings and the weekends for successfully handling stressful and difficult tasks during a day or the week."

→ The implication here is that there are alternative ways of rewarding oneself (not only by smoking).

- **Smoking as an adaptive function**

"Your smoking behaviour can be viewed as a means of avoiding conflict or tension in your relationships. Your smoking behaviour tends to keep the *status quo*, to keep things as they are. It seems like you have been using smoking to keep your relationships intact. Yet, you seem uncomfortable with this arrangement."

→ The implication is that the patient cares about the relationship and has been trying to keep it together, but needs to find more effective ways to do this.

The general idea in reframing is to place the problem behaviour in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change the problem*.

8. Summarizing

It is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a longer summary reflection of what the patient has said. It is especially useful to repeat and summarize the patient's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the patient. Such a summary serves the function of allowing the

patient to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Along the way during a session, shorter "progress" summaries can be given. Here is an example of how you might offer a summary to a patient at the end of a first session:

Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you to tell me about your nicotine consumption and smoking habits, and you told me several things. You said that your nicotine consumption has been increasing rapidly, and you notice that smoking is good for you because for you it is psychologically calming. You've been spending a lot of money on cigarettes and tobacco, and you're worried that you could get physical problems, like breathlessness, bronchial asthma or lung cancer included its consequences. There have been some real somatic symptoms, and you're concerned about how all of this is affecting your body and physical health. On the feedback, you were somewhat surprised to learn that your nicotine consumption in general is very high compared to the general population. You have seen some signs that your nicotine consumption is starting to damage you physically. I appreciate how open you have been to all this feedback, and I can see you have some real concerns now about your nicotine consumption and your smoking behaviour. Is that a pretty good summary? Did I miss anything?

Phase 2: Strengthening Commitment to Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation, and to help tip the patient's decisional balance in favour of change. A second major process in MI is to consolidate the patient's commitment to change, once sufficient motivation is present (Miller & Rollnick, 1991).

Timing is a key issue - knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente-Model, this is the stage of *DETERMINATION*, when the balance of contemplation has tipped in favour of change, and the patient is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the patient's decision.

There are no universal signs of crossing over into the determination stage. Here are some changes you might observe (Miller & Rollnick, 1991):

- The patient stops resisting and raising objections
- The patient asks fewer questions
- The patient appears more settled, resolved, unburdened, or peaceful
- The patient makes self-motivational statements indicating a decision (or openness) to change ["I guess I have to do something to reduce my nicotine consumption." "If I wanted to reduce my nicotine consumption, what could I do?"]
- The patient begins imagining how life might be after a change.

Here is a checklist of issues to assist you in determining a patient's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment:

- Has the patient missed previous appointments or cancelled prior sessions without rescheduling?
- If the patient was coerced into treatment, has the patient discussed with you his or her reactions to this involuntariness - anger, relief, confusion, acceptance, etc.?
- Does the patient show a certain amount of indecisiveness or hesitancy about scheduling future sessions?
- Is the treatment being offered quite different from what the patient has experienced or expected in the past; and if so, have these differences and the patient's reactions been discussed?
- Does the patient seem to be very guarded during sessions, or otherwise seem to be hesitant or resistant when a suggestion is offered?
- Does the patient perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the patient's uncertainties and ambivalence about quit smoking or reduce nicotine consumption, and change. It is also wise to delay any decision-making or attempts to obtain firm commitment to a plan of action.

For many patients, there may not be a clear point of decision or determination. Often people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and

effective. Then they commit to change. Thus the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a patient appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the patient has decided to change, there is no longer any need for Phase I strategies. Likewise you should proceed carefully with patients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment.

The following strategies are useful once the initial phase has been passed, and the patient is moving toward change.

Asking Key Questions

One useful strategy in making the transition from Phase 1 to Phase 2 is to provide the kind of summary statement described earlier, summing up all of the reasons for change that the person has given, while also acknowledging remaining points of ambivalence. At the end of this summary, ask a *key question* such as:

- What do you make of all this?
- Where does this leave you in terms of nicotine consumption and smoking habits?
- What's your plan? What are you thinking you will do?
- I wonder what you're thinking about your nicotine consumption at this point.
- Now that you're this far, I wonder what you might do about these concerns.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (Phase 1: building motivation) to strengthening commitment and negotiating a *plan* for change (Phase 2). Patients may initiate this transition by stating a need or desire to change, or by asking what he or she could do. Alternatively, you may trigger this transition with a key question.

Your goal during Phase 2 is to elicit from the patient some ideas and ultimately a plan for what to do about the patient's smoking behaviour. It is not your task at this point to prescribe a plan for *how* the patient should change, or to teach specific skills for doing so. The overall message is: "Only *you* can change your nicotine consumption and smoking behaviour, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?"

Communicating Free Choice

An important and consistent message throughout MI is the patient's responsibility and freedom of choice. Reminders of this theme should be included during the commitment strengthening process:

Examples:

- It's up to you what you do about this.
- No one can decide this for you.
- No one can change your smoking behaviour for you. Only you can do it.
- You can decide to continue with your nicotine consumption, or to make a change.

Consequences of Action and Inaction

A useful strategy is to ask the patient to anticipate what the result would be if the patient continued as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the patient.

For a more complete picture, you could also discuss what the patient *fears* about changing. What might be the negative consequences of giving up the previous behaviour patterns, for example? What are the advantages of continuing to smoke as before? Reflection, summarizing, and reframing are appropriate therapist responses. One possibility here is to construct a formal "decisional balance" sheet, by having the patient generate (and writing down) the pros and cons of change options. What are the positive and negative aspects of continuing as before? What are the possible benefits and costs of making a change?

Information and Advice

Often patients will ask for key information, as important input for their decisional process. In general, however, you should feel free to provide accurate, specific information that is requested by patients. It is often helpful to ask for the patient's response to any information that you provide: Does it make sense to you? Does that surprise you? What do *you* think about it?

Patients may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree.

For example:

- If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.
- I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

- I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life.
- I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

When it comes to "how to do," it is often best not to prescribe specific strategies or attempt to train specific skills at the outset. Instead try turning the challenge back to the patient:

- How do you think you might be able to do that?
- What might stand in your way?
- You'd have to be pretty creative [strong, clever, and resourceful] to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a chewing gum that you can take once a day and then it is easy to quit smoking. How does it work?"). Accurate and specific information can be provided in such cases. A patient may well ask for information that you do not have. Do not feel obliged to know all the answers. It is okay to say that you do not know it, but will find out. You can offer to research a question and get back to the patient at the next session.

The goal of change behaviour

The goal of change is, in fact, a choice that each patient must and does make for him/herself. Within the MI style, it is not up to you to "permit" or "let" or "allow" patients to make choices. The choice is theirs to make, and you cannot make it for them.

At the same time many patients, at least initially, find a suggested goal unacceptable, or view it as unattainable. Therapist insistence in such cases may only increase resistance and risk of drop-out. It is helpful here to keep in mind the emerging "harm reduction" perspective: basically, that any step in the right direction is a step in the right direction. What goals, then, can be considered as harm reduction? The more specific question here is: What kind of change(s) is the patient willing to pursue?

It is important to be clear, here, that you are not *advocating* continued (excessive) smoking. Your overall goal in counselling is to help the patient move away from harmful nicotine consumption and smoking habits. In certain cases, you may feel particular responsibility to encourage a specific behaviour, if the patient appears to be leaning in a different direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MI. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . .").

Dealing with Resistance

The same principles used for defusing resistance in the first phase of MI therapy also apply here. Reluctance and ambivalence are not challenged directly, but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MI. One form of such statements is permission to continue unchanged:

- Maybe you'll decide that it's worth it to you to keep on using the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

- I wonder if it's really possible for you to continue the excessive nicotine consumption and still maintain your physical fitness and attractiveness, too.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2, to help in specifying the patient's action plan. You can use it as a format for taking notes as the patient's plan emerges. Do not start Phase 2 by filling out the CPW. Rather the information needed for the CPW should emerge through the motivational dialogue described above. This information can then be used as a basis for your recapitulation (see below). Use the CPW as a guide, to ensure that you have covered these aspects of the patient's plan:

The changes I want to make are...

In what ways or areas does the patient want to make a change? Be specific. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviours).

The most important reasons why I want to make these changes are...

What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the patient?

The steps I plan to take in changing are...

How does the patient plan to achieve his/her goals? How could the desired change be accomplished? Within the general plan and strategies described, what are some specific, concrete first steps that the patient can take? When, where, and how will these steps be taken?

I will know that my plan is working if...

What does the patient hope will happen as a result of this change plan? What benefits could be expected from this change?

Some things that could interfere with my plan are...

Help the patient to anticipate situations or changes that could undermine the plan. What could go wrong? How could the patient stick with the plan despite these problems or setbacks?

Recapitulating

Toward the end of the commitment process, as you sense that the patient is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired. This may include a repetition of the reasons for concern uncovered in the Phase 1 (see "Summarizing"), as well as new information developed during Phase 2. Emphasis should be given to the patient's self-motivational statements, the patient's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

Let me see if I understand where you are. Last time we reviewed the reasons why you have been concerned about your nicotine consumption and your excessive smoking behaviour. There were a number of these. You were both concerned that your nicotine consumption has contributed to somatic complaints. You were worried, too, about the amount of the money you have been spending for cigarettes, and about the general bad feeling with regard to your body. These had helped you to realize that it was time to do something, to realize that it was time to reduce your nicotine consumption. But I think you were still surprised when I gave you the feedback, just how much in danger for physical illness you were.

We've talked about what you might do about this, and you had different ideas at first. You thought you'd just change your smoking behaviour on your own. We talked about what the results might be if you tried different approaches. You were concerned that if you didn't make a sharp break or change, you'd probably slip right back into your "regular" smoking behaviour, and forget what we've discussed here. You agreed that would be a risk. You didn't like the idea of attending a stop-smoking group outside your facility because you were concerned that you do not have appropriate communication skills and social skills, even though, as we discussed, there is a possibility to learn these skills.

Where you seem to be headed now is toward trying out a "period without cigarettes", for four weeks at least, to see how it goes and how you feel. You like the idea to spend more

time with several other residents with a similar “smoking problem” as you, so you can go and talk together about your experiences with your changed behaviour and do things together in the evening or on weekends not to be alone and not to be at increased risk for excessive smoking. You also thought you would get involved again in some of the facility or community activities you used to enjoy during the afternoon. Do I have it right? What have I missed?

If the patient offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the patient's situation, as above, and responded to additional points and concerns raised by the patient, move toward getting a formal commitment to change. In essence, the patient is to commit verbally to take concrete, planned steps to bring about the needed change. The closing question (not necessarily in these words) is:

Are you ready, then, to commit yourself to do this?

As you discuss this commitment, also cover the following points:

- Clarify what, exactly, the patient plans to do. Give the patient the completed Change Plan Worksheet, and discuss it.
- Reinforce what the patient perceives to be likely benefits of making a change, as well as the consequences of inaction.
- Ask what concerns, fears, or doubts the patient may have, which might interfere with carrying out the plan.
- Ask what other obstacles might be encountered, which could divert the patient from the plan. Ask the patient to suggest how they could deal with these.
- Clarify the social environment's role in helping the patient to make the desired change.
- Determine what additional help the patient would like to have from you or from other treatment agencies. If you are terminating your treatment, remind the patient that there will be a follow-up interview to see how they are doing.

If the patient is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the patient the signed original, retaining a copy for your file.

Some patients are unwilling to commit themselves to a change goal or program. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the "smoking problem", you may ask the person to defer the decision until a later time. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing patients the opportunity to postpone such decision-making, is that the motivational processes will act more favourably on them over time. Such flexibility provides patients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the patient may feel coerced into making a commitment before she or he is ready to take action. In this case, a patient may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don't you think about it between now and our next session, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later. I'm sure it will become clear to you what you want to do. OK?

It can be helpful in this way to express explicit understanding and acceptance of the patient's ambivalence, as well as confidence in his or her ability to resolve the dilemma.

Phase 3: Follow-Through Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the patient's commitment to change (Phase 2), MI focuses on follow-through. This may occur as early as the second session, depending upon the patient's pace of progress. Three processes are involved in follow-through:

- reviewing progress,
- renewing motivation, and
- redoing commitment.

It is also in Phase 3 that the need for further treatment or referral is assessed.

Reviewing Progress

Begin a follow-through session with a review of what has happened since your last session. Discuss with the patient what commitment and plans were made, and explore what progress the patient has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes ("Building Motivation for Change") can be used again here to renew motivation for change. The extent to which this is done will depend upon your judgment as to the patient's current commitment to change. This may be assessed by asking the patient what he/she remembers as the most important reasons for making a change in smoking behaviour.

Redoing Commitment

The Phase 2 processes ("Consolidating Commitment to Change") can also be continued during follow-through. This may simply be a reaffirmation of the commitment made earlier. If the patient has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the patient's sense of autonomy and self-efficacy, an ability to carry out self-chosen goals and plans.

Further Treatment

Through the motivational enhancement processes described above, the patient may decide that he or she would like specific additional treatment to help in pursuing goals. The important Phase 3 task here is to clarify with the patient what goals are to be

achieved through such treatment, and then to determine what type of treatment services are mostly likely to be effective in meeting these goals.

THE STRUCTURE OF MI SESSIONS

The preceding sections outlined the basic flow of MI from Phase 1 through Phase 3. This section will address issues involved in the planning and conduct of the MI sessions.

The Initial Session

Preparing for the First Session

The general intent is to provide the patient with objective feedback regarding his or her nicotine consumption and smoking behaviour and related problems.

Presenting the Rationale and Limits of Treatment

Begin by explaining the nature of this approach. Here is an example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent several times completing the questionnaires that we need, and we appreciate the time you put into that process. We'll make good use of that information today. I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing to be done here, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

After we have worked together for a few sessions you should have a better sense of what you want to do. If you decide that you would like to make some changes and want some consultation with that, I may be able to help, and we could work together. If you need other kinds of help or support, I'll refer you. Do you have any questions about what we'll be doing?

After this introduction, start the first session with a brief structuring of the first session. Tell the patient that you will be giving them feedback from the pre-treatment questionnaires and interviews, but first you want to understand better how they see their

(= the patient's) situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening with Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Patient," "Handling Resistance," and "Reframing" are also quite appropriate here. When you sense that you have elicited the major themes of concern from the patient, offer a summary statement (see "Summarizing"). If this seems acceptable to the patient, indicate that the next step is for you to provide feedback from the patient's initial assessment. Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session.

Whenever you do complete the feedback process, ask for the patient's overall response. One possible query would be:

- I've given you quite a bit of information here, and at this point I wonder what you make of all this, and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected, and used as a bridge to the next phase of MI.

After obtaining the patient's responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process, and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MI: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the patient [see "Recognizing Change Readiness"], begin eliciting thoughts, ideas, and plans for what might be done to address the problem [see "Discussing a Plan"]. During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the patient what are perceived to be the possible benefits of action, and the likely negative consequences of inaction [see "Consequences of Action"]. These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to make a change) and given to the patient. The basic patient-centred stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly, is to be maintained throughout this and all MI sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard [see "Asking for Commitment"]. It can be helpful to write down the patient's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the patient. Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a patient may drop out of treatment rather than "go back on" the agreement.

Ending the (First) Session(s)

Always end the (first) session(s) by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the sessions presenting feedback and dealing with concerns or resistance. In other cases, the patient will be well along toward determination, and you may be into Phase II (strengthening commitment) strategies by the end of the session. The speed with which this session proceeds will depend upon the patient's current stage of change. Where possible, it is desirable to elicit some patient self motivational statements about change within the first session, and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the patient will do and what changes will be made (if any) between the first and second sessions. Don't hesitate to move toward commitment to change in the first session if this seems appropriate. On the other hand, don't feel pressed to do so. Premature commitment is ephemeral, and pressuring a patient toward change before he or she is ready will evoke resistance and undermine the MI process.

Missed Appointments

When a patient misses a scheduled appointment, respond immediately and cover the following basic points:

- Clarify the reasons for the missed appointment
- Affirm the patient - reinforce for having come
- Express your eagerness to see the patient again, and encouragement to continue
- Briefly mention serious concerns that emerged, and your appreciation (as appropriate) that the patient is exploring these
- Express your optimism about the prospects for change, and for benefit to the patient
- Ask whether there are any questions that you can answer for the patient
- Reschedule the appointment

If no reasonable explanation is offered for the missed appointment (e.g., illness), explore with the patient whether the missed appointment might reflect any of the following:

- uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)
- ambivalence about making a change
- frustration or anger about having to participate in treatment (particularly with patients coerced into entering the program)

Handle such concerns in a manner consistent with MI (e.g., with reflective listening, reframing).

Indicate that it is not surprising, in the beginning phase of consultation, for a person to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the patient to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any resistance that is encountered. Affirm the patient for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the patient in this regard. Reschedule the appointment. Research indicates that a prompt note and telephone call significantly increases the likelihood that the patient will return.

Follow-Through MI Sessions

The **second session** should not be more than a week later. It should begin with a brief summary of what transpired during the first session. Then proceed with the MI process, picking up where you left off. Continue with the patient's personal feedback from assessment, if this was not completed during the first session. Proceed toward Phase II strategies and commitment to change, if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with follow-through procedures.

Begin each session with a discussion of what has transpired since the last session, and a review of what has been accomplished in previous sessions. Specific use is made in each session of the follow-through strategies outlined earlier: (1) reviewing progress; (2) renewing motivation, and (3) redoing commitment.

Complete each session with a summary of where the patient is at present (e.g., the patient's reasons for concern, the main themes of the feedback, the plan that has been negotiated - see "Recapitulation"), eliciting the patient's perceptions of what steps should be taken next. The plan for change (if previously negotiated) can be reviewed, revised, and (if previously written down) rewritten. During follow-through sessions, be careful not to assume that ambivalence has been resolved, and that commitment is firm. It is safer to assume that the patient is still ambivalent, and to continue using the motivation-building strategies of Phase I, as well as the commitment-strengthening strategies of Phase II.

There should be a clear sense of continuity of care. MI sessions should be presented as progressive consultations, and as continuous with subsequent treatment and (research) follow-up sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions (including the research follow-ups) serve as periodic check-ups of progress toward change. It can be helpful during follow-through sessions to discuss specific situations that have occurred since the last session.

Sessions 3 and 4 are to be scheduled for weeks 3 and 4, respectively. Further sessions can be scheduled as "booster" sessions to reinforce the motivational process.

In case of several weeks lapse between sessions, you could use "**5-minutes-talks**" as boosters and you should telephone the patient a few days before the scheduled appointment. This express continued active interest in your patient and serves as a reminder. Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where your patient is at present, eliciting the patient's perceptions of what steps should be taken next. During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the patient is still ambivalent and to continue using the motivation building strategies.

Transition or Referral

When a clear change plan develops, the next step is to determine what, if any, additional treatment or consultation the patient would like to have in support of change (e.g. skills training). If you are personally able to provide some or all of the desired treatment, proceed. If not, help the patient to identify the appropriate treatment resources and make the referral. (Whenever possible, make the referral call personally from your office while the patient is present, and make a specific appointment for the patient.)

Termination

Formal termination of the MI phase is generally accomplished by a final recapitulation of the patient's situation and progress through the MI sessions. Your final summary should include these elements:

- Reviewing the most important factors motivating the patient for change, and reconfirming these self-motivational themes.
- Summarizing the commitments and changes that have been made thus far.
- Affirming and reinforcing the patient for commitments and changes that have been made.
- Exploring additional areas for change that the patient wants to accomplish in the future.
- Eliciting self-motivational statements for the maintenance of change, and for further changes.
- Supporting patient self-efficacy, emphasizing the patient's ability to change.
- Dealing with any special problems that are evident.
- Reminding the patient of the follow-up interview(s), emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

To consolidate motivation, it may be useful to ask the patient what would be the worst things that could happen if he/she went back to nicotine consumption and smoking behaviour as before. Help the patient look to the immediate future, to anticipate upcoming events or potential obstacles that could contribute to relapse.

MI – Smoking Cessation



WORKSHEETS

Your Smoking Behaviour

- When did you start smoking?
- Why did you start smoking?
- How has it modified and changed over time?
- What are reasons for smoking?
- How many cigarettes you smoke on a day?
- Which factors (e.g. situations, mood) trigger your smoking?
- What are the factors that maintain your smoking behaviour?
- Have you ever tried quitting smoking?
- How does the smoking affect your body?
- How does the smoking affect your mood?
- What are the positive/negative influences in the social network towards smoking?
- What (health) beliefs do you have about smoking?
- Is there a relationship between your smoking and your mental illness?
- What are your worries about your smoking habits?
- What makes you think that you may need to make a change in your smoking behaviour?
- Is there anything else you would like to tell me?

What I want to change:

The image displays 15 empty rounded rectangular boxes, arranged in a grid-like pattern. The boxes are organized into four rows: the first row has 5 boxes, the second and third rows each have 3 boxes, and the fourth row has 4 boxes. All boxes are identical in size and shape, with rounded corners and a thin black border. They are intended for a matching exercise where students place a letter from the word 'MATHS' into the correct box.

Importance Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how important is it for you to make this change?

1 2 3 4 5 6 7 8 9 10



Not at all important

Extremely important

Confidence Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how confident are you that you could make this change?

1 2 3 4 5 6 7 8 9 10



Not at all confident

Extremely confident

Readiness Ruler

Name: _____

Date: _____

Change Behaviour: **Nicotine Consumption / Smoking Behaviour**

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

I am not ready**I am unsure****I am ready**

My Change of Behaviour Plan

Name: _____

Date: _____

I want to change the following behaviour:

The most important reason why I want to make this change is:

Further reasons why I want to make this change are:

My main goal for myself in making this change is:

To reach my goal I will do the following things:

The first 3 steps I plan to take in changing are:

I will know that my Change of Behaviour Plan is working when:

WEIGHING DECISIONS

When you weigh decisions, you are looking at the costs and benefits of whatever you are doing.

You may have been up to now smoking excessive because you believe the benefits of nicotine consumption and smoking behaviour outweigh the costs of smoking.

Weighing decisions involves personal choices, your choices.

CONSEQUENCES

Consequences are the results of your behavioural changes associated with smoking. They can be both negative and positive. For example, in the short-term, smoking may help you psychologically calming, but in the long run it could negatively affect your physical health.

Several people are able to change smoking habits on their own, and when they are asked about what made them change, they often say that they just “thought about it.” People often do things as a result of the decisions they make. They evaluate the consequences of their change behaviour (decisional balance) before making the final decision to change.

This is exactly what you can do!

Think of a weight scale with the costs (negatives) of your smoking behaviour on one side, and the benefits (positives) on the other side. If the costs and benefits are pretty equal, there is nothing compelling you to change. If you keep adding weights to either side of the scale, an

imbalance will occur. To change, you need to tip the scale. You need to personally evaluate your behaviour associated with smoking so the negatives of your nicotine consumption and smoking habits outweigh the positives.

This process is called decisional balancing.

We do it all the time: weighing the pros and cons of change. For example, people weigh the pros and cons of making changes in their jobs and their relationships. Making decisions about whether to quit smoking, is the same as making decisions about other areas in your life.

THINKING ABOUT YOUR BEHAVIOUR ASSOCIATED WITH SMOKING

In thinking about your nicotine consumption and smoking habits, ask yourself:

What can I win and lose if I continue smoking?

What role has smoking in my life?

At some point, you may have received real benefits from your nicotine consumption and smoking habits – a sense that you “fit in” among friends who smoke. – However, since you are now reading this, you are reconsidering these benefits and focusing on the costs of your smoking behaviour.

DECISION TO CHANGE

One of the things that can help you clarify your thoughts about nicotine consumption and smoking habits is to list all the benefits and costs of behaviour associated with smoking. This exercise is intended to help you think about what is involved in your decision to change. Remember that it is **your decision** to change! You are the one who must decide what it will take for you to tip the scale in favour of change.

**Good things about your
actual nicotine consumption
and smoking behaviour**

**Good things about
stop/reduce smoking**

**Bad things about your
actual nicotine consumption
and smoking behaviour**

**Bad things about
stop/reduce smoking**

My Change of Behaviour Plan

- Hooks and Obstacles

Name: _____

Date: _____

I want to change the following behaviour:

These are some possible hooks & obstacles that could impede my change:

How can I handle these hooks & obstacles?

MI - ORAL HEALTH



**Motivational Interviewing – Adapted to the field of
oral health and oral hygiene practice**

Research manual drafted for the HELPS Project

**This Manual based on the Motivational Enhancement Therapy Manual
(1995) by William Miller, Allen Zweben, Carlo DiClemente, and Roberto
Rychtarik. NIH Publication No. 943723**

PREFACE

MI Oral Health is a systematic intervention approach for evoking change. It is based on principles of motivational psychology, and is designed to produce rapid, internally-motivated change regarding oral health habits and oral hygiene practice. This treatment strategy employs motivational strategies to mobilize the patient's own change resources. It may be delivered as an intervention in itself, may be used as a prelude or in addition to further treatment.

The MI Oral Health manual is provided to the public to permit replication of the treatment procedures and approaches developed in the HELPS project. It is a research guide for clinical staff in applying an adapted Motivational Interviewing Style (MIS) for people with problems concerning oral and tooth health and oral hygiene practice. This manual was prepared as part of the HELPS project funded by the European Commission (DG Sanco, Contract No 2006224).

MI Oral Health is grounded in the clinical approach known as motivational interviewing (Miller, 1983; Miller & Rollnick, 1991). This document is an adaptation and extension of the Project MATCH MET therapist manual. Large portions of the basic text have been adopted and adapted directly from that public domain manual. New examples have been inserted to illustrate applications in the field of unhealthy habits concerning oral health and hygiene.

This MI Oral Health manual was prepared for MI offered in an inpatient and outpatient setting, although its application in residential settings for people with a mental disorder is also feasible. No claims are made regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MI are well-grounded in clinical and experimental research, the specific efficacy of MI Oral Health as outlined in this manual remains to be tested.

The MI Oral Health manual begins with an overview of Motivational Interviewing Style and a description of the general principles to be applied. Specific guidelines are provided for how to structure the MI sessions. Finally, recommendations are made for dealing with special problems that can arise in conducting MI.

INTRODUCTION

Motivational Interviewing - Adaptation for Oral Health and Oral Hygiene Practice

Motivational Interviewing for changing poor habits concerning oral health and oral hygiene practice include the fact that this behaviour involves modification as well as elimination (e.g., “acid” drinks like high-proof alcohol or “acid” food like sugar), and reshaping as well as abstaining. Whereas there is generally no “quit day”, there may be concrete behavioural targets such as tooth brushing two times daily or reducing acid food intake.

Changes in the field of oral health and oral hygiene must be long-term, if not for a life time, so that they are effective on the physical health status of a patient (e.g., avoiding dental caries and tooth decay). Thus, ambivalence may centre on the long-term burden of change.

Motivational Interviewing for this target group should focus on helping them come to grips with the chronic nature of their condition, as well as identify ways to reduce what can be perceived as an overwhelming burden. Moreover, giving up or reducing the intake of “acid foods” (e.g., sweets or high-proof alcohol) are often perceived as unpleasurable or a sacrifice, and such change can manifest similar to withdrawal. Thus, a key goal for a motivational interviewing counsellor may be to help an individual reframe their change in positive terms – for example, what is gained versus what is lost.

Motivation for Change

There are six core elements which are active ingredients of the relatively brief interventions that have been shown by research to induce change, summarized by the acronym **FRAMES**:

FEEDBACK of personal risk or impairment

Emphasis on personal **RESPONSIBILITY** for change

Clear **ADVICE** to change

A **MENU** of alternative change options

Therapist **EMPATHY**

Facilitation of patient **SELF-EFFICACY** or optimism

These therapeutic elements are consistent with a larger review of research on what motivates change (Miller, 1985; Miller & Rollnick, 1991).

Stages of Change

Prochaska and DiClemente (1982, 1984, 1985, 1986) have described a transtheoretical model of how people change behaviours, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviours. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages have been identified in this model (Prochaska & DiClemente, 1984, 1986).

Individuals who are not considering change in their problem behaviour are described as being in **PRECONTEMPLATION**. The **CONTEMPLATION** stage entails the person's beginning to consider both the existence of a problem and the feasibility and costs of changing the problem behaviour. As this individual progresses, he or she moves on to the **DETERMINATION** stage where the decision is made to take action and change. Once the individual begins to modify the problem behaviour, he or she enters the **ACTION** stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to **MAINTENANCE** or sustained change. If these efforts fail, a **RELAPSE** occurs, and the individual begins another cycle. The ideal path is progress directly from one stage to the next until maintenance is achieved. For most people with specific unhealthy oral health and oral hygiene habits, however, the process to healthy oral health and hygiene habits involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process. Several revolutions through this cycle of change are common before the individual maintains change successfully.

From a stages-of-change perspective, the MI approach addresses where the patient is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. For the MI therapist, the contemplation and determination stages are most critical. The objective is to help patients consider seriously two basic issues. The first is, how much of an oral health problem or a poor oral hygiene practice poses for them, and how it is affecting them (both positively and negatively). Tipping the balance of these pros and cons of poor oral health habits and poor oral hygiene practice toward change is essential for movement from contemplation to determination. Secondly, the patient in contemplation assesses the possibility and the

costs/benefits of changing the poor oral health status and habits and the poor oral hygiene practice. Patients consider whether they will be able to make a change, and how that change will impact their lives. In the determination stage, patients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their poor oral health habits and poor hygiene practice in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the MI therapist to empathize with the patient, and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

MI is well-grounded in theory and research on motivation for change. It is consistent with an understanding of the stages and processes that underlie change in poor oral health behaviours. It draws on motivational principles that have been derived from both experimental and clinical research. The motivational approach is well supported by clinical trials: its overall effectiveness compares favourably with outcomes of alternative treatments, and when cost-effectiveness is considered, the MI strategy fares well indeed in comparison with other approaches (Holder et al., 1991).

CLINICAL CONSIDERATIONS

Rationale and Basic Principles

The MI approach begins with the assumption that the responsibility and capability for change lie within the patient. The therapist's task is to create a set of conditions that will enhance the patient's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the patient's inner resources. MI seeks to support *intrinsic* motivation for change, which will lead the patient to initiate, persist in, and comply with behaviour change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express Empathy
- Develop Discrepancy
- Avoid Argumentation
- Roll with Resistance
- Support Self-Efficacy

Express Empathy

The MI therapist seeks to communicate great respect for the patient. Communications that imply a superior/inferior relationship between therapist and patient are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The patient's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the patient who can decide to change and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MI is listening rather than telling. Persuasion is gentle, subtle, always with the assumption that change is up to the patient. The power of such gentle, non-aggressive persuasion has been widely recognized in clinical writings. Reflective listening (accurate empathy) is a key skill in motivational interviewing. It communicates an acceptance of patients as they are, while also supporting them in the process of change.

Develop Discrepancy

Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The MI approach seeks to enhance and focus the patient's attention on such discrepancies with regard to poor oral health, healthy gums and teeth. In certain cases (e.g., the "precontemplators" in Prochaska and DiClemente's model) it may be necessary first to develop such discrepancy by raising the patient's awareness of the adverse personal consequences of his or her poor gums or teeth and his or her poor oral hygiene practice. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy and regain emotional equilibrium. In other cases, the patient enters treatment in a later "contemplation" stage, and it takes less time and effort to move the patient along to the point of determination for change.

Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the patient's discomfort but do not alter poor oral hygiene practice and poor oral health habits and related risks. An unrealistic (from the patient's perspective) attack on his or her unhealthy oral health behaviours tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand. The MI style explicitly avoids direct argumentation, which tends to evoke resistance. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the patient to see accurately the consequences of unhealthy oral health habits, and to begin devaluing the perceived positive aspects of unhealthy activities concerning oral health. When MI is conducted

properly, it is the patient and not the therapist who voices the arguments for change (Miller & Rollnick, 1991).

Roll with Resistance

How the therapist handles patients "resistance" is a crucial and defining characteristic of the MI approach. MI strategies do not meet resistance head-on, but rather "roll with" the momentum, with a goal of shifting patient perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the patient rather than provided by the therapist. This approach for dealing with resistance will be described in more detail later.

Support Self-efficacy

A person who is persuaded that he or she has a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described *self efficacy* as a critical determinant of behaviour change. Self-efficacy is, in essence, the belief that one *can* perform a particular behaviour or accomplish a particular task. In this case, the patient must be persuaded that it is possible to change his or her own unhealthy oral health habits and poor oral hygiene practice and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an overall optimistic nature that is crucial here. Rather, it is the patient's specific belief that he or she can change the poor habits concerning oral health. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort, without changing behaviour. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

MI emphasizes the patient's personal choice regarding future oral health and oral hygiene. Whereas the MI approach views ambivalence as a normal stage of change, consequently an MI therapist meets resistance with reflection rather than argumentation and emphasizes the patient's ability to change (self-efficacy). The MI therapist builds motivation and elicits ideas from the patient as to how change might occur.

Whereas skill training strategies implicitly assume readiness to change, MI focuses explicitly on motivation as the key factor in triggering lasting change (Miller & Rollnick, 1991). In the absence of motivation and commitment, skill training is premature. Once such a motivational shift has occurred, however, the ordinary resources of the individual may well suffice. For many individuals a skill training approach may be inefficacious

precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller & Brown, 1991). However, MI is not incompatible with skills trainings.

PRACTICAL STRATEGIES

Phase 1: Building Motivation for Change

Motivational counselling can be divided into two major phases: (1) building motivation for change, and (2) strengthening commitment to change (Miller & Rollnick, 1991). The early phase of MI focuses on developing the patient's motivation to make a change in his or her oral health habits and poor oral hygiene practice. Patients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family or legal authorities. Most patients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

This may be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989). One side of the seesaw favours status quo (e.g., continued poor oral health hygiene practice as before), whereas the other favours change. The former side of the decisional balance is weighed down by perceived positive benefits from unhealthy oral health behaviour and poor health hygiene practice and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's oral health hygiene style, and feared consequences of continuing unchanged. Your task is to shift the balance of weight in favour of change. Several strategies toward this end (Miller & Rollnick, 1991) are outlined in this section.

1. Eliciting Self-Motivational Statements

The positive side of the coin here is that the MI therapist seeks to elicit from the patients certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983). These include statements of:

- being open to input about poor oral health behaviour patterns, poor oral hygiene practice and effects
- acknowledging real or potential problems related to unhealthy oral health habits and poor oral hygiene practice
- expressing a need, desire, or willingness to change
- expressing optimism about the possibility of change.

There are several ways to elicit such statements from patients. One is to ask for them directly, via open-ended questions. Some examples: I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your oral health, tooth health, or oral hygiene practice. Tell me more about it. Tell me a little about your oral health habits and oral hygiene practice. What is positive about your behaviours which affect your oral health and tooth health? And what is the other side? What are your worries about having these habits? Tell me what you've noticed about your oral health hygiene and related problems. How have they changed over time? What things have you noticed that concern you and that you think could be problems, or might become problems? What have other people told you about your oral hygiene? What are other people worried about? What makes you think that you may need to make a change in your oral health hygiene behaviour?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking "What else?", etc. If it bogs down, you can inventory general areas. Here are some areas you should include:

- Is the patient's care for oral health decreasing?
- Has the poor hygiene practice caused problems with gums and teeth and oral diseases?
- Has the poor hygiene practice caused trouble with the social environment?
 - What effects does poor oral hygiene behaviour have on the patient's family?
 - How do the poor oral hygiene habits affect the patient's relationships with loved ones and friends?
 - How do the poor oral hygiene habits and its consequences affect the patient's self esteem?
 - How does the poor oral hygiene practice impact the patient's physical attractiveness, sexual drive, and sexual relationships?
- How do the poor oral hygiene habits and its consequences affect the patient's employment?

2. Listening with Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to patients' statements. The therapeutic skill of accurate empathy (active listening, reflection, understanding) is an optimal response within the MI strategy.

In popular conceptions, empathy is thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the patient is saying, and then reflects it back to the patient, often in a slightly modified or reframed form. Acknowledgment of the patient's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke patient resistance; (2) it encourages the patient to keep talking and exploring the topic; (3) it communicates respect and caring, and builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the patient means; and (5) it can be used to reinforce ideas expressed by the patient.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the patient has said, and passing over others. In this way, patients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the patient to elaborate the reflected statement.

Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favour of continued exploration of the patient's own processes. It may be of further help to contrast reflective with other kinds of possible therapist responses to some patient statements:

PATIENT: I guess I neglect tooth brushing and my oral hygiene. I have bad breath and a little bit dental caries. But I don't think that I have a real *problem* with my gums and teeth, and I do not have an oral disease.

CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .

QUESTION: Why do you think you don't have a problem?

REFLECTION: So, on the one hand you can see some reasons for concern, you talk about your bad breath and dental caries, *and* on the other hand you do not want to be labelled as "having a problem".

This style of reflective listening is to be used throughout MI. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to patient statements. As the following sections indicate, however, the MI therapist also uses a variety of other strategies.

Finally, it should be noted here that selective reflection *can* backfire. For a patient who is ambivalent, reflection of one side of the dilemma ("So you can see that your poor oral hygiene are causing you some physical health problems") may evoke the other side from the patient ("Well, I don't think I have a *problem* really, I have no oral disease."). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the patient's discrepancy. These may be joined in the middle by the conjunction "but" or "and", though we favour the latter to highlight the ambivalence:

Example: Double-sided Reflection

You don't think that your poor oral hygiene are harming you seriously now, and at the same time you *are* concerned that your poor oral hygiene could affect your social environment, e.g. by bad breath, and also your physical health later, e.g. by dental caries and tooth failure.

3. Questioning

The MI style does include some purposeful questioning as an important therapist response. Rather than *telling* the patient how he/she should feel, or what to do, the therapist *asks* the patient about his/her own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or reframing.

4. Presenting Personal Feedback

The first MI session should always include feedback to the patient from the pre-treatment assessment. This is done in a structured way, providing patients with a written report of their results (e.g., Worksheet "What is your oral health style?"), and comparing these with normative ranges. To initiate this phase, give the patient the worksheet "What is your oral health style?", retaining a copy for your own reference and the patient's file. Go through the worksheet step by step, explaining each item of information, pointing out the patient's score, and comparing it with the normative data provided. A very important

part of this process is your own monitoring of and responding to the patient during the feedback. Observe the patient as you provide personal feedback. Allow time spaces for the patient to respond verbally. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection.

5. Affirming the Patient

You should also seek opportunities to affirm, compliment, and reinforce the patient sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting patient self-esteem. Statements for example:

- I appreciate your hanging in there through this feedback, which must be pretty rough for you.
- I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
- You really have some good ideas for how you might change.
- You have taken a big step today and I really respect you for it.

6. Handling Resistance

Patient resistance is a legitimate concern. Failure to comply with a therapist's instructions, and resistant behaviours within treatment sessions (e.g., arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some patient behaviours that have been found to be predictive of poor treatment outcome:

Interrupting:	cutting off or talking over the therapist
Arguing:	challenging the therapist, discounting the therapist's views, disagreeing, hostility
Sidetracking:	changing the subject, not responding, not paying attention
Defensiveness:	minimizing or denying the problem, excusing one's own behaviour, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

An important goal in MI style is to *avoid* evoking patient resistance (anti-motivational statements). How you *respond* to resistant behaviours is one of the defining characteristics of MI.

A first rule of thumb is never meet resistance head-on. Certain kinds of reactions are likely to exacerbate resistance, back the patient further into a corner, and elicit anti-motivational statements from the patient.

These therapist responses include:

- Arguing, disagreeing, challenging
- Judging, criticizing, blaming
- Warning of negative consequences
- Seeking to persuade with logic or evidence
- Interpreting or analyzing the "reasons" for resistance
- Confronting with authority
- Using sarcasm or incredulity

Even direct questions as to *why* the patient is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the patient further defence of the anti motivational position, and leave you in the logical position of counter argument. If you find yourself in the position of arguing with the patient to acknowledge a problem and the need for change, then shift your strategies.

Remember that you want the *patient* to make self-motivational statements (basically, "I have a problem" and "I need to do something about it"), and if you defend these positions yourself it may evoke the opposite from the patient. Here are several strategies for deflecting resistance:

- **Simple reflection.** One strategy is simply to reflect what the patient is saying. This sometimes has the effect of eliciting the opposite, and balancing the picture.
- **Reflection with amplification.** A modification is to reflect, but exaggerate or amplify what the patient is saying to the point where the patient is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.
- **Double-sided reflection.** A double-sided reflection is another way to deal with resistance. If a patient offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

- **Shifting focus.** Another strategy is to defuse resistance by shifting attention away from the problematic issue.

Example:

PATIENT: But I can't just stop eating cakes and cookies. And I can't always brush my teeth after I had sweets. This is impossible in my job! And by the way, I will not stop eating sweets. I need it.

THERAPIST: You're getting way ahead of things. I'm not talking about your quitting here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing right now - going through your feedback - and later on we can worry about what, if anything, you want to do about it.

- **Rolling with resistance.** Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the patient back to a balanced or opposite perspective. This strategy can be particularly useful with patients who present in a highly oppositional manner, and who seem to reject every idea or suggestion.

7. Reframing

Reframing is a strategy whereby the therapist invites the patient to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said.

When a patient is receiving feedback that confirms the poor oral hygiene problems, a friend's reaction of "That's what I've been trying to tell you" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much."

Reframing can be used to help motivate the patient and so to deal with unhealthy oral health habits and poor oral hygiene practice. In placing current problems in a more positive or optimistic frame, the MI therapist hopes to communicate that the problem is solvable and changeable. In developing the reframe it is important to use the patient's own views, words, and perceptions about poor oral health and neglected oral hygiene.

The general idea in reframing is to place the problem behaviour in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change the problem*.

8. Summarizing

It is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a longer summary reflection of what the patient has said. It is especially useful to repeat and summarize the patient's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the patient. Such a summary serves the function of allowing the patient to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Along the way during a session, shorter "progress" summaries can be given. Here is an example of how you might offer a summary to a patient at the end of a first session:

Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you to tell me about your oral health and your oral hygiene practice, and you told me several things. You said that your sweets intake has been increasing rapidly, and you notice that the sweets destroy your teeth through dental caries. Moreover, you're worried that you could get more physical problems, like gums diseases included its consequences like tooth failure for example. There have been some real somatic symptoms, and you're concerned about how all of this is affecting your physical attractiveness and physical health. On the feedback, you were somewhat surprised to learn that your oral hygiene practice in general is very low compared to other residents in the facility. You have seen some signs that your poor oral hygiene practice is starting to damage you physically. I appreciate how open you have been to all this feedback, and I can see you have some real concerns now about your poor oral health habits and your low oral hygiene practice. Is that a pretty good summary? Did I miss anything?

Phase 2: Strengthening Commitment to Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation, and to help tip the patient's decisional balance in favour of change. A second major process in MI is to consolidate the patient's commitment to change, once sufficient motivation is present (Miller & Rollnick, 1991).

Timing is a key issue - knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente-Model,

this is the stage of *DETERMINATION*, when the balance of contemplation has tipped in favour of change, and the patient is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the patient's decision.

There are no universal signs of crossing over into the determination stage. Here are some changes you might observe (Miller & Rollnick, 1991):

- The patient stops resisting and raising objections
- The patient asks fewer questions
- The patient appears more settled, resolved, unburdened, or peaceful
- The patient makes self-motivational statements indicating a decision (or openness) to change ["I guess I need to do some oral hygiene practice to improve my oral health and to stop bad breath and dental caries and so on." "If I wanted to improve my oral health status, what could I do?"]
- The patient begins imagining how life might be after a change.

Here is a short checklist of issues to assist you in determining a patient's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment:

- Has the patient missed previous appointments or cancelled prior sessions without rescheduling?
- If the patient was coerced into treatment, has the patient discussed with you his or her reactions to this involuntariness - anger, relief, confusion, acceptance, etc.?
- Does the patient show a certain amount of indecisiveness or hesitancy about scheduling future sessions?
- Is the treatment being offered quite different from what the patient has experienced or expected in the past; and if so, have these differences and the patient's reactions been discussed?
- Does the patient seem to be very guarded during sessions, or otherwise seem to be hesitant or resistant when a suggestion is offered?
- Does the patient perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the patient's uncertainties and ambivalence about oral

hygiene practice, oral health habits and behaviour change. It is also wise to delay any decision-making or attempts to obtain firm commitment to a plan of action.

For many patients, there may not be a clear point of decision or determination. Often people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a patient appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the patient has decided to change, there is no longer any need for Phase I strategies. Likewise you should proceed carefully with patients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment.

The following strategies are useful once the initial phase has been passed, and the patient is moving toward change.

Asking Key Questions

One useful strategy in making the transition from Phase 1 to Phase 2 is to provide the kind of summary statement described earlier, summing up all of the reasons for change that the person has given, while also acknowledging remaining points of ambivalence. At the end of this summary, ask a *key question* such as:

- What do you make of all this?
- Where does this leave you in terms of oral hygiene and oral health?
- What's your plan? What are you thinking you will do?
- I wonder what you're thinking about your oral hygiene habits at this point.
- Now that you're this far, I wonder what you might do about these concerns.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (Phase 1: building motivation) to strengthening commitment and negotiating a *plan* for change (Phase 2). Patients may initiate this transition by stating a need or desire to change, or by asking what he or she could do. Alternatively, you may trigger this transition with a key question.

Your goal during Phase 2 is to elicit from the patient some ideas and ultimately a plan for what to do. It is not your task at this point to prescribe a plan for *how* the patient should change, or to teach specific skills for doing so. The overall message is: "Only *you* can change your oral health status and improve your oral hygiene practice, it is up to you." Further questions may help: "How do you think you might do that? What do you think might help?"

Communicating Free Choice

An important and consistent message throughout MI is the patient's responsibility and freedom of choice. Reminders of this theme should be included during the commitment strengthening process:

Examples:

- It's up to you what you do about this.
- No one can decide this for you.
- No one can change your poor oral hygiene practice and your oral health habits for you. Only you can do it.
- You can decide to continue with your poor oral hygiene practice, or to make a change.

Consequences of Action and Inaction

A useful strategy is to ask the patient to anticipate what the result would be if the patient continued using as before. What would be the likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the patient.

For a more complete picture, you could also discuss what the patient *fears* about changing. What might be the negative consequences of giving up the previous behaviour patterns, for example? What are the advantages of continuing poor oral hygiene practice as before? Reflection, summarizing, and reframing are appropriate therapist responses. One possibility here is to construct a formal "decisional balance" sheet, by having the

patient generate (and writing down) the pros and cons of change options. What are the positive and negative aspects of continuing to eat as before? What are the possible benefits and costs of making a change?

Information and Advice

Often patients will ask for key information, as important input for their decisional process. In general, however, you should feel free to provide accurate, specific information that is requested by patients. It is often helpful to ask for the patient's response to any information that you provide: Does it make sense to you? Does that surprise you? What do *you* think about it?

Patients may also ask you for advice. "What do *you* think I should do?" It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree.

For example:

- If you want my opinion, I can certainly give it to you, but you're the one who has to make up your mind in the end.
- I can tell you what I think I would want to do in your situation, and I'll be glad to do that, but remember that it's your choice. Do you want my opinion?

Being just a little resistive or "hard to get" in this situation can also be useful:

- I'm not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life.
- I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

When it comes to "how to do," it is often best not to prescribe specific strategies or attempt to train specific skills at the outset. Instead try turning the challenge back to the patient:

- How do you think you might be able to do that?

- What might stand in your way?
- You'd have to be pretty creative [strong, clever, and resourceful] to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a chewing gum that you can take once a day and it keeps you from dental caries. How does it work?"). Accurate and specific information can be provided in such cases.

A patient may well ask for information that you do not have. Do not feel obliged to know all the answers. It is okay to say that you do not know it, but will find out. You can offer to research a question and get back to the patient at the next session.

The goal of change behaviour

The goal of change is, in fact, a choice that each patient must and does make for him/herself. Within the MI style, it is not up to you to "permit" or "let" or "allow" patients to make choices. The choice is theirs to make, and you cannot make it for them.

At the same time many patients, at least initially, find a suggested goal unacceptable, or view it as unattainable. Therapist insistence in such cases may only increase resistance and risk of drop-out. It is helpful here to keep in mind the emerging "harm reduction" perspective: basically, that any step in the right direction is a step in the right direction. What goals, then, can be considered as harm reduction? The more specific question here is: What kind of change(s) is the patient willing to pursue?

It is important to be clear, here, that you are not *advocating* continued poor oral hygiene practice. Your overall goal in counselling is to help the patient move away from poor oral hygiene practice and harmful oral health habits. In certain cases, you may feel particular responsibility to encourage a specific hygiene habit (e.g., using dental floss), if the patient appears to be leaning in a different direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MI. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . .").

Dealing with Resistance

The same principles used for defusing resistance in the first phase of MI therapy also apply here. Reluctance and ambivalence are not challenged directly, but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MI. One form of such statements is permission to continue unchanged:

- Maybe you'll decide that it's worth it to you to keep on using the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

- I wonder if it's really possible for you to continue your poor oral hygiene practice and still maintain your physical attractiveness, too.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2, to help in specifying the patient's action plan. You can use it as a format for taking notes as the patient's plan emerges. Do not start Phase 2 by filling out the CPW. Rather the information needed for the CPW should emerge through the motivational dialogue described above. This information can then be used as a basis for your recapitulation (see below).

Use the CPW as a guide, to ensure that you have covered these aspects of the patient's plan:

The changes I want to make are...

In what ways or areas does the patient want to make a change? Be specific! It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviours).

The most important reasons why I want to make these changes are...

What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the patient?

The steps I plan to take in changing are...

How does the patient plan to achieve his/her goals? How could the desired change be accomplished? Within the general plan and strategies described, what are some specific, concrete first steps that the patient can take? When, where, and how will these steps be taken?

I will know that my plan is working if...

What does the patient hope will happen as a result of this change plan? What benefits could be expected from this change?

Some things that could interfere with my plan are...

Help the patient to anticipate situations or changes that could undermine the plan. What could go wrong? How could the patient stick with the plan despite these problems or setbacks?

Recapitulating

Toward the end of the commitment process, as you sense that the patient is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired. This may include a repetition of the reasons for concern uncovered in the Phase 1 (see "Summarizing"), as well as new information developed during Phase 2. Emphasis should be given to the patient's self-motivational statements, the patient's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

Let me see if I understand where you are. Last time we reviewed the reasons why you have been concerned about your oral health. You were both concerned that your poor oral health has contributed to somatic complaints (e.g. dental caries) and problems in your social environment (e.g., caused by bad breath). You were worried, too, about the amount of the money you have been spending for all the "acid food" (e.g. sweets or high-proof alcohol), and the fact that your oral health status seems to be getting worse. The accident that you had helped you to realize that it was time to do something about your oral hygiene practice, but I think you were still surprised when I gave you the feedback, just how much in danger for oral diseases and in general physical illness you were.

We've talked about what you might do about this, and you had different ideas at first. You thought you'd just change your oral hygiene practice on your own. We talked about

what the results might be if you tried different approaches. You were concerned that if you didn't make a sharp break or change with your hygiene practice, you'd probably slip right back into regular behaviour, and forget what we've discussed here. You agreed that that would be a risk. You didn't like the idea of attending a dentist because you were concerned that the dentist would see you there with your dental caries and lost teeth, even though, as we discussed, there is a medical pledge of secrecy. Where you seem to be headed now is toward trying out a period of good oral hygiene practice, for four weeks at least, to see how it goes and how you feel. You like the idea to get more information about oral hygiene and oral diseases and you will go in contact with your health insurance for more information. Do I have it right? What have I missed?

If the patient offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the patient's situation, as above, and responded to additional points and concerns raised by the patient, move toward getting a formal commitment to change. In essence, the patient is to commit verbally to take concrete, planned steps to bring about the needed change. The closing question (not necessarily in these words) is:

Are you ready, then, to commit yourself to do this?

As you discuss this commitment, also cover the following points:

- Clarify what exactly the patient plans to do. Give the patient the completed Change Plan Worksheet, and discuss it.
- Reinforce what the patient perceives to be likely benefits of making a change, as well as the consequences of inaction.
- Ask what concerns, fears, or doubts the patient may have, which might interfere with carrying out the plan.
- Ask what other obstacles might be encountered, which could divert the patient from the plan. Ask the patient to suggest how they could deal with these.

- Clarify the social environment's role in helping the patient to make the desired change.
- Determine what additional help the patient would like to have from you or from other treatment agencies. If you are terminating your treatment, remind the patient that there will be a follow-up interview to see how they are doing.

If the patient is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the patient the signed original, retaining a copy for your file.

Some patients are unwilling to commit themselves to a change goal or program. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the oral health and hygiene problem, you may ask the person to defer the decision until a later time. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing patients the opportunity to postpone such decision-making is that the motivational processes will act more favourably on them over time. Such flexibility provides patients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the patient may feel coerced into making a commitment before she or he is ready to take action. In this case, a patient may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don't you think about it between now and our next session, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later I'm sure it will become clear to you what you want to do. Okay?

It can be helpful in this way to express explicit understanding and acceptance of the patient's ambivalence, as well as confidence in his or her ability to resolve the dilemma.

Phase 3: Follow-Through Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the patient's commitment to change (Phase 2), MI focuses on follow-through. This may occur as early as the second session, depending upon the patient's pace of progress. Three processes are involved in follow-through:

- reviewing progress,
- renewing motivation, and
- redoing commitment.

It is also in Phase 3 that the need for further treatment or referral is assessed.

Reviewing Progress

Begin a follow-through session with a review of what has happened since your last session. Discuss with the patient what commitment and plans were made, and explore what progress the patient has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes ("Building Motivation for Change") can be used again here to renew motivation for change. The extent to which this is done will depend upon your judgment as to the patient's current commitment to change. This may be assessed by asking the patient what he/she remembers as the most important reasons for making a change in oral health habits and oral hygiene practice.

Redoing Commitment

The Phase 2 processes ("Consolidating Commitment to Change") can also be continued during follow-through. This may simply be a reaffirmation of the commitment made earlier. If the patient has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the patient's sense of autonomy and self-efficacy, an ability to carry out self-chosen goals and plans.

Further Treatment

Through the motivational enhancement processes described above, the patient may decide that he or she would like specific additional treatment to help in pursuing goals.

The important Phase 3 task here is to clarify with the patient what goals are to be achieved through such treatment, and then to determine what type of treatment services are mostly likely to be effective in meeting these goals.

THE STRUCTURE OF MI SESSIONS

The preceding sections outlined the basic flow of MI from Phase 1 through Phase 3. This section will address issues involved in the planning and conduct of the MI sessions.

The Initial Session

Preparing for the First Session

The general intent is to provide the patient with objective feedback regarding his or her poor oral health status and poor oral health practice and related problems.

Presenting the Rationale and Limits of Treatment

Begin by explaining the nature of this approach. Here is an example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent several times completing the questionnaires that we need, and we appreciate the time you put into that process. We'll make good use of that information today. I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing to be done here, *you* will be the one who does it. Nobody can tell you what to do, nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of that is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

After we have worked together for a few sessions you should have a better sense of what you want to do. If you decide that you would like to make some changes and want some consultation with that, I may be able to help, and we could work together. If you need other kinds of help or support, I'll refer you. Do you have any questions about what we'll be doing? After this introduction, start the first session with a brief structuring of the first session.

Tell the patient that you will be giving them feedback from the pre-treatment questionnaires and interviews, but first you want to understand better how they see their

(= the patient's) situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening with Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Patient," "Handling Resistance," and "Reframing" are also quite appropriate here. When you sense that you have elicited the major themes of concern from the patient, offer a summary statement (see "Summarizing"). If this seems acceptable to the patient, indicate that the next step is for you to provide feedback from the patient's initial assessment. Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session.

Whenever you do complete the feedback process, ask for the patient's overall response. One possible query would be:

- I've given you quite a bit of information here, and at this point I wonder what you make of all this, and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected, and used as a bridge to the next phase of MI.

After obtaining the patient's responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process, and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MI: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the patient [see "Recognizing Change Readiness"], begin eliciting thoughts, ideas, and plans for what might be done to address the problem [see "Discussing a Plan"]. During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the patient what are perceived to be the possible benefits of action, and the likely negative consequences of inaction [see "Consequences of Action"]. These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to make a change) and given to the patient. The basic patient-centred stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly, is to be maintained throughout this and all MI sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard [see "Asking for Commitment"]. It can be helpful to write down the patient's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the patient. Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a patient may drop out of treatment rather than "go back on" the agreement.

Ending the (First) Session(s)

Always end the (first) session(s) by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the sessions presenting feedback and dealing with concerns or resistance. In other cases, the patient will be well along toward determination, and you may be into Phase II (strengthening commitment) strategies by the end of the session. The speed with which this session proceeds will depend upon the patient's current stage of change. Where possible, it is desirable to elicit some patient self motivational statements about change within the first session, and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the patient will do and what changes will be made (if any) between the first and second sessions. Don't hesitate to move toward commitment to change in the first session if this seems appropriate. On the other hand, don't feel pressed to do so. Premature commitment is ephemeral, and pressuring a patient toward change before he or she is ready will evoke resistance and undermine the MI process.

Missed Appointments

When a patient misses a scheduled appointment, respond immediately and cover the following basic points:

- Clarify the reasons for the missed appointment
- Affirm the patient - reinforce for having come
- Express your eagerness to see the patient again, and encouragement to continue
- Briefly mention serious concerns that emerged, and your appreciation (as appropriate) that the patient is exploring these
- Express your optimism about the prospects for change, and for benefit to the patient
- Ask whether there are any questions that you can answer for the patient
- Reschedule the appointment

If no reasonable explanation is offered for the missed appointment (e.g., illness), explore with the patient whether the missed appointment might reflect any of the following:

- uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)
- ambivalence about making a change
- frustration or anger about having to participate in treatment (particularly with patients coerced into entering the program)

Handle such concerns in a manner consistent with MI (e.g., with reflective listening, reframing).

Indicate that it is not surprising, in the beginning phase of consultation, for a person to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the patient to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any resistance that is encountered. Affirm the patient for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the patient in this regard. Reschedule the appointment. Research indicates that a prompt note and telephone call significantly increases the likelihood that the patient will return.

Follow-Through MI Sessions

The **second session** should not be more than a week later. It should begin with a brief summary of what transpired during the first session. Then proceed with the MI process, picking up where you left off. Continue with the patient's personal feedback from assessment, if this was not completed during the first session. Proceed toward Phase II strategies and commitment to change, if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with follow-through procedures.

Begin each session with a discussion of what has transpired since the last session, and a review of what has been accomplished in previous sessions. Specific use is made in each session of the follow-through strategies outlined earlier: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment.

Complete each session with a summary of where the patient is at present (e.g., the patient's reasons for concern, the main themes of the feedback, the plan that has been negotiated - see "Recapitulation"), eliciting the patient's perceptions of what steps should be taken next. The plan for change (if previously negotiated) can be reviewed, revised, and (if previously written down) rewritten. During follow-through sessions, be careful not to assume that ambivalence has been resolved, and that commitment is firm. It is safer to assume that the patient is still ambivalent, and to continue using the motivation-building strategies of Phase I, as well as the commitment-strengthening strategies of Phase II.

There should be a clear sense of continuity of care. MI sessions should be presented as progressive consultations, and as continuous with subsequent treatment and (research) follow-up sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions (including the research follow-ups) serve as periodic check-ups of progress toward change. It can be helpful during follow-through sessions to discuss specific situations that have occurred since the last session.

Sessions 3 and 4 are to be scheduled for weeks 3 and 4, respectively. Further sessions can be scheduled as "booster" sessions to reinforce the motivational process.

In case of several weeks lapse between sessions, you could use 5-minutes-talks as boosters and you should telephone the patient a few days before the scheduled appointment. This express continued active interest in your patient and serves as a reminder. Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where your patient is at present, eliciting the patient's perceptions of what steps should be taken next.

During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the patient is still ambivalent and to continue using the motivation building strategies.

Transition or Referral

When a clear change plan develops, the next step is to determine what, if any, additional treatment or consultation the patient would like to have in support of change (e.g. skills training). If you are personally able to provide some or all of the desired treatment, proceed. If not, help the patient to identify the appropriate treatment resources and

make the referral. (Whenever possible, make the referral call personally from your office while the patient is present, and make a specific appointment for the patient.)

Termination

Formal termination of the MI phase is generally accomplished by a final recapitulation of the patient's situation and progress through the MI sessions. Your final summary should include these elements:

- Reviewing the most important factors motivating the patient for change, and reconfirming these self-motivational themes.
- Summarizing the commitments and changes that have been made thus far.
- Affirming and reinforcing the patient for commitments and changes that have been made.
- Exploring additional areas for change that the patient wants to accomplish in the future.
- Eliciting self-motivational statements for the maintenance of change, and for further changes.
- Supporting patient self-efficacy, emphasizing the patient's ability to change.
- Dealing with any special problems that are evident.
- Reminding the patient of the follow-up interview(s), emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

To consolidate motivation, it may be useful to ask the patient what would be the worst things that could happen if he/she went back to poor oral health practice as before. Help the patient look to the immediate future, to anticipate upcoming events or potential obstacles that could contribute to relapse.

MI - Oral Health and Oral Hygiene Practice



WORKSHEETS

What Is Your Oral Health Style?

How often do you...

(Never, Sometimes, Often)

- talk with your doctor about your oral health?
- find ways to add more oral health behaviour to your every day life: cleaning your teeth, using tooth paste, gargling, using dental floss?
- do you visit a dentist?
- take painkiller instead of visit a dentist?

If most of your checks are in the "Often" column – *Great!*

If most of your checks are in the "Never" or "Sometimes" columns, you have an opportunity to boost your healthy activity level.

Where would you choose to begin?

What I want to change:

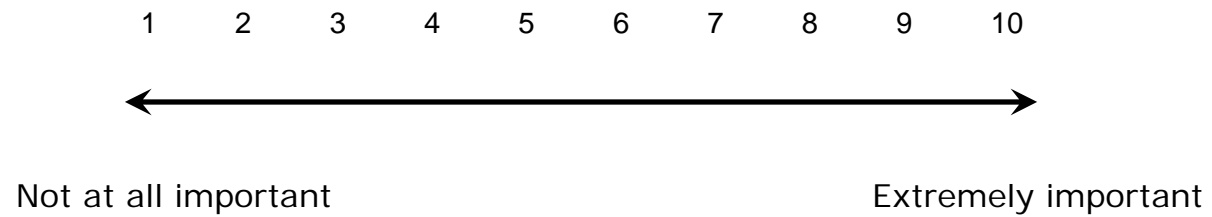
The image displays 18 empty rounded rectangular boxes, organized into three main sections. The top section contains 10 boxes arranged in three rows: two in the first row, three in the second, and five in the third. The middle section contains 5 boxes arranged in two rows: two in the first and three in the second. The bottom section consists of a single horizontal row of 3 boxes. All boxes are identical in size and shape, with rounded corners and a thin black border, and are intended for a matching exercise.

Importance Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how important is it for you to make this change?

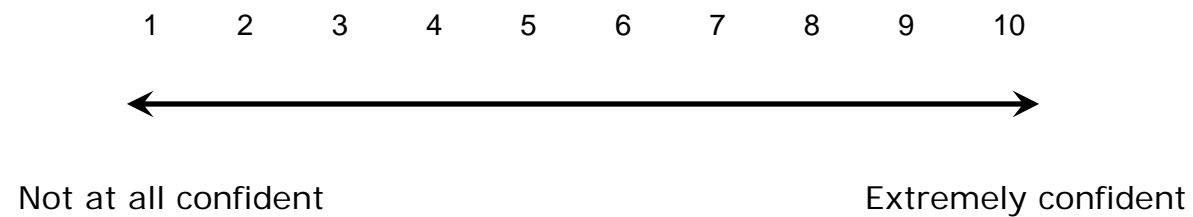


Confidence Ruler

Name: _____

Date: _____

On a scale of 1 to 10, how confident are you that you could make this change?



Readiness Ruler

Name: _____

Date: _____

Change Behaviour:

Oral Health

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

I am not ready

I am unsure

I am ready

My Change of Behaviour Plan

Name: _____

Date: _____

I want to change the following behaviour:

The most important reason why I want to make this change is:

Further reasons why I want to make this change are:

My main goal for myself in making this change is:

To reach my goal I will do the following things:

The first 3 steps I plan to take in changing are:

I will know that my Change of Behaviour Plan is working when:

WEIGHING DECISIONS

When you weigh decisions, you are looking at the costs and benefits of whatever you are doing.

You may have been up to now inactive with regard to your oral health because you believe the benefits of a lifestyle which neglect your oral health outweigh the costs of a lifestyle which cares for oral health.

Weighing decisions involves personal choices, your choices.

CONSEQUENCES

Consequences are the results of your behavior, e.g., not brushing the teeth. They can be both negative and positive. For example, in the short-term, oral health neglected lifestyle habits may help you feel more unstressed, but in the long run it could negatively affect your oral health by karies or tooth failure.

Several people are able to change their unhealthy behaviour on their own, and when they are asked about what made them change, they often say that they just "thought about it." People often do things as a result of the decisions they make. They evaluate the consequences of their change behavior (decisional balance) before making the final decision to change.

This is exactly what you can do!

Think of a weight scale with the costs (negatives) of your lack of oral health behaviour on one side, and the benefits (positives) on the other side. If the costs and benefits are pretty equal, there is nothing compelling

you to change. If you keep adding weights to either side of the scale, an imbalance will occur. To change, you need to tip the scale. You need to personally evaluate your lifestyle which neglect oral health habits so the negatives of your lack of exercise outweigh the positives.

This process is called decisional balancing.

We do it all the time: weighing the pros and cons of change. For example, people weigh the pros and cons of making changes in their jobs and their relationships. Making decisions about whether to increase oral health habits is the same as making decisions about other areas in your life.

THINKING ABOUT YOUR ORAL HEALTH STATUS AND HABITS CONCERNING YOUR ORAL HEALTH

In thinking about your oral health status and your oral health habits, ask yourself:

What can I win and lose if I continue my lifestyle which neglected the oral health?

What role has oral health in my life?

DECISION TO CHANGE

One of the things that can help you clarify your thoughts about your oral health habits and lack of tooth health is to list all the benefits and costs of your oral health habits and lack of tooth health. This exercise is intended to help you think about what is involved in your decision to change. Remember that it is **your decision** to change! You are the one who must decide what it will take for you to tip the scale in favor of change.

Good things about your actual oral health status, oral health habits and lack of your tooth health

Good things about caring more for your oral health

Bad things about your actual oral health status, oral health habits and lack of your tooth health

Bad things about caring more for your oral health

My Change of Behaviour Plan

- Hooks and Obstacles

Name: _____

Date: _____

I want to change the following behaviour:

These are some possible hooks & obstacles that could impede my change:

How can I handle these hooks & obstacles?

VOLUME
2

National Institute on Alcohol Abuse and Alcoholism

PROJECT
MATCH
MONOGRAPH
S E R I E S

MOTIVATIONAL ENHANCEMENT THERAPY MANUAL

A Clinical Research Guide for
Therapists Treating Individuals With
Alcohol Abuse and Dependence



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism
Project MATCH Monograph Series
Volume 2

MOTIVATIONAL ENHANCEMENT THERAPY MANUAL

**A Clinical Research Guide for
Therapists Treating Individuals
With Alcohol Abuse and Dependence**

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Foreword

A major focus of the efforts of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in treatment research is to rigorously test the patient-treatment matching approach to the clinical management of alcoholism. This commitment is particularly reflected in its multi-site clinical trial, Project MATCH. This study is the first national, multisite trial of patient-treatment matching and one of the two largest current initiatives of NIAAA. Established under a cooperative agreement that allows direct collaboration between the Institute and the researcher, the project involves nine geographically representative clinical sites and a data coordinating center. Researchers in Project MATCH are among the most senior and experienced treatment scientists in the field. Both public and private treatment facilities, as well as hospital and university outpatient facilities, are represented.

The manuals in this series are the result of the collaborative efforts of the Project MATCH investigators and are used as guides by therapists in the trial. They are presented to the alcohol research community as standardized, well-documented intervention tools for alcoholism treatment research. The final reports of Project MATCH will inform us on the relative efficacy of the interventions being evaluated in the trial and on the types of clients who benefit the most from each of the therapies.

Until the final results from Project MATCH are presented to the community, these interim manuals summarize the consensus of the investigators on reasonable intervention approaches based on present knowledge. We look forward to offering further refinements of these approaches as Project MATCH data are analyzed and published and as the alcohol treatment field advances through the efforts of other ongoing research.

Enoch Gordis, M.D.
Director
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and Alcoholism

Preface

This manual for therapists is provided to the public to permit replication of the treatment procedures employed in Project MATCH, a multisite clinical trial of patient-treatment matching sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). It describes Motivational Enhancement Therapy (MET), one of three treatment approaches studied in Project MATCH. Therapist manuals for the other treatments—Twelve-Step Facilitation Therapy (TSF) and Cognitive-Behavioral Coping Skills Therapy (CBT)—are available in volumes 1 and 3 of this series, respectively.

Rationale for Patient-Treatment Matching

Although a number of therapies have had varying degrees of success, no single treatment has been shown to be effective for all individuals diagnosed with alcohol abuse or dependence. In recent years, interest in the field has increasingly focused on patient-treatment matching to improve outcome. The hypothesis is that more beneficial results can be obtained if treatment is prescribed on the basis of individual patient needs and characteristics as opposed to treating all patients with the same diagnosis in the same manner.

Many investigators have turned their attention from main effects evaluations (i.e., studies that ask whether one intervention is more effective than another) to studies specifically designed to identify interactions between particular treatments and patient variables. While treatments may not appear to differ in effectiveness when applied to a heterogeneous client population, specific treatments may indeed be more or less effective for specific, clinically meaningful subgroups.

This reasoning has led to a new generation of alcoholism treatment research studies whose design is driven by the objective of finding effective “matches.” Ultimately, the goal of this line of research is to provide the clinician with valid and practical rules applicable across a variety of treatment settings to assign patients to those treatment regimens particularly suited to them.

Project MATCH: An Overview

Project MATCH, a 5-year study, was initiated by the Treatment Research Branch of NIAAA in 1989. The details of the design and implementation of Project MATCH will be described in full in forthcoming publications. This section outlines the major features of the study.

The objective of Project MATCH is to determine if varying subgroups of alcohol abusing or dependent patients respond differentially to three treatments: (1) Twelve-Step Facilitation Therapy, (2) Cognitive-Behavioral Coping Skills Therapy, and (3) Motivational Enhancement Therapy. Each treatment is delivered during a 12-week period by trained therapists following a standardized protocol.

The project consists of two independent treatment-matching studies, one with clients recruited at five outpatient settings, the second with patients receiving aftercare treatment at four sites following an episode of standard inpatient treatment. Patients are randomly assigned to one of the three treatment approaches. Each study evaluates the interaction effects between selected patient characteristics and the three treatments.

Each of the nine study sites is recruiting approximately 150–200 clients. Clients are evaluated at intake and again at 3, 6, 9, 12, and 15 months. Outcome measures for the trial include drinking behavior, psychological and social function, and consequences of drinking. Analyses of a priori hypotheses, as well as exploratory analyses, will show whether different patient characteristics are associated with differential treatment outcomes in each of the three therapeutic interventions.

Motivational Enhancement Therapy. MET is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own resources. MET consists of four carefully planned and individualized treatment sessions. The first two sessions focus on structured feedback from the initial assessment, future plans, and motivation for change. The final two sessions at the midpoint and end of treatment provide opportunities for the therapist to reinforce progress, encourage reassessment, and provide an objective perspective on the process of change.

The manual for this modality begins with an overview of MET and a description of the general principles to be applied. A special section discusses how to involve a significant other in MET. Then, specific guidelines are provided for how to structure the four MET sessions. Finally, recommendations are made for dealing with special problems that can arise in conducting MET. Appendix A offers specific instructions for preparing and explaining an individualized client feedback form. Copies of materials provided to MET clients are also included.

Appendix B offers guidelines for how to apply the manual—written from the perspective of outpatient treatment—within a program of aftercare following residential care.

Twelve-Step Facilitation Approach. This therapy is grounded in the concept of alcoholism as a spiritual and medical disease. The content of this intervention is consistent with the 12 Steps of Alcoholics Anonymous (AA), with primary emphasis given to Steps 1 through 5. In addition to abstinence from alcohol, a major goal of the treatment is to foster the patient's commitment to participation in AA. During the course of the program's 12 sessions, patients are actively encouraged to attend AA meetings and to maintain journals of their AA attendance and participation. Therapy sessions are highly structured, following a similar format each week that includes symptoms inquiry, review and reinforcement for AA participation, introduction and explication of the week's theme, and setting goals for AA participation for the next week. Material introduced during treatment sessions is complemented by reading assignments from AA literature.

Cognitive-Behavioral Coping Skills Therapy. This therapy is based on the principles of social learning theory and views drinking behavior as functionally related to major problems in the person's life. It posits that addressing this broad spectrum of problems will prove more effective than focusing on drinking alone. Emphasis is placed on overcoming skill deficits and increasing the person's ability to cope with high-risk situations that commonly precipitate relapse, including both interpersonal difficulties and intrapersonal discomfort, such as anger or depression. The program consists of 12 sessions with the goal of training the individual to use active behavioral or cognitive coping methods to deal with problems, rather than relying on alcohol as a maladaptive coping strategy. The skills also provide a means of obtaining social support critical to the maintenance of sobriety.

Caveats and Critical Considerations

Although all three manuals were developed for a randomized clinical trial focusing on patient-treatment matching hypotheses, the substance of the interventions is equally suitable for other research questions and designs. However, the reader needs to be aware of the parameters of Project MATCH.

Therapy is delivered in a structured research situation. All three treatments are manual guided and administered by experienced therapists who receive specialized training in one of the three project interventions. Therapists closely follow the procedures outlined in their manual, with regular supervision (by observation of videotapes) from both local and projectwide clinical supervisors.

This manual is written for therapists with similar intensive training and supervision. A summary of the procedures used to select, train, and supervise therapists in Project MATCH is provided in appendix C.

There is an important difference between a therapy textbook and a therapy manual. A therapy *textbook* is a comprehensive presentation of a particular therapeutic approach, usually describing a conceptual model, general principles, and a broad range of applications and examples. It is typically meant to facilitate broad utilization of a therapeutic approach by a wide range of practitioners in a variety of settings. A therapy *manual*, on the other hand, is intended to operationalize and standardize a treatment approach to be used in a particular context, usually a specific clinical trial. In writing a therapy manual, the authors must make a number of specific decisions (e.g., the number and timing of sessions, the content of each session) that are ordinarily left to clinical judgment in a therapy textbook.

This manual is designed to standardize MET as a four-session treatment modality within the particular context of Project MATCH. All treatments are preceded by the same extensive assessment battery, requiring approximately 7–8 hours. Abstinence is the expressed goal of all treatments, and except in unusual situations, all sessions are videotaped. Each treatment session is preceded by a breath test to ensure sobriety, and a positive breath alcohol reading results in rescheduling the session. Therapists are prohibited from mixing MET with other treatment approaches, and the purity of approach is maintained by local and national supervisors who review videotapes. All therapy has to be completed within 90 days. A significant other can be invited to participate in up to two sessions.

Other design requirements of clinical trials are likewise standardized across all sites, including features such as defined patient eligibility criteria, randomized assignment of treatment, and guidelines for dealing with patients who are late or absent for treatment sessions or who show significant clinical deterioration during the course of the intervention. Guidelines regulate and document the amount and type of therapy over and above that provided by Project MATCH that a client receives during the study. Data collection and delivery of treatment are kept strictly separate, with the former being handled by research assistants under the supervision of the project coordinators. The three manuals refer to these Project MATCH-specific procedures with the knowledge that some readers may wish to follow similar guidelines, while others may choose to devise new guidelines more appropriate to the requirements of their own project.

The therapist style and many specific concepts embodied in this manual were drawn from Miller and Rollnick's (1991) *Motivational Interviewing*. We are grateful to Guilford Press for their permission to publish this specific adaptation. Similar approaches have been more

briefly described elsewhere (Edwards and Orford 1977; Miller 1983; van Bilsen and van Emst 1986; Zweben et al. 1983, 1988). The bibliography of this manual provides a range of clinical, videotape, and research resources for further reference.

The general therapeutic principles underlying MET can be applied in many other ways than those delineated here (Miller and Rollnick 1991). Under ordinary circumstances, the number, duration, and distribution of sessions could be flexible. Significant others might be involved in all sessions or none at all. The goals of therapy might be more flexible (Miller 1987), and motivational-counseling procedures could be intermixed with other therapeutic strategies. The specific prescriptions outlined in this manual are imposed for purposes of standardization and separation of treatments in Project MATCH.

The staffs of Project MATCH and NIAAA make no claims or guarantees regarding the effectiveness of the treatment procedures described in this manual. Although the principles of MET are well grounded in clinical and experimental research, the specific efficacy of MET as outlined in this manual remains to be tested. The final reports of Project MATCH will provide clearer information on the efficacy of this approach relative to others and on the types of clients for whom it may be optimal. In the interim, this manual offers a detailed description of MET procedures as constructed by consensus among the investigators and implemented by the therapists of Project MATCH. All manuals of this kind should be regarded as under development and subject to ongoing improvement based on subsequent research and experience.

The planning and operation of Project MATCH and the products now resulting from it, including this series of manuals, reflect the efforts of many individuals over a period of several years. Their dedication and collegial collaboration have been remarkable and will enrich the field of alcoholism treatment research for years to come.

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Introduction

Overview

Motivational Enhancement Therapy (MET) is a systematic intervention approach for evoking change in problem drinkers. It is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This treatment strategy does not attempt to guide and train the client, step by step, through recovery, but instead employs motivational strategies to mobilize the client's own change resources.

Treatment is preceded by an extensive assessment battery (appendix A) requiring approximately 7–8 hours. Each treatment session is preceded by a breath test to ensure sobriety, and a positive breath alcohol reading is cause for rescheduling the session.

As offered in Project MATCH, MET consists of four carefully planned and individualized treatment sessions. Whenever possible, the client's spouse or another "significant other" is included in the first two of these four sessions. The first treatment session (week 1) focuses on (1) providing structured feedback from the initial assessment regarding problems associated with drinking, level of consumption and related symptoms, decisional considerations, and future plans and (2) building client motivation to initiate or continue change. The second session (week 2) continues the motivation enhancement process, working toward consolidating commitment to change. In two followthrough sessions, at week 6 and week 12, the therapist continues to monitor and encourage progress. All therapy is completed within 90 days.

MET is not intended to be a minimal or control treatment condition. MET is, in its own right, an effective outpatient treatment strategy which, by virtue of its rationale and content, requires fewer therapist-directed sessions than some alternatives. It may, therefore, be particularly useful in situations where contact with problem drinkers is limited to few or infrequent sessions (e.g., in general medical practice or in employee assistance programs). Treatment outcome research strongly supports MET strategies as effective in producing change in problem drinkers.

The initial presentation of MET in this manual is written from the perspective of outpatient treatment. These procedures can also be

applied in aftercare, however, and such adaptation is addressed in appendix B.

Research Basis for MET

For more than two decades, research has pointed to surprisingly few differences in outcome between longer, more intensive alcohol treatment programs and shorter, less intensive, even relatively brief alternative approaches (Annis 1985; Miller and Hester 1986b; Miller and Rollnick 1991; U. S. Congress, Office of Technology Assessment 1983). One interpretation of such findings is that all alcohol treatments are equally ineffective. A larger review of the literature, however, does not support such pessimism. Significant differences among alcohol treatment modalities are found in nearly half of clinical trials, and relatively brief treatments have been shown in numerous studies to be more effective than no intervention (Holder et al. 1991).

An alternative interpretation of this outcome picture is that many treatments contain a common core of ingredients which evoke change and that additional components of more extensive approaches may be unnecessary in many cases. This has led, in the addictions field as elsewhere, to a search for the critical conditions that are necessary and sufficient to induce change (e.g., Orford 1986). Miller and Sanchez (in press) described six elements which they believed to be active ingredients of the relatively brief interventions that have been shown by research to induce change in problem drinkers, summarized by the acronym FRAMES:

- FEEDBACK of personal risk or impairment
- Emphasis on personal RESPONSIBILITY for change
- Clear ADVICE to change
- A MENU of alternative change options
- Therapist EMPATHY
- Facilitation of client SELF-EFFICACY or optimism

These therapeutic elements are consistent with a larger review of research on what motivates problem drinkers for change (Miller 1985; Miller and Rollnick 1991).

Therapeutic interventions containing some or all of these motivational elements have been demonstrated to be effective in initiating treatment and in reducing long-term alcohol use, alcohol-related problems, and health consequences of drinking. Table 1 summarizes this research. It is noteworthy that, in a number of these studies, the

Table 1. Specific FRAMES components of evaluated brief interventions

Author	Feedback	Response	Advice	Menu	Empathy	Self-Efficacy	Outcome
*Anderson and Scott 1992	Yes	Yes	Yes	Yes	Yes	Yes	Brief > No counseling
*Babor and Grant 1991	Yes	Yes	Yes	Manual	Yes	Yes	Brief > No counseling
*Bien 1991	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Brown and Miller 1992	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Carpenter et al. 1985	Yes	No	Yes	No	No	No	Brief = Extended counseling
*Chapman and Huygens 1988	Yes	Yes	Yes	Yes	No	Yes	Brief = IPT = OPT treatment
*Chick et al. 1985	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Chick et al. 1988	No	Yes	Yes	No	No	No	Brief < Extended motiv cnslg
Daniels et al. 1992	Yes	No	Yes	Manual	No	No	Advice + Manual = No advice
Drummond et al. 1992	Yes	No	Yes	No	No	No	Brief = OPT treatment
Edwards et al. 1977	Yes	Yes	Yes	No	Yes	Yes	Brief = OPT/IPT treatment
Elvy et al. 1988	Yes	No	Yes	No	No	No	Brief > No counseling
*Harris and Miller 1990	No	Yes	Yes	Manual	Yes	Yes	Brief = Extended > No treatment
*Heather et al. 1986	Yes	Yes	Manual	Manual	No	No	Manual > No manual
*Heather et al. 1987	Yes	Yes	Yes	Manual	No	No	Brief = No counseling
*Heather et al. 1990	Yes	Yes	Yes	Manual	No	No	Manual > No manual
*Kristenson et al. 1983	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
Kuchipudi et al. 1990	Yes	No	Yes	Yes	No	No	Brief = No counseling
Maheswaran et al. 1990	Yes	No	Yes	No	No	No	Brief > No counseling
*Miller and Taylor 1980	No	Yes	Yes	Manual	Yes	Yes	Brief = Behavioral counseling
*Miller et al. 1980	No	Yes	Yes	Manual	Yes	Yes	Brief = Behavioral counseling
*Miller et al. 1981	No	Yes	Yes	Manual	Yes	Yes	Brief = Behavioral counseling
*Miller et al. 1988	Yes	Yes	Yes	Yes	Yes	Yes	Brief > No counseling
*Miller et al. 1991	Yes	Yes	Yes	Yes	Yes	Yes	Brief > No counseling
*Persson and Magnusson 1989	Yes	Yes	Yes	No	Yes	Yes	Brief > No counseling
*Robertson et al. 1986	Yes	Yes	Yes	Yes	Yes	Yes	Brief < Behavioral counseling
*Romelsjo et al. 1989	Yes	Yes	Yes	No	Yes	Yes	Brief = OPT treatment
*Sannibale 1989	Yes	Yes	Yes	No	Yes	Yes	Brief = OPT treatment
*Scott and Anderson 1990	Yes	Yes	Yes	Yes	Yes	Yes	Brief = No counseling
*Skutle and Berg 1987	No	Yes	Yes	Yes+Man	Yes	Yes	Brief = Behavioral counseling
*Wallace et al. 1988	Yes	Yes	Yes	Manual	Yes	Yes	Brief > No counseling
*Zweben et al. 1988	Yes	Yes	Yes	Yes	No	Yes	Brief = Conjoint therapy
Percent Yes	81	81	100	59	63	69	

Source: Bien, Miller, and Tonigan 1992.

NOTE: Components listed are characteristics of the *brief* intervention in each study.

* Additional information obtained from the study's authors.

Manual = Manual-guided therapy; IPT = Inpatient treatment setting; OPT = Outpatient treatment setting

motivational intervention yielded comparable outcomes even when compared with longer, more intensive alternative approaches.

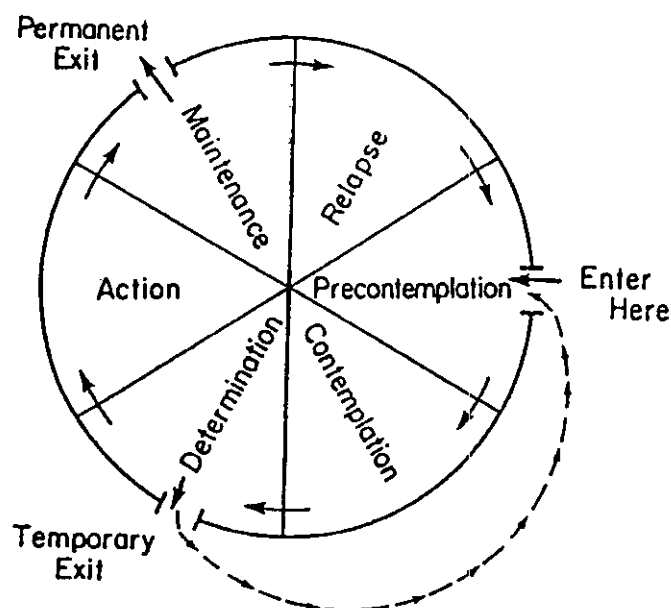
Further evidence supports the efficacy of the therapeutic *style* that forms the core of MET. The therapist characteristic of "accurate empathy," as defined by Carl Rogers and his students (e.g., Rogers 1957, 1959; Truax and Carkhuff 1967), has been shown to be a powerful predictor of therapeutic success with problem drinkers, even when treatment is guided by another (e.g., behavioral) rationale (Miller et al. 1980; Valle 1981). Miller, Benefield, and Tonigan (in press) reported that the degree to which therapists engaged in direct confrontation (conceptually opposite to an empathic style) was predictive of continued client drinking 1 year after treatment.

Stages of Change

The MET approach is further grounded in research on processes of natural recovery. Prochaska and DiClemente (1982, 1984, 1985, 1986) have described a transtheoretical model of how people change addictive behaviors, with or without formal treatment. In a transtheoretical perspective, individuals move through a series of stages of change as they progress in modifying problem behaviors. This concept of stages is important in understanding change. Each stage requires certain tasks to be accomplished and certain processes to be used in order to achieve change. Six separate stages were identified in this model (Prochaska and DiClemente 1984, 1986).

Figure 1. A Stage Model of the Process of Change

Prochaska and DiClemente



People who are not considering change in their problem behavior are described as PRECONTEMPLATORS. The CONTEMPLATION stage entails individuals' beginning to consider both that they have a problem and the feasibility and costs of changing that behavior. As individuals progress, they move on to the DETERMINATION stage, where the decision is made to take action and change. Once individuals begin to modify the problem behavior, they enter the ACTION stage, which normally continues for 3–6 months. After successfully negotiating the action stage, individuals move to MAINTENANCE or sustained change. If these efforts fail, a RELAPSE occurs, and the individual begins another cycle (see figure 1).

The ideal path is directly from one stage to the next until maintenance is achieved. For most people with serious problems related

to drinking, however, the process involves several slips or relapses which represent failed action or maintenance. The good news is that most who relapse go through the cycle again and move back into contemplation and the change process. Several revolutions through this cycle of change are often needed to learn how to maintain change successfully.

From a stages-of-change perspective, the MET approach addresses where the client currently is in the cycle of change and assists the person to move through the stages toward successful sustained change. For the ME therapist, the contemplation and determination stages are most critical. The objective is to help clients seriously consider two basic issues. The first is how much of a problem their drinking behavior poses for them and how their drinking is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drinking toward change is essential for movement from contemplation to determination. Second, the client in contemplation assesses the possibility and the costs/benefits of changing the problem behavior. Clients consider whether they will be able to make a change and how that change will affect their lives.

In the determination stage, clients develop a firm resolve to take action. That resolve is influenced by past experiences with change attempts. Individuals who have made unsuccessful attempts to change their drinking behavior in the past need encouragement to decide to go through the cycle again.

Understanding the cycle of change can help the ME therapist to empathize with the client and can give direction to intervention strategies. Though individuals move through the cycle of change in their own ways, it is the same cycle. The speed and efficiency of movement through the cycle, however, will vary. The task is to assist the individual in moving from one stage to the next as swiftly and effectively as possible.

In sum, MET is well grounded in theory and research on the successful resolution of alcohol problems. It is consistent with an understanding of the stages and processes that underlie change in addictive behaviors. It draws on motivational principles that have been derived from both experimental and clinical research. A summary of alcohol treatment outcome research reveals that a motivational approach of this kind is strongly supported by clinical trials: its overall effectiveness compares favorably with outcomes of alternative treatments, and when cost-effectiveness is considered, an MET strategy fares well indeed in comparison with other approaches (Holder et al. 1991).

Clinical Considerations

Rationale and Basic Principles

The MET approach begins with the assumption that the responsibility and capability for change lie within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change. Rather than relying upon therapy sessions as the primary locus of change, the therapist seeks to mobilize the client's inner resources as well as those inherent in the client's natural helping relationships. MET seeks to support *intrinsic* motivation for change, which will lead the client to initiate, persist in, and comply with behavior change efforts. Miller and Rollnick (1991) have described five basic motivational principles underlying such an approach:

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy

Express Empathy

The ME therapist seeks to communicate great respect for the client. Communications that imply a superior/inferior relationship between therapist and client are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The client's freedom of choice and self-direction are respected. Indeed, in this view, *only* the clients can decide to make a change in their drinking and carry out that choice. The therapist seeks ways to compliment rather than denigrate, to build up rather than tear down. Much of MET is *listening rather than telling*. Persuasion is gentle, subtle, always with the assumption that change is up to the client. The power of such gentle, nonaggressive persuasion has been widely recognized in clinical writings, including Bill Wilson's own advice to alcoholics on "working with others" (*Alcoholics Anonymous* 1976). Reflective listening (accurate empathy) is a key skill in motivational interviewing. It

communicates an acceptance of clients as they are, while also supporting them in the process of change.

Develop Discrepancy

Motivation for change occurs when people *perceive a discrepancy between where they are and where they want to be*. The MET approach seeks to enhance and focus the client's attention on such discrepancies with regard to drinking behavior. In certain cases (e.g., the pre-contemplators in Prochaska and DiClemente's model), it may be necessary first to *develop* such discrepancy by raising clients' awareness of the personal consequences of their drinking. Such information, properly presented, can precipitate a crisis (critical mass) of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options in order to reduce the perceived discrepancy and regain emotional equilibrium. When the client enters treatment in the later contemplation stage, it takes less time and effort to move the client along to the point of determination for change.

Avoid Argumentation

If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the client's discomfort but do not alter drinking and related risks. An unrealistic (from the clients' perspective) attack on their drinking behavior tends to evoke defensiveness and opposition and suggests that the therapist does not really understand.

The MET style explicitly avoids direct argumentation, which tends to evoke resistance. No attempt is made to have the client accept or "admit" a diagnostic label. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the client to see accurately the consequences of drinking and to begin devaluing the perceived positive aspects of alcohol. When MET is conducted properly, *the client and not the therapist voices the arguments for change* (Miller and Rollnick 1991).

Roll With Resistance

How the therapist handles client "resistance" is a crucial and defining characteristic of the MET approach. MET strategies do not meet resistance head on, but rather "roll with" the momentum, with a goal of shifting client perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. *Solutions are usually evoked from the client rather than provided by the therapist*. This approach for dealing with resistance is described in more detail later.

Support Self-Efficacy

People who are persuaded that they have a serious problem will still not move toward change unless there is hope for success. Bandura (1982) has described "self-efficacy" as a critical determinant of behav-

ior change. Self-efficacy is, in essence, the belief that one *can* perform a particular behavior or accomplish a particular task. In this case, clients must be persuaded that it is possible to change their own drinking and thereby reduce related problems. In everyday language, this might be called hope or optimism, though an *overall* optimistic nature is not crucial here. Rather, it is the clients' *specific belief that they can change* the drinking problem. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g., rationalization, denial) to reduce discomfort without changing behavior. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

Differences From Other Treatment Approaches

The MET approach differs dramatically from confrontational treatment strategies in which the therapist takes primary responsibility for “breaking down the client’s denial.” Miller (1989, p. 75) provided these contrasts between approaches:

Confrontation-of-Denial Approach	Motivational-Interviewing Approach
Heavy emphasis on acceptance of self as “alcoholic”; acceptance of diagnosis seen as essential for change	Deemphasis on labels; acceptance of “alcoholism” label seen as unnecessary for change to occur
Emphasis on disease of alcoholism which reduces personal choice and control	Emphasis on personal choice regarding future use of alcohol and other drugs
Therapist presents perceived evidence of alcoholism in an attempt to convince the client of the diagnosis	Therapist conducts objective evaluation but focuses on eliciting the client’s own concerns
Resistance seen as “denial,” a trait characteristic of alcoholics requiring confrontation	Resistance seen as an interpersonal behavior pattern influenced by the therapist’s behavior
Resistance is met with argumentation and correction	Resistance is met with reflection

A goal of the ME therapist is to evoke *from the client* statements of problem perception and a need for change (see “Eliciting Self-Motivational Statements”). This is the conceptual opposite of an approach in which the therapist takes responsibility for voicing these perspectives (“You’re an alcoholic, and you have to quit drinking”) and persuading

the client of the truth. The ME therapist emphasizes the client's ability to change (self-efficacy) rather than the client's helplessness or powerlessness over alcohol. As discussed earlier, arguing with the client is carefully avoided, and strategies for handling resistance are more reflective than exhortational. The ME therapist, therefore, does *not*—

- Argue with clients.
- Impose a diagnostic label on clients.
- Tell clients what they “must” do.
- Seek to “break down” denial by direct confrontation.
- Imply clients’ “powerlessness.”

The MET approach also differs substantially from cognitive-behavioral treatment strategies that prescribe and attempt to teach clients specific coping skills. No direct skill training is included in the MET approach. Clients are not taught “how to.” Rather, the MET strategy relies on the client's own natural change processes and resources. Instead of telling clients how to change, the ME therapist builds motivation and elicits ideas as to how change might occur. Thus, the following contrasts apply:

Cognitive-Behavioral Approach

Assumes that the client is motivated; no direct strategies for building motivation for change

Seeks to identify and modify maladaptive cognitions

Prescribes specific coping strategies

Teaches coping behaviors through instruction, modeling, directed practice, and feedback

Specific problem-solving strategies are taught

Motivational Enhancement Approach

Employs specific principles and strategies for building client motivation

Explores and reflects client perceptions without labeling or “correcting” them

Elicits possible change strategies from the client and significant other

Responsibility for change methods is left with the client; no training, modeling, or practice

Natural problem-solving processes are elicited from the client and significant other

(Miller and Rollnick 1991)

MET, then, is an entirely different strategy from skill training. It assumes that the key element for lasting change is a motivational shift that instigates a decision and commitment to change. In the absence of such a shift, skill training is premature. Once such a shift has occurred, however, people's ordinary resources and their natural relationships may well suffice. Syme (1988), in fact, has argued that for many individuals a skill-training approach may be inefficacious precisely because it removes the focus from what is the key element of transformation: a clear and firm *decision* to change (cf. Miller and Brown 1991).

Finally, it is useful to differentiate MET from nondirective approaches with which it might be confused. In a strict Rogerian approach, the therapist does not direct treatment but follows the client's direction wherever it may lead. In contrast, MET employs systematic strategies toward specific goals. The therapist seeks actively to create discrepancy and to channel it toward behavior change (Miller 1983). Thus MET is a directive and persuasive approach, not a nondirective and passive approach.

Nondirective Approach

Allows the client to determine the content and direction of counseling

Avoids injecting the counselor's own advice and feedback

Empathic reflection is used noncontingently

Explores the client's conflicts and emotions as they are currently

Motivational Enhancement Approach

Systematically directs the client toward motivation for change

Offers the counselor's own advice and feedback where appropriate

Empathic reflection is used selectively to reinforce certain points

Seeks to create and amplify the client's discrepancy in order to enhance motivation for change

(Miller and Rollnick 1991)

Practical Strategies

Phase 1: Building Motivation for Change

Motivational counseling can be divided into two major phases: building motivation for change and strengthening commitment to change (Miller and Rollnick 1991). The early phase of MET focuses on developing clients' motivation to make a change in their drinking. Clients will vary widely in their readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation and to begin consolidating commitment. Others will be reluctant or even hostile at the outset. At the extreme, some true precontemplators may be coerced into treatment by family, employer, or legal authorities. Most clients, however, are likely to enter the treatment process somewhere in the contemplation stage. They may already be dabbling with taking action but still need consolidation of motivation for change.

This phase may be thought of as tipping the motivational balance (Janis and Mann 1977; Miller 1989; Miller et al. 1988). One side of the seesaw favors status quo (i.e., continued drinking as before), whereas the other favors change. The former side of the decisional balance is weighed down by perceived positive benefits from drinking and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's drinking and feared consequences of continuing unchanged. Your task is to shift the balance in favor of change. Eight strategies toward this end (Miller and Rollnick 1991) are outlined in this section.

Eliciting Self-Motivational Statements

There is truth to the saying that we can "talk ourselves into" a change. Motivational psychology has amply demonstrated that when people are subtly enticed to speak or act in a new way, their beliefs and values tend to shift in that direction. This phenomenon has sometimes been described as cognitive dissonance (Festinger 1957). Self-perception theory (Bem 1965, 1967, 1972), an alternative account of this phenomenon, might be summarized: "As I hear myself talk, I learn what I believe." That is, the words which come out of a person's mouth are quite persuasive to that person—more so, perhaps, than words spoken by another. "If I say it, and no one has forced me to say it, then I must believe it!"

If this is so, then the *worst* persuasion strategy is one that evokes defensive argumentation from the person. Head-on confrontation is rarely an effective sales technique (“Your children are educationally deprived, and you will be an irresponsible parent if you don’t buy this encyclopedia”). This is a flawed approach not only because it evokes hostility, but also because it provokes the client to verbalize precisely the *wrong* set of statements. An aggressive argument that “You’re an alcoholic and you have to stop drinking” will usually evoke a predictable set of responses: “No I’m not, and no I don’t.” Unfortunately, counselors are sometimes trained to understand such a response as client “denial” and to push all the harder. The likely result is a high level of client resistance.

The positive side of the coin is that the ME therapist seeks to elicit from the client certain kinds of statements that can be considered, within this view, to be self-motivating (Miller 1983). These include statements of—

- Being open to input about drinking.
- Acknowledging real or potential problems related to drinking.
- Expressing a need, desire, or willingness to change.

There are several ways to elicit such statements from clients. One is to ask for them directly, via open-ended questions. Some examples:

- I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your drinking. Tell me about those.
- Tell me a little about your drinking. What do you like about drinking? What’s positive about drinking for you? And what’s the other side? What are your worries about drinking?
- Tell me what you’ve noticed about your drinking. How has it changed over time? What things have you noticed that concern you, that you think could be problems, or might become problems?
- What have other people told you about your drinking? What are other people worried about? (If a spouse or significant other is present, this can be asked directly.)
- What makes you think that perhaps you need to make a change in your drinking?

Once this process is rolling, simply keep it going by using reflective listening (see below), by asking for examples, by asking “What else?,” and so forth. If it bogs down, you can inventory general areas such as—

- *Tolerance*—does the client seem to be able to drink more than other people without showing as much effect?
- *Memory*—has the client had periods of not remembering what happened while drinking or other memory problems?
- *Relationships*—has drinking affected relationships with spouse, family, or friends?
- *Health*—is the client aware of any health problems related to using alcohol?
- *Legal*—have there been any arrests or other brushes with the law because of behavior while drinking?
- *Financial*—has drinking contributed to money problems?

Information from the pretreatment assessment (to be used as feedback later) may also suggest some areas to explore.

If you encounter difficulties in eliciting client concerns, still another strategy is to employ gentle paradox to evoke self-motivational statements. In this table-turning approach, you subtly take on the voice of the client’s “resistance,” evoking from the client the opposite side. Some examples:

- You haven’t convinced me yet that you are seriously concerned. You’ve come down here and gone through several hours of assessment. Is that *all* you’re concerned about?
- I’ll tell you one concern I have. This program is one that requires a fair amount of motivation from people, and frankly, I’m not sure from what you’ve told me so far that you’re motivated enough to carry through with it. Do you think we should go ahead?
- I’m not sure how much you are interested in changing, or even in taking a careful look at your drinking. It sounds like you might be happier just going on as before.

Particularly in the presence of a significant other, such statements may elicit new self-motivational material. Similarly, a client may back down from a position if you state it more extremely, even in the form of a question. For example:

- So drinking is really *important* to you. Tell me about that.
- What is it about drinking that you really need to hang onto, that you can't let go of?

In general, however, the best opening strategy for eliciting self-motivational statements is to ask for them:

- Tell me what concerns you about your drinking.
- Tell me what it has cost you.
- Tell me why you think you might need to make a change.

Listening With Empathy

The eliciting strategies just discussed are likely to evoke some initial offerings, but it is also crucial how you *respond* to clients' statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is an optimal response within MET.

Empathy is commonly thought of as "feeling with" people, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Carl Rogers, however, introduced a new technical meaning for the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers 1957, 1959). In this style, the therapist listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form. Acknowledgment of the client's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke client resistance, (2) it encourages the client to keep talking and exploring the topic, (3) it communicates respect and caring and builds a working therapeutic alliance, (4) it clarifies for the therapist exactly what the client means, and (5) it can be used to reinforce ideas expressed by the client.

This last characteristic is an important one. You can reflect quite selectively, choosing to reinforce certain components of what the client has said and ignoring others. In this way, clients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the client to elaborate the reflected statement. Here is an example of this process.

THERAPIST: What else concerns you about your drinking?

CLIENT: Well, I'm not sure I'm *concerned* about it, but I do wonder sometimes if I'm drinking too much.

T: Too much for . . .

C: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.

T: It messes up your thinking, your concentration.

C: Yes, and sometimes I have trouble remembering things.

T: And you wonder if that might be because you're drinking too much.

C: Well, I know it is sometimes.

T: You're pretty sure about that. But maybe there's more.

C: Yeah—even when I'm not drinking, sometimes I mix things up, and I wonder about that.

T: Wonder if . . .

C: If alcohol's pickling my brain, I guess.

T: You think that can happen to people, maybe to you.

C: Well, can't it? I've heard that alcohol kills brain cells.

T: Um-hmm. I can see why that would worry you.

C: But I don't think I'm an alcoholic or anything.

T: You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.

C: Yeah.

T: Kind of a scary thought. What else worries you?

This therapist is responding primarily with reflective listening. This is not, by any means, the *only* strategy used in MET, but it is an important one. Neither is this an easy skill. Easily parodied or done poorly, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses. Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning in favor of continued exploration of the

client's own processes. (For more detail, see Egan 1982; Miller and Jackson 1985.)

It may be of further help to contrast reflective with alternative therapist responses to some client statements:

CLIENT: I guess I do drink too much sometimes, but I don't think I have a *problem* with alcohol.

- CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .
- QUESTION: Why do you think you don't have a problem?
- REFLECTION: So on the one hand, you can see some reasons for concern, *and* you really don't want to be labeled as "having a problem."

CLIENT: My wife is always telling me that I'm an alcoholic.

- JUDGING: What's wrong with that? She probably has some good reasons for thinking so.
- QUESTION: Why does she think that?
- REFLECTION: And that really annoys you.

CLIENT: If I quit drinking, what am I supposed to do for friends?

- ADVICE: I guess you'll have to get some new ones.
- SUGGESTION: Well, you could just tell your friends that you don't drink anymore, but you still want to see them.
- REFLECTION: It's hard for you to imagine living without alcohol.

This style of reflective listening is to be used throughout MET. It is not to be used to the exclusion of other kinds of responses, but it should be your predominant style in responding to client statements. As the following sections indicate, however, the ME therapist also uses a variety of other strategies.

Finally, it should be noted that selective reflection can backfire. For a client who is ambivalent, reflection of one side of the dilemma ("So you can see that drinking is causing you some problems") may evoke the other side from the client ("Well, I don't think I have a *problem* really"). If this occurs, the therapist should reflect the ambivalence. This is often best done with a double-sided reflection that captures both sides of the client's discrepancy. These may be joined in the middle by the

conjunction “but” or “and,” though we favor the latter to highlight the ambivalence:

DOUBLE-SIDED REFLECTIONS

- You don’t think that alcohol is harming you seriously now, and at the same time you *are* concerned that it might get out of hand for you later.
- You really enjoy drinking and would hate to give it up, and you can also see that it is causing serious problems for your family and your job.

Questioning

The MET style also includes questioning as an important therapist response. Rather than *telling* clients how they should feel or what to do, the therapist *asks* clients about their own feelings, ideas, concerns, and plans. Elicited information is then responded to with empathic reflection, affirmation, or refraining (see below).

Presenting Personal Feedback

The first MET session should always include feedback to the client from the pretreatment assessment. This is done in a structured way, providing clients with a written report of their results (Personal Feedback Report) and comparing these with normative ranges.

To initiate this phase, give the client (and significant other, if attending) the Personal Feedback Report (PFR), retaining a copy for your own reference. Go through the PFR step by step, explaining each item of information, pointing out the client’s score and comparing it with normative data. The specific protocol used in Project MATCH is provided in appendix A along with suggestions for developing alternative batteries.

A very important part of this process is your own monitoring of and responding to the client during the feedback. Observe the client as you provide personal feedback. Allow time for the client (and significant other) to respond verbally. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to resistance statements, perhaps reframing them or embedding them in a double-sided reflection. Examples:

CLIENT: Wow! I’m drinking a lot more than I realized.
THERAPIST: It looks awfully high to you.

CLIENT: I can’t believe it. I don’t see how my drinking can be affecting me that much.
THERAPIST: This isn’t what you expected to hear.

CLIENT: No, I don't really drink that much more than other people.

THERAPIST: So this is confusing to you. It seems like you drink about the same amount as your friends, yet here are the results. Maybe you think there's something wrong with the tests.

CLIENT: More bad news!

THERAPIST: This is pretty difficult for you to hear.

CLIENT: This gives me a lot to think about.

THERAPIST: A lot of reasons to think about making a change.

The same style of responding can be used with the client's significant other (SO). In this case, it is often helpful to reframe or emphasize the caring aspects behind what the SO is saying:

WIFE: I always thought he was drinking too much.

THERAPIST: You've been worried about him for quite a while.

HUSBAND: (weeping) I've *told* you to quit drinking!

THERAPIST: You really care about her a lot. It's hard to sit there and hear these results.

After reflecting an SO's statement, it is often wise to ask for the client's perceptions and to reflect self-motivational elements:

FRIEND: I never really thought he drank that much!

THERAPIST: This is taking you by surprise. (To client:) How about you? Does this surprise you, too?

WIFE: I've been trying to tell you all along that you were drinking too much. Now maybe you'll believe me.

THERAPIST: You've been worrying about this for a long time, and I guess you're hoping now he'll see why you've been so concerned. (To client:) What *are* you thinking about all this? You're getting a lot of input here.

Often a client will respond *nonverbally*, and it is possible also to reflect these reactions. A sigh, a frown, a slow sad shaking of the head, a whistle, a snort, or tears can communicate a reaction to feedback. You can respond to these with a reflection of the apparent feeling.

If the client is not volunteering reactions, it is wise to pause periodically during the feedback process to ask:

- What do you make of this?
- Does this make sense to you?

- Does this surprise you?
- What do you think about this?
- Do you understand? Am I being clear here?

Clients will have questions about their feedback and the tests on which their results are based. For this reason, you need to be quite familiar with the assessment battery and its interpretation. In Project MATCH, additional interpretive information is provided for the client to take home.

In the training videotape, "Motivational Interviewing," developed by and available from Dr. William Miller, this style of presenting assessment feedback to a resistant problem drinker is demonstrated.

Affirming the Client

You should also seek opportunities to affirm, compliment, and reinforce the client sincerely. Such affirmations can be beneficial in a number of ways, including (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting client self-esteem. Some examples:

- I appreciate your hanging in there through this feedback, which must be pretty rough for you.
- I think it's great that you're strong enough to recognize the risk here and that you want to do something before it gets more serious.
- You've been through a lot together, and I admire the kind of love and commitment you've had in staying together through all this.
- You really have some good ideas for how you might change.
- Thanks for listening so carefully today.
- You've taken a big step today, and I really respect you for it.

Handling Resistance

Client resistance is a legitimate concern. Failure to comply with a therapist's instructions and resistant behaviors within treatment sessions (e.g., arguing, interrupting, denying a problem) are responses that predict poor treatment outcome.

What is resistance? Here are some client behaviors that have been found to be predictive of poor treatment outcome:

- *Interrupting*—cutting off or talking over the therapist
- *Arguing*—challenging the therapist, discounting the therapist's views, disagreeing, open hostility
- *Sidetracking*—changing the subject, not responding, not paying attention
- *Defensiveness*—minimizing or denying the problem, excusing one's own behavior, blaming others, rejecting the therapist's opinion, showing unwillingness to change, alleged impunity, pessimism

What too few therapists realize, however, is the extent to which such client resistance during treatment is powerfully affected by the therapist's own style. Miller, Benefield, and Tonigan (in press) found that when problem drinkers were randomly assigned to two different therapist styles (given by the same therapists), one confrontational-directive and one motivational-reflective, those in the former group showed substantially higher levels of resistance and were much less likely to acknowledge their problems and need to change. These client resistance patterns were, in turn, predictive of less long-term change. Similarly, Patterson and Forgatch (1985) had family therapists switch back and forth between these two styles within the *same* therapy sessions and demonstrated that client resistance and noncompliance went up and down markedly with therapist behaviors. The picture that emerges is one in which the therapist dramatically influences client defensiveness, which, in turn, predicts the degree to which the client will change.

This is in contrast with the common view that alcoholics are resistant because of pernicious personality characteristics that are part of their condition. Denial is often regarded as a trait of alcoholics. In fact, extensive research has revealed few or no consistent personality characteristics among alcoholics, and studies of defense mechanisms have found that alcoholics show no different pattern from nonalcoholics (Miller 1985). In sum, people with alcohol problems do not, in general, walk through the therapist's door already possessing high levels of denial and resistance. These important client behaviors are more a function of the interpersonal interactions that occur during treatment.

An important goal in MET, then, is to avoid evoking client resistance (antimotivational statements). Said more bluntly, *client resistance is a therapist problem*. How you *respond* to resistant behaviors is one of the defining characteristics of MET.

A first rule of thumb is *never meet resistance head on*. Certain kinds of reactions are likely to exacerbate resistance, back the client further

into a corner, and elicit antimotivational statements from the client (Gordon 1970; Miller and Jackson 1985). These therapist responses include—

- Arguing, disagreeing, challenging.
- Judging, criticizing, blaming.
- Warning of negative consequences.
- Seeking to persuade with logic or evidence.
- Interpreting or analyzing the “reasons” for resistance.
- Confronting with authority.
- Using sarcasm or incredulity.

Even direct questions as to why the client is “resisting” (e.g., Why do you think that you don’t have a problem?) only serve to elicit from the client further defense of the antimotivational position and leave you in the logical position of counterargument. *If you find yourself in the position of arguing with the client to acknowledge a problem and the need for change, shift strategies.*

Remember that you want the *client* to make self-motivational statements (basically, “I have a problem” and “I need to do something about it”), and if you defend these positions it may evoke the opposite. Here are several strategies for deflecting resistance (Miller and Rollnick 1991):

- *Simple reflection.* One strategy is simply to reflect what the client is saying. This sometimes has the effect of eliciting the opposite and balancing the picture.
- *Reflection with amplification.* A modification is to reflect but exaggerate or amplify what the client is saying to the point where the client is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility.

CLIENT: But I’m not an alcoholic, or anything like that.

THERAPIST: You don’t want to be labeled.

C: No. I don’t think I have a drinking problem.

T: So as far as you can see, there really haven’t been any problems or harm because of your drinking.

C: Well, I wouldn't say that.

T: Oh! So you do think sometimes your drinking has caused problems, but you just don't like the idea of being called an alcoholic.

- *Double-sided reflection.* The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a client offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

C: But I can't quit drinking. I mean, all of my friends drink!

T: You can't imagine how you could not drink with your friends, and at the same time you're worried about how it's affecting you.

- *Shifting focus.* Another strategy is to defuse resistance by shifting attention away from the problematic issue.

C: But I can't quit drinking. I mean, all of my friends drink!

T: You're getting way ahead of things. I'm not talking about your quitting drinking here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing here—going through your feedback—and later on we can worry about what, if anything, you want to do about it.

- *Rolling with.* Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this, which often will bring the client back to a balanced or opposite perspective. This strategy can be particularly useful with clients who present in a highly oppositional manner and who seem to reject every idea or suggestion.

C: But I can't quit drinking. I mean, all of my friends drink!

T: And it may very well be that when we're through, you'll decide that it's worth it to keep on drinking as you have been. It may be too difficult to make a change. That will be up to you.

Reframing

Reframing is a strategy whereby therapists invite clients to examine their perceptions in a new light or a reorganized form. New meaning is given to what has been said. When a client is receiving feedback that confirms drinking problems, a wife's reaction of "I knew it" can be

recast from “I’m right and I told you so” to “You’ve been so worried about him, and you care about him very much.”

The phenomenon of tolerance provides an excellent example for possible reframing (Miller and Rollnick 1991). Clients will often admit, even boast of, being able to “hold their liquor”—to drink more than other people without looking or feeling as intoxicated. This can be reframed (quite accurately) as a risk factor, the absence of a built-in warning system that tells people when they have had enough. Given high tolerance, people continue to drink to high levels of intoxication that can damage the body but fail to realize it because they do not look or feel intoxicated. Thus, what seemed good news (“I can hold it”) becomes bad news (“I’m especially at risk”).

Reframing can be used to help motivate the client and SO to deal with the drinking behavior. In placing current problems in a more positive or optimistic frame, the counselor hopes to communicate that the problem is solvable and changeable (Bergaman 1985; Fisch et al. 1982). In developing the reframe, it is important to use the client’s own views, words, and perceptions about drinking. Some examples of reframes that can be utilized with problem drinkers are:

- *Drinking as reward.* “You may have a need to reward yourself on the weekends for successfully handling a stressful and difficult job during the week.” The implication here is that there are alternative ways of rewarding oneself without going on a binge.
- *Drinking as a protective function.* “You don’t want to impose additional stress on your family by openly sharing concerns or difficulties in your life [give examples]. As a result, you carry all this yourself and absorb tension and stress by drinking, as a way of trying not to burden your family.” The implication here is that the problem drinker has inner strength or reserve, is concerned about the family, and could discover other ways to deal with these issues besides drinking.
- *Drinking as an adaptive function.* “Your drinking can be viewed as a means of avoiding conflict or tension in your marriage. Your drinking tends to keep the status quo, to keep things as they are. It seems like you have been drinking to keep your marriage intact. Yet both of you seem uncomfortable with this arrangement.” The implication is that the client cares about the marriage and has been trying to keep it together but needs to find more effective ways to do this.

The general idea in reframing is to place the problem behavior in a more positive light, which in itself can have a paradoxical effect (prescribing the symptom), but to do so in a way that causes the person to take action to *change* the problem.

Summarizing

It is useful to summarize periodically during a session, particularly toward the end of a session. This amounts to a longer, summary reflection of what the client has said. It is especially useful to repeat and summarize the client's self-motivational statements. Elements of reluctance or resistance may be included in the summary, to prevent a negating reaction from the client. Such a summary serves the function of allowing clients to hear their own self-motivational statements yet a third time, after the initial statement and your reflection of it. Here is an example of how you might offer a summary to a client at the end of a first session:

Let me try to pull together what we've said today, and you can tell me if I've missed anything important. I started out by asking you what you've noticed about your drinking, and you told me several things. You said that your drinking has increased over the years, and you also notice that you have a high tolerance for alcohol—when you drink a lot, you don't feel it as much. You've also had some memory blackouts, which I mentioned can be a worrisome sign. There have been some problems and fights in the family that you think are related to your drinking. On the feedback, you were surprised to learn that you are drinking more than 95 percent of the U.S. adult population and that your drinking must be getting you to fairly high blood alcohol levels even though you're not feeling it. There were some signs that alcohol is starting to damage you physically and that you are becoming dependent on alcohol. That fits with your concerns that it would be very hard for you to give up drinking. And I remember that you were worried that you might be labeled as an alcoholic, and you didn't like that idea. I appreciate how open you have been to this feedback, though, and I can see you have some real concerns now about your drinking. Is that a pretty good summary? Did I miss anything?

Along the way during a session, shorter "progress" summaries can be given:

So, thus far, you've told me that you are concerned you may be damaging your health by drinking too much and that sometimes you may not be as good a parent to your children as you'd like because of your drinking. What else concerns you?

Phase 2: Strengthening Commitment To Change

Recognizing Change Readiness

The strategies outlined above are designed to build motivation and to help tip the client's decisional balance in favor of change. A second major process in MET is to consolidate the client's commitment to change, once sufficient motivation is present (Miller and Rollnick 1991).

Timing is a key issue—knowing *when* to begin moving toward a commitment to action. There is a useful analogy to sales here—knowing when the customer has been convinced and one should move toward “closing the deal.” Within the Prochaska/DiClemente model, this is the determination stage, when the balance of contemplation has tipped in favor of change, and the client is ready for action (but not necessarily for maintenance). Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the client's decision.

There are no universal signs of crossing over into the determination stage. These are some changes you might observe (Miller and Rollnick 1991):

- The client stops resisting and raising objections.
- The client asks fewer questions.
- The client appears more settled, resolved, unburdened, or peaceful.
- The client makes self-motivational statements indicating a decision (or openness) to change (“I guess I need to do something about my drinking.” “If I wanted to change my drinking, what could I do?”).
- The client begins imagining how life might be after a change.

Here is a checklist of issues to assist you in determining a client's readiness to accept, continue in, and comply with a change program. These questions may also be useful in recognizing individuals at risk for prematurely withdrawing from treatment (Zweben et al. 1988).

- Has the client missed previous appointments or canceled prior sessions without rescheduling?

- If the client was coerced into treatment (e.g., for a drunk-driving offense), has the client discussed with you his or her reactions to this involuntariness—anger, relief, confusion, acceptance, and so forth?
- Does the client show a certain amount of indecisiveness or hesitancy about scheduling future sessions?
- Is the treatment being offered quite different from what the client has experienced or expected in the past? If so, have these differences and the client's reactions been discussed?
- Does the client seem to be very guarded during sessions or otherwise seem to be hesitant or resistant when a suggestion is offered?
- Does the client perceive involvement in treatment to be a degrading experience rather than a "new lease on life"?

If the answers to these questions suggest a lack of readiness for change, it might be valuable to explore further the client's uncertainties and ambivalence about drinking and change. It is also wise to delay any decisionmaking or attempts to obtain firm commitment to a plan of action.

For many clients, there may not be a clear point of decision or determination. Often, people begin considering and trying change strategies while they are in the later part of the contemplation stage. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Then they commit to change. Thus, the shift from contemplation to action may be a gradual, tentative transition rather than a discrete decision.

It is also important to remember that even when a client appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the client has decided to change, Phase 1 strategies are no longer needed. Likewise, you should proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, a point comes when you should move toward strategies designed to consolidate commitment. The following strategies are useful once the initial phase has been passed and the client is moving toward change.

Discussing a Plan

The key shift for the therapist is from focusing on *reasons* for change (building motivation) to negotiating a *plan* for change. Clients may initiate this by stating a need or desire to change or by asking what they could do. Alternatively, the therapist may signal this shift (and test the water) by asking a transitional question such as:

- What do you make of all this? What are you thinking you'll do about it?
- Where does this leave you in terms of your drinking? What's your plan?
- I wonder what you're thinking about your drinking at this point.
- Now that you're this far, I wonder what you might do about these concerns.

Your goal during this phase is to elicit from the client (and SO) some ideas and ultimately a plan for what to do about the client's drinking. It is not your task to prescribe a plan for *how* the client should change or to teach specific skills for doing so. The overall message is, "Only *you* can change your drinking, and it's up to you." Further questions may help: "How do you think you might do that? What do you think might help?" and to the SO, "How do you think you might help?" Reflecting and summarizing continue to be good therapeutic responses as more self-motivational statements and ideas are generated.

Communicating Free Choice

An important and consistent message throughout MET is the client's responsibility and freedom of choice. Reminders of this theme should be included during the commitment-strengthening process:

- It's up to you what you do about this.
- No one can decide this for you.
- No one can change your drinking for you. Only you can do it.
- You can decide to go on drinking just as you were or to change.

Consequences of Action and Inaction

A useful strategy is to ask the client (and SO) to anticipate the result if the client continues drinking as before. What would be likely consequences? It may be useful to make a written list of the possible negative consequences of not changing. Similarly, the anticipated benefits of change can be generated by the client (and SO).

For a more complete picture, you could also discuss what the client *fears* about changing. What might be the negative consequences of

stopping drinking, for example? What are the advantages of continuing to drink as before? Reflection, summarizing, and reframing are appropriate therapist responses.

One possibility here is to construct a formal “decisional balance” sheet, by having the client generate (and write down) the pros and cons of change options. What are the positive and negative aspects of continuing with drinking as before? What are the possible benefits and costs of making a change in drinking?

Information and Advice

Often clients (and SOs) will ask for key information as important input for their decisional process. Such questions might include:

- Do alcohol problems run in families?
- Does the fact that I can hold my liquor mean I’m addicted?
- How does drinking damage the brain?
- What’s a safe level of drinking?
- If I quit drinking, will these problems improve?
- Could my sleep problems be due to my drinking?

The number of possible questions is too large to plan specific answers here. In general, however, you should provide accurate, specific information that is requested by clients and SOs. It is often helpful afterward to ask for the client’s response to this information: Does it make sense to you? Does that surprise you? What do *you* think about it?

Clients and SOs may also ask you for advice. “What do *you* think I should do?” It is quite appropriate to provide your own views in this circumstance, with a few caveats. It is often helpful to provide qualifiers and permission to disagree. For example:

- If you want my opinion, I can certainly give it to you, but you’re the one who has to make up your mind in the end.
- I can tell you what I think I would want to do in your situation, and I’ll be glad to do that, but remember that it’s your choice. Do you want my opinion?

Being just a little resistive or “hard to get” in this situation can also be useful:

- I’m not sure I should tell you. Certainly I have an opinion, but you have to decide for yourself how you want to handle your life.

I guess I'm concerned that if I give you my advice, then it looks like I'm the one deciding instead of you. Are you sure you want to know?

Within this general set, feel free to give the client your best advice as to what change should be made, specifically with regard to—

- What change should be made in the client's drinking (e.g., "I think you need to quit drinking altogether").
- The need for the client and SO to work together.
- General kinds of changes that the client might need to make in order to support sobriety (e.g., find new ways to spend time that don't involve drinking).

With regard to specific "how to's," however, you should *not* prescribe specific strategies or attempt to train specific skills. This challenge is turned back to the client (and SO):

- How do you think you might be able to do that?
- What might stand in your way?
- You'd have to be pretty creative (strong, clever, resourceful) to find a way around that. I wonder how you could do it.

Again, you may be asked for specific information as part of this process (e.g., "I've heard about a drug that you can take once a day and it keeps you from drinking. How does it work?"). Accurate and specific information can be provided in such cases.

A client may well ask for information that you do not have. Do not feel obliged to know all the answers. It is fine to say that you do not know, but will find out. You can offer to research a question and get back to the client at the next session or by telephone.

Emphasizing Abstinence

Every client should be given, at some point during MET, a rationale for abstinence from alcohol. Avoid communications that seem to coerce or impose a goal, since this is inconsistent with the style of MET. Within this style, it is not up to you to "permit" or "let" or "allow" clients to make choices. The choice is theirs. You should, however, commend (not prescribe) abstinence and offer the following points in all cases:

- Successful abstinence is a safe choice. If you don't drink, you can be sure that you won't have problems because of your drinking.

- There are good reasons to at least *try* a period of abstinence (e.g., to find out what it's like to live without alcohol and how you feel, to learn how you have become dependent on alcohol, to break your old habits, to experience a change and build some confidence, to please your spouse).
- No one can guarantee a safe level of drinking that will cause you no harm.

In certain cases, you have an additional responsibility to advise against a goal of moderation if the client appears to be deciding in that direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of MET. ("It is your choice, of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned. . ."). Among the reasons for advising against a goal of moderation are (Miller and Caddy 1977)—

- Medical conditions (e.g., liver disease) that contraindicate any drinking.
- Psychological problems likely to be exacerbated by any drinking.
- A diagnosis of idiosyncratic intoxication (DSM-III-R 291.40).
- Strong external demands on the client to abstain.
- Pregnancy.
- Use/abuse of medications that are hazardous in combination with alcohol.
- A history of severe alcohol problems and dependence.

The data in table 2 may be useful in determining cases in which moderation should be more strongly opposed. They are derived from long-term followups (3 to 8 years) of problem drinkers attempting to moderate their drinking (Miller et al. 1992). "Abstainers" are those who had been continuously abstinent for at least 12 months at followup; "asymptomatic drinkers" had been drinking moderately without problems for this same period. The "improved but impaired" group showed reduction in drinking and related problems but continued to show some symptoms of alcohol abuse or dependence. The AB:AS column shows the ratio, within each of four client ranges, of successful abstainers to successful asymptomatic drinkers.

In addition to the commendation of abstinence given in all cases, clients falling into ranges 3 or 4 should receive further counsel if they are entertaining a moderation goal. They can be advised that in a study

Table 2. Relationship of severity measures to types of treatment outcome

Severity		Treatment Outcome								
Range	Scores	Total abstainers		Asymptomatic drinkers		Improved but impaired		Not improved		Ratio AB:AS
		<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	
Michigan Alcoholism Screening Test (MAST)										
1	0–10	3	14 %	5	23 %	8	36 %	6	27 %	3:5
2	11–18	7	21	7	21	6	18	14	41	1:1
3	19–28	10	40	2	8	4	16	9	36	5:1
4	29+	4	29	0	0	4	29	6	43	4:0
	Median	19.5		12.0		15.0		18.0		
	Mean	19.0		13.2		18.0		18.6		
	SD	7.6		6.2		12.5		9.1		
Alcohol Dependence Scale (ADS)										
Lifetime Accumulation of Symptoms										
1	0–14	2	8 %	6	24 %	9	36 %	8	32 %	1:3
2	15–20	4	14	4	14	4	14	16	57	1:1
3	21–27	11	35	6	19	5	16	9	29	11:6
4	28+	6	75	0	0	2	25	0	0	6:0
	Median	22.5		19.0		15.0		16.5		
	Mean	27.2		16.6		17.1		18.0		
	SD	14.5		7.8		7.7		5.4		

Source: Data from Miller et al. 1992.

NOTE: Asymptomatic = Drinking moderately with no evidence of problems

Improved = Drinking less, but still showing alcohol-related problems

AB/AS Ratio = Ratio of successful abstainers to asymptomatic drinkers

of problem drinkers attempting to moderate their drinking, people with severity scores resembling theirs were much more likely to succeed with abstinence. Those falling in range 4 can further be advised that in this same study, no one with scores like theirs managed to maintain problem-free drinking. Clients who are unwilling to discuss immediate and long-term abstinence as a goal might be more responsive to intermediate options, such as a short-term (e.g., 3-month) trial abstinence period, or tapering off of drinking toward an ultimate goal of abstention (Miller and Page 1991).

Dealing With Resistance

The same principles used for defusing resistance in the first phase of MET also apply here. Reluctance and ambivalence are not challenged directly but rather can be met with reflection or reframing. Gently paradoxical statements may also be useful during the commitment phase of MET. One form of such statements is permission to continue unchanged:

- Maybe you'll decide that it's worth it to you to keep on drinking the way you have been, even though it's costing you.

Another form is designed to pose a kind of crisis for the person by juxtaposing two important and inconsistent values:

- I wonder if it's really possible for you to keep drinking and still have your marriage, too.

The Change Plan Worksheet

The Change Plan Worksheet (CPW) is to be used during Phase 2 to help in specifying the client's action plan. You can use it as a format for taking notes as the client's plan emerges. Do not *start* Phase 2 by filling out the CPW. Rather, the information needed for the CPW should emerge through the motivational dialog described above. This information can then be used as a basis for your recapitulation (see below). Use the CPW as a guide to ensure that you have covered these aspects of the client's plan:

- *The changes I want to make are . . .* In what ways or areas does the client want to make a change? Be specific. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something) and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviors).
- *The most important reasons why I want to make these changes are . . .* What are the likely consequences of action and inaction? Which motivations for change seem most impelling to the client?

- *The steps I plan to take in changing are . . .* How does the client plan to achieve the goals? How could the desired change be accomplished? Within the general plan and strategies described, what are some specific, concrete first steps that the client can take? When, where, and how will these steps be taken?
- *The ways other people can help me are . . .* In what ways could other people (including the significant other, if present) help the client in taking these steps toward change? How will the client arrange for such support?
- *I will know that my plan is working if . . .* What does the client hope will happen as a result of this change plan? What benefits could be expected from this change?
- *Some things that could interfere with my plan are . . .* Help the client to anticipate situations or changes that could undermine the plan. What could go wrong? How could the client stick with the plan despite these problems or setbacks?

Preprinted Change Plan Worksheet forms are convenient for MET therapists. Carbonless copy forms are recommended so you can write or print on the original and automatically have a copy to keep in the client's file. Give the original to the client and retain the copy for the file.

Change Plan Worksheet

The changes I want to make are:

The most important reasons why I want to make these changes are:

The steps I plan to take in changing are:

The ways other people can help me are:

Person	Possible ways to help
--------	-----------------------

I will know that my plan is working if:

Some things that could interfere with my plan are:

Recapitulating

Toward the end of the commitment process, as you sense that the client is moving toward a firm decision for change, it is useful to offer a broad summary of what has transpired (Miller and Rollnick 1991). This may include a repetition of the reasons for concern uncovered in Phase 1 (see "Summarizing") as well as new information developed during Phase 2. Emphasis should be given to the client's self-motivational statements, the SO's role, the client's plans for change, and the perceived consequences of changing and not changing. Use your notes on the Change Plan Worksheet as a guide. Here is an example of how a recapitulation might be worded:

Let me see if I understand where you are. Last time, we reviewed the reasons why you and your husband have been concerned about your drinking. There were a number of these. You were both concerned that your drinking has contributed to problems in the family, both between you and with the children. You were worried, too, about the test results you received indicating that alcohol has been damaging your health. Your drinking seems to have been increasing slowly over the years, and with it, your dependence on alcohol. The accident that you had helped you realize that it was time to do something about your drinking, but I think you were still surprised when I gave you your feedback, just how much in danger you were.

We've talked about what you might do about this, and you and your husband had different ideas at first. He thought you should go to AA, and you thought you'd just cut down on your drinking and try to avoid drinking when you are alone. We talked about what the results might be if you tried different approaches. Your husband was concerned that if you didn't make a sharp break with this drinking pattern you've had for so many years, you'd probably slip back into drinking too much and forget what we've discussed here. You agreed that that would be a risk and could imagine talking yourself into drinking alone or drinking to feel high. You didn't like the idea of AA, because you were concerned that people would see you there, even though, as we discussed, there is a strong principle of anonymity.

Where you seem to be headed now is toward trying out a period of not drinking at all, for 3 months at least, to see how it goes and how you feel. Your husband likes this idea, too, and has agreed to spend more time with you so you can do things together in the evening or on weekends. You also thought you would get involved again in some of the community activities you used to enjoy during the day or maybe look for a job to keep you busy. Do I have it right? What have I missed?

If the client offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Change Plan Worksheet.

Asking for Commitment

After you have recapitulated the client's situation and responded to additional points and concerns raised by the client (and SO), move toward getting a formal commitment to change. In essence, the client is to commit verbally to take concrete, planned steps to bring about the needed change. The key question (not necessarily in these words) is:

- Are you ready to commit yourself to doing this?

As you discuss this commitment, also cover the following points:

- Clarify what, exactly, the client plans to do. Give the client the completed Change Plan Worksheet and discuss it.
- Reinforce what the client (and SO) perceive to be likely benefits of making a change, as well as the consequences of inaction.
- Ask what concerns, fears, or doubts the client (and SO) may have that might interfere with carrying out the plan.
- Ask what other obstacles might be encountered that could divert the client from the plan. Ask the client (and SO) to suggest how they could deal with these.
- Clarify the SO's role in helping the client to make the desired change.
- Remind the client (and SO) that you will be seeing the client for followthrough visits (scheduled at weeks 6 and 12) to see how he/she is doing.

If the client is willing to make a commitment, ask him/her to sign the Change Plan Worksheet and give the client the signed original, retaining a copy for your file.

Some clients are unwilling to commit themselves to a change goal or program. When clients remain ambivalent or hesitant about making a written or verbal commitment to deal with the alcohol problem, you may ask them to defer the decision until later. A specific time should be agreed upon to reevaluate and resolve the decision. The hope in allowing clients the opportunity to postpone such decisionmaking is that the motivational processes will act more favorably on them over time (Goldstein et al. 1966). Such flexibility provides clients with the opportunity to explore more fully the potential consequences of change

and prepare themselves to deal with the consequences. Otherwise, clients may feel coerced into making a commitment before they are ready to take action.

In this case, clients may withdraw prematurely from treatment, rather than “lose face” over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you’re really not quite ready to make this decision yet. That’s perfectly understandable. This is a very tough choice for you. It might be better not to rush things here, not to try to make a decision right now. Why don’t you think about it between now and our next visit, consider the benefits of making a change and of staying the same. We can explore this further next time, and sooner or later I’m sure it will become clear to you what you want to do. OK?

It can be helpful in this way to express explicit understanding and acceptance of clients’ ambivalence as well as confidence in their ability to resolve the dilemma.

Involving a Significant Other

When skillfully handled by the therapist, the involvement of a significant other (spouse, family member, friend) can enhance motivational discrepancy and commitment to change. Whenever possible, clients in MET will be strongly urged to bring an SO to the first two MET sessions. At these meetings, the SO is actively engaged in the treatment process. Emphasis is placed on the need for the client and SO to work collaboratively on the drinking problem.

The MET approach recognizes the importance of the significant other in affecting the client’s decision to change drinking behavior. This emphasis is based upon recent findings from a variety of alcohol treatment studies. For example, alcoholics seen in an outpatient setting were found more likely to remain in a spouse-involved treatment than in an individual approach (Zweben et al. 1983). Similarly, clients maintaining positive ties with family members fared better in a relationship enhancement therapy than in an intervention focused primarily on the psychological functioning of the client (Longabaugh et al. in press).

Involvement of an SO in the treatment process offers several advantages. It provides the SO an opportunity for firsthand understanding of the problem. It permits the SO to provide input and feedback in the development and implementation of treatment goals. The client and SO can also work collaboratively on issues and problems that might interfere with the attainment of treatment goals.

Goals for Significant Other Involvement

The following are general goals for the two SO-involved sessions:

- Establish rapport between the SO and the counselor.
- Raise the awareness of the SO about the extent and severity of the alcohol problem.
- Strengthen the SO's commitment to help the client overcome the drinking problem.
- Strengthen the SO's belief in the importance of his or her own contribution in changing the client's drinking patterns.
- Elicit feedback from the SO that might help motivate the problem drinker to change the drinking behavior. For example, a spouse might be asked to share concerns about the client's past, present, and future drinking. Having the spouse "deliver the message" can be valuable in negotiating suitable treatment goals.
- Promote higher levels of marital/family cohesiveness and satisfaction.

MET does not include intensive marital/family therapy. The main principle here is to elicit from client and SO those aspects of their relationship which are seen as most positive and to explore how they can work together in overcoming the drinking problem. Both client and SO can be asked to describe the other's strengths and positive attributes. Issues raised during SO-involved sessions can be moved toward the adoption of specific change goals. The counselor should *not* allow the client and SO to spend significant portions of a session complaining, denigrating, or criticizing. Such communications tend to be destructive and do not favor an atmosphere that motivates change.

Explaining the Significant Other's Role

Ideally, a client will be accompanied by an SO at the first session. The invitation to the SO should be made for the first session only, allowing you the flexibility to include or not include the SO in a second session. In the beginning of the session, the counselor should comment favorably on the SO's willingness to attend sessions with the problem drinker. The rationale is then presented for having the SO attend:

- The SO cares about the client, and changes will have direct impact on both their lives.
- The SO's input will be valuable in setting treatment goals and developing strategies.

- The SO may be directly helpful by working with the client to resolve the drinking problem.

Emphasize that ultimate responsibility for change remains with the client but that the SO can be very helpful. It is useful here to explore tentatively, with both the SO and the client, how the SO might be supportive in resolving the drinking problem. You might ask the following:

- To SO: In what ways do you think you could be helpful to ____?
- To SO: What has been helpful to ____ in the past?
- To client: How do you think ____ might be supportive to you now, as you're taking a look at your drinking?

Be careful not to "jump the gun" at this point. Asking such questions may elicit defensiveness and resistance if the client is not ready to consider change.

It is also important to remember that your role does *not* include prescribing specific tasks, offering spouse training, or conducting marital therapy. The MET approach provides the SO an opportunity to demonstrate support, verbally and behaviorally, and encourages the SO and client to generate their own solutions.

The Significant Other in Phase 1

In the first conjoint session, an important goal is to establish rapport—to create an environment in which the SO can feel comfortable about openly sharing concerns and disclosing information that may help promote change. The SO could also be expected to identify potential problems or issues that might arise which could interfere with attaining these objectives. To begin with, the counselor should attempt to "join" with the SO by asking about her or his own (past and present) experiences with the alcohol problem.

- What has it been like for you?
- What have you noticed about [client's] drinking?
- What has discouraged you from trying to help in the past?
- What do you see that is encouraging?

Emphasis should be placed on positive attempts to deal with the problem. At the same time, negative experiences—stress, family disorganization, job and employment difficulties—should be discussed and reframed as *normative*, that is, events that are common in families with an alcohol problem. Such a perspective should be communicated

to the family member in the interview. The counselor might compare the SO's experiences to the personal stress experienced by families confronted with other chronic mental health or physical disorders such as heart disease, diabetes, and depression (without going into depth about such experiences).

Any concerns that the SO may have about the amount or type of treatment should be explored. Again, concerns expressed by family members or SOs should be responded to in an accepting, reflective, reassuring manner. SOs who express concern about the brevity of MET can be told about the findings of previous research (see table 1), namely, that people can and do overcome their drinking problems given even briefer treatment than this, and that making a firm commitment is the key.

The SO can often play an important role in helping the client resolve uncertainties or ambivalence about drinking and change during Phase 1. The SO can be asked to elaborate on the risks and costs of continued heavy drinking. For example, one spouse revealed during counseling that she was becoming increasingly alienated from her partner as a result of the negative impact that the drinking was having on their children. These questions, asked of the SO in the presence of the client, can be helpful in eliciting such concerns:

- How has the drinking affected you?
- What is different now that makes you more concerned about the drinking?
- What do you think will happen if the drinking continues as it has been?

Feedback provided by the SO can often be more meaningful to a client than information presented by the counselor. It can help the client mobilize commitment to change (Pearlman et al. 1989). In sharing information about the potential consequences of the drinking problem for family members, an SO may cause the client to experience emotional conflict (discrepancy) about drinking. Thus, the client may be confronted with a dilemma in which it is not possible both to continue drinking and to have a happy family. In this way, the decisional balance can be further tipped in favor of changing the drinking. One client became more conflicted about his drinking after his wife described the negative impact it was having on their children. He subsequently decided to give up drinking rather than to experience himself as a harmful parent.

At the same time, there is a danger of overwhelming the client if the feedback given by the SO is new, extremely negative, or presented in a hostile manner. Negative information presented by both the SO and

the counselor may result in the client's feeling "ganged up on" in the session and could result in treatment dropout. The MET approach relies primarily upon instilling intrinsic motivation for change in the client rather than using external motivators such as pressure from SOs.

Therefore, when involving an SO in a session, it may be useful to go slowly in presenting material to the client. You may gauge the mood or state of clients by allowing them the opportunity to respond to specific items before soliciting further comments from the SO. You may ask whether the client is ready to examine the consequences (i.e., both personal and family concerns) that have followed from drinking. If feedback provided seems to be particularly aversive to the client, then it is important to intersperse affirmations of the client. The SO can be asked questions to elicit supportive and affirming comments:

- What are the things you like most about [client] when he/she is not drinking?
- What positive signs of change have you noticed that indicate [client] really wants to make a change?
- What are the things that give you hope that things can change for the better?

Supportive and affirming statements from the counselor and SO can further enhance commitment to change.

The client-centered nature of MET can be further emphasized by focusing on the client's responses to what the SO has offered. You might ask, for example:

- Of these things your husband has mentioned, which concern you most?
- How important do you think it is for you to deal with these concerns that your wife has raised?

Feedback provided from the assessment battery is also presented and discussed during SO-involved sessions. SOs can be asked for their own comments and reactions to the material being presented.

- What do you think about this? Is this consistent with what you have been thinking about [client's] drinking? Does any of this surprise you?

Such questions may help to confirm the SO's own perceptions about the severity of the alcohol problem as well as to clarify any misunderstandings about the problems being dealt with in treatment sessions.

The same strategies used to evoke client self-motivational statements can be applied with the SO as well. Once an agreement is reached about the seriousness of the problem, the counselor should explore how the SO might be helpful and supportive in dealing with the problem. Remember that MET is not a skill-training approach; the primary mechanism here is to elicit ideas from the SO and client about what could be done. In raising the awareness of the spouse about the client's drinking and related issues, the counselor mainly seeks to *motivate* the SO to play an active role in dealing with the problem.

The Significant Other in Phase 2

A spouse or other significant person who is attending sessions may be engaged in a helpful way in the commitment process of Phase 2. An SO can play a positive role in instigating and sustaining change, particularly in situations where interpersonal commitment is high. The SO can be involved in a number of ways.

Eliciting Feedback From the SO

The SO might provide further examples of the negative effects of drinking on the family, such as not showing up for meals, missing family celebrations such as birthday parties, embarrassing the family by being intoxicated, or alienating children and relatives. This is an extension of the SO's role in Phase 1.

Eliciting Support

The SO can comment favorably on the positive steps undertaken by the client to make a change in drinking, and you should encourage such expression of support. The SO may also agree to join with the client in change efforts (e.g., spending time in nondrinking settings).

Eliciting Self-Motivational Statements From the SO

This strategy should be employed in the second SO-involved session, after the client and SO have had a chance to reflect upon the information presented earlier. Clients may become less resistant after they have had more time to think about drinking and related issues (see "Asking for Commitment"). If, in the second interview, the client still appears to be hesitant or reluctant about dealing with the drinking and related matters, then an attempt should be made to acknowledge the feelings of frustration and helplessness experienced by the SO and to examine alternative ways to handle these frustrations:

I know that you both want to do what's best for the family. However, there are times when there are differences in what the two of you want. It can be frustrating when you can't seem to agree about what to do. (Turning to the spouse). In this case, you have a number of options. You can try to change your

[husband's/wife's] attitude about drinking—I think you've tried that in the past without much success, right? Or you could do nothing and just wait. But that still leaves you feeling frustrated or helpless, maybe even hopeless, and that's no good. Or you can concentrate your energies on yourself and other members of your family and focus on developing a lifestyle for yourself that will take you away from drinking. What do you think about this third option? What things could you do to keep from being involved in drinking situations yourself and to develop a more rewarding life away from drinking?

In response to this question, one spouse determined that she would no longer accompany her spouse to the neighborhood tavern. Another went a step further and indicated that he would not be involved in any drinking-related activities with his wife. By eliciting such self-motivational statements and plans from SOs, it is possible to tip the client's balance further in favor of change (cf. Sisson and Azrin 1986).

Addressing the SO's Expectations

When goals and strategies for change are being discussed, SOs are invited to express their own views and to contribute to generating options. Any discrepancy between the client and SO with respect to future alcohol use should be addressed. Information from the pretreatment assessment may be used here to reach a consensus between client and SO (e.g., severity of alcohol problems, consumption pattern). If agreement cannot be reached, a decision may be delayed, allowing further opportunity to consider the issues (see "Asking for Commitment"). The objective is to establish goals that are mutually satisfactory. This can further reinforce commitment to the relationship as well as the resolution of alcohol problems.

Handling SO Disruptiveness

In some cases, SO involvement could become an obstacle in motivating the client to change and could even lead to a worsening of the drinking problem. It is important to identify these potentially problematic situations and to deal with them. The following scenarios are provided to illustrate circumstances where SO involvement might have a negative impact on MET:

- Comments are made by the SO that appear to exacerbate an already strained relationship and to evoke further resistance from the client. Your efforts at eliciting verbal support from the SO are met with resistance. Your own efforts to elicit self-motivational statements from the client are hindered by SO remarks that foster client defensiveness.
- Comments made by the SO suggest an indifferent or hostile attitude toward the client. The SO demonstrates a lack of con-

cern about whether the client makes a commitment or is attempting to resolve the drinking problem. The involvement of the SO appears to have little or no beneficial impact on eliciting self-motivational statements from the client. When the client does make self-motivational statements, the SO offers no support.

- The SO seems unwilling or unable to make changes requested by the client that might facilitate an improvement in the drinking pattern or their relationship. For example, despite strong requests from the client (and perhaps from you) to place a moratorium on negative communication patterns, the SO continues to harass the client about past drinking habits.

In these or other ways, involvement of the SO may prove more disruptive than helpful to treatment. The first approach in this case is to use MET procedures (reflection, reframing) to acknowledge and highlight the problematic interactions. If usual MET strategies do not result in a decrease in SO disruptiveness, intervene directly to stop the pattern. The following are potentially useful strategies for minimizing SO interference with the attainment of treatment goals and are consistent with the general MET approach. Note that these are departures from the usual procedures for MET spouse involvement and are implemented for “damage control.”

- Limit the amount of involvement of the SO in sessions. You might explicitly limit SO involvement to (1) providing collateral information about the extent and pattern of drinking and (2) acquiring knowledge and understanding about the severity of the alcohol problem and the type of treatment being offered. Your interactions with the SO can be limited to clarifying factual information and ensuring that the SO has a good understanding of the client’s alcohol problem and the plan for change. Typical structuring questions of this kind would be, “Do you understand what has been presented thus far?” “Do you have any questions about the material we have discussed so far?”
- Focus the session(s) on the client. You can announce that the focus of discussion should be on the client in terms of helping to resolve the concerns that brought him or her to treatment. Indicate that the drinking needs priority and that other concerns are best dealt with after the client has completed the MET program. Then direct the discussion to the client’s concerns.
- Limit the SO’s involvement in decisionmaking activities. If SO participation is problematic, allow the SO to be a witness to change, without requesting his or her direct involvement inside or outside of sessions. Avoid requesting input from the SO in

formulating change goals and developing the plan of action. Do not request or expect SO affirmation of decisions made by the client with regard to drinking and change.

Remember that it is not necessary to invite the SO back for a second session. This is easiest if your initial invitation did not mention two sessions. Also, remember that the maximum number of sessions that may be attended by any SO is two (not including emergency sessions).

Phase 3: Followthrough Strategies

Once you have established a strong base of motivation for change (Phase 1) and have obtained the client's commitment to change (Phase 2), MET focuses on followthrough. This may occur as early as the second session, depending on the client's progress. Three processes are involved in followthrough: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment.

Reviewing Progress

Begin a followthrough session with a review of what has happened since your last session. Discuss with the client what commitment and plans were made, and explore what progress the client has made toward these. Respond with reflection, questioning, affirmation, and reframing, as before. Determine the extent to which previously established goals and plans have been implemented.

Renewing Motivation

The Phase 1 processes can be used again to renew motivation for change. The extent of this renewal depends on your judgment of the client's current commitment to change. This may be assessed by asking clients what they remember as the most important reasons for changing their drinking.

Redoing Commitment

The Phase 2 processes can also be continued during followthrough. This may simply be a reaffirmation of the commitment made earlier. If the client has encountered significant problems or doubts about the initial plan, however, this is a time for reevaluation, moving toward a new plan and commitment. Seek to reinforce the client's sense of autonomy and self-efficacy—an ability to carry out self-chosen goals and plans.

The Structure of MET Sessions

The preceding sections outline the basic flow of MET from Phase 1 through Phase 3. This section addresses issues involved in planning and conducting the four specific sessions.

The Initial Session

Preparation for the First Session

Before treatment begins, clients are given an extensive battery of assessment instruments; the results are used as the basis for personal feedback in the first session. Appendix A discusses the instruments used in Project MATCH and various alternatives.

When you contact clients to make your first appointment, stress the importance of bringing along to this session their spouse or, if unmarried, someone else to whom they are close and who could be supportive. Typically, this would be a family member or a close friend. The critical criteria are that the SO is considered to be an "important person" to the client and that the SO ordinarily spends a significant amount of time with the client. Those designated as significant others are asked to participate in assessment and also to attend two (and only two) treatment sessions. If no such person is initially identified, explore further during the first session whether an SO can be designated. The intended support person is contacted either by the client or by the therapist (whichever is desired by the client) and invited to participate in the client's treatment. Again, the initial invitation should be for one visit only, to allow flexibility regarding a second session.

Also explain that the client must come to this session sober, that a breath test will be administered, and that any significant alcohol in the breath will require rescheduling. All MET sessions are preceded by a breath alcohol test to ensure sobriety. The client's blood alcohol concentration must be no higher than .05 (50 mg%) in order to proceed. Otherwise, the session must be rescheduled.

Presenting the Rationale and Limits of Treatment

The MET approach may be surprising for some clients, who come with an expectation of being led step by step through an intensive process of therapist-directed change (Edwards and Orford 1977). For this reason, you must be prepared to give a clear and persuasive explanation of the rationale for this approach. The timing of this rationale is a matter for your own judgment. It may not be necessary at the outset of MET. At least *some* structuring of what to expect, however, should be given to the client at the beginning of the first session. Here is an example of what you might say:

Before we begin, let me just explain a little about how we will be working together. You have already spent time completing the tests that we need, and we appreciate the effort you put into that process. We'll make good use of the information from those tests today. This is the first of four sessions that we will be spending together, during which we'll take a close look together at your situation. I hope that you'll find these four sessions interesting and helpful.

I should also explain right up front that I'm not going to be changing you. I hope that I can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing, *you* will be the one who does it. Nobody can tell you what to do; nobody can make you change. I'll be giving you a lot of information about yourself and maybe some advice, but what you do with all of that after our four sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is *you*. How does that sound to you?

Many clients will find this a very comfortable and compatible approach. Some, in fact, will express relief, having feared being castigated or coerced. Other clients or their significant others, however, may be uneasy with this approach and may need additional explanation and assurance. Here are several lines of followup discussion in such cases:

- Even with very extensive kinds of treatment, it is still the person who, in the end, decides what happens. *You* will determine what happens with your drinking.
- Longer and shorter treatment programs don't seem to produce different results. People in longer or more intensive programs don't do any better, overall, than those getting good consultation like this. Again, no one can "do it to you." In fact, many people change their drinking or quit smoking without any formal treatment at all.

- You are not alone. We will be keeping in touch with you to see how you are doing. If at followup visits, you still need more help, this can be arranged.
- You can call if you need to. I'm available here by telephone.
- I understand your worries, and it's perfectly understandable that you would be unsure at this point. Let's just get started, and we'll see where we are after we've had a chance to work together.

After this introduction, start with a brief structuring of the first session and, if applicable, the SO's role in this process (refer to the section on "Involving a Significant Other"). Tell the client (and SO) that you will be giving them feedback from the assessment instruments they completed, but first you want to understand better how they see the client's situation. Then proceed with strategies for "Eliciting Self-Motivational Statements." Use reflection ("Listening With Empathy") as your primary response during this early phase. Other strategies described under "Affirming the Client," "Handling Resistance," and "Reframing" are also quite appropriate here. (The "Motivational Interviewing" videotape by Dr. Miller demonstrates this early phase of MET.)

When you sense that you have elicited the major themes of concern from the client (and SO), offer a summary statement (see "Summarizing"). If this seems acceptable to the client (and SO), indicate that the next step is for you to provide feedback from the client's initial assessment. Give the client a copy of the Personal Feedback Report and review it step by step (see "Presenting Personal Feedback"). Again, you should use reflection, affirmation, reframing, and procedures for handling resistance, as described earlier. You might not complete this feedback process in the first session. If not, explain that you will continue the feedback in your next session, and *take back the client's copy of the PFR* for use in your second session, indicating that you will give it back to keep after you have completed reviewing the feedback next week.

If you do complete the feedback process, ask for the client's (and SO's) overall response. One possible query would be:

- I've given you quite a bit of information here, and at this point, I wonder what you make of all this and what you're thinking.

Both the feedback and this query will often elicit self-motivational statements that can be reflected and used as a bridge to the next phase of MET.

After obtaining the client's (and SO's) responses to the feedback, offer one more summary, including both the concerns raised in the first "eliciting" process and the information provided during the feedback (see "Summarizing"). This is the transition point to the second phase of MET: consolidating commitment to change. (Again, you will not usually get this far in the first session, and this process is continued in subsequent sessions.)

Using cues from the client and SO (see "Recognizing Change Readiness"), begin eliciting thoughts, ideas, and plans for what might be done to address the problem (see "Discussing a Plan"). During this phase, also use procedures outlined under "Communicating Free Choice" and "Information and Advice." Specifically elicit from the client (and SO) what are perceived to be the possible benefits of action and the likely negative consequences of inaction (see "Consequences of Action"). These can be written down in the form of a balance sheet (reasons to continue as before versus reasons to change) and given to the client. The standard commendation of abstinence is to be included during this phase at an appropriate time. If a high-severity client (range 3 or 4 in table 2) appears to be headed toward a moderation goal, this is also the time to employ the abstinence advice procedure outlined in "Emphasizing Abstinence." The basic client-centered stance of reflection, questioning, affirming, reframing, and dealing with resistance indirectly is to be maintained throughout this and all MET sessions.

This phase proceeds toward the confirmation of a plan for change, and you should seek to obtain whatever commitment you can in this regard (see "Asking for Commitment"). It can be helpful to write down the client's goals and planned steps for change on the Change Plan Worksheet. If appropriate, this plan can be signed by the client (and SO). Be careful, however, not to press prematurely for a commitment. If a plan is signed before commitment is firm, a client may drop out of treatment rather than renege on the agreement.

Ending the First Session

Always end the first session by summarizing what has transpired. The content of this summary will depend upon how far you have proceeded. In some cases, progress will be slow, and you may spend most of the first session presenting feedback and dealing with concerns or resistance. In other cases, the client will be well along toward determination, and you may be into Phase 2 (strengthening commitment) strategies by the end of the first session. The speed with which this session proceeds will depend upon the client's current stage of change. Where possible, it is desirable to elicit some client self-motivational statements about change within the first session and to take some steps toward discussing a plan for change (even if tentative and incomplete). Also discuss what the client will do and what changes will be made (if any) between the first and second sessions. Do not hesitate

to move toward commitment to change in the first session if this seems appropriate. On the other hand, do not feel pressed to do so. Premature commitment is ephemeral, and pressuring clients toward change before they are ready will evoke resistance and undermine the MET process.

At the end of the first session, always provide the client with a copy of *Alcohol and You* (Miller 1991) or other suitable reading material. If feedback has been completed, also give the client the Personal Feedback Report and a copy of "Understanding Your Personal Feedback Report."

The Followup Note

After the first session, prepare a handwritten note to be mailed to the client. This is *not* to be a form letter, but rather a personalized message in your own handwriting. (If your handwriting is illegible, make other arrangements, but the note should be handwritten, not typed.)

Several personalized elements can be included in this note:

- A "joining message" ("I was glad to see you" or "I felt happy for you and your wife after we spoke today")
- Affirmations of the client (and SO)
- A reflection of the seriousness of the problem
- A brief summary of highlights of the first session, especially self-motivational statements that emerged
- A statement of optimism and hope
- A reminder of the next session

Here is an example of what such a note might say:

Dear Mr. Robertson:

This is just a note to say that I'm glad you came in today. I agree with you that there are some serious concerns for you to deal with, and I appreciate how openly you are exploring them. You are already seeing some ways in which you might make a healthy change, and your wife seems very caring and willing to help. I think that together you will be able to find a way through these problems. I look forward to seeing you again on Tuesday the 24th at 2:00.

Keep a copy of the note for your records.

Followthrough Sessions

The Second Session

The second session is scheduled 1 to 2 weeks after session 1 and should begin with a brief summary of what transpired during the first session. Then proceed with the MET process, picking up where you left off. Continue with the client's personal feedback from assessment if this was not completed during the first session, and give the client the PFR and a copy of "Understanding Your Personal Feedback Report" (see appendix A) to take home. Proceed toward Phase 2 strategies and commitment to change if this was not completed in the first session. If a firm commitment was obtained in the first session, then proceed with followthrough procedures.

At the end of the second session, in all cases, offer a closing summary of the client's reasons for concern, the main themes of the feedback, and the plan that has been negotiated (see "Recapitulation"). This is the closing of the second session. If no commitment to change has been made, indicate that you will see how the client is doing at the followup in 4 weeks and will continue the discussion at that point. In any event, remind the client of the third session at week 6. When a spouse or SO has been involved in the first two sessions, thank the SO for participating in those sessions and explain that the next two sessions will be with the client alone. If the SO was not involved in both of the initial sessions, he or she may return for the third session. (The SO's involvement is not to exceed two sessions.)

Sessions 3 and 4

Sessions 3 and 4 are to be scheduled for weeks 6 and 12, respectively. They are important as "booster" sessions to reinforce the motivational processes begun in the initial sessions. As before, the therapist does not offer skill training or prescribe a specific course of action. Rather, the same motivational principles are applied throughout MET. Specific use is made in each session of the followthrough strategies outlined earlier: (1) reviewing progress, (2) renewing motivation, and (3) redoing commitment. Sessions 3 and 4 do *not* include the SO, unless the SO has not already attended two sessions.

Because several weeks normally lapse between sessions 2 and 3 and between sessions 3 and 4, you should send the client a handwritten note or telephone the client a few days before the scheduled appointment. This serves as a reminder and also expresses continued active interest in your client.

Begin each session with a discussion of what has transpired since the last session and a review of what has been accomplished in previous sessions. Complete each session with a summary of where the client is at present, eliciting the client's perceptions of what steps should be

taken next. The prior plan for change can be reviewed, revised, and (if previously written down) rewritten.

During these sessions, be careful not to assume that ambivalence has been resolved and that commitment is firm. It is safer to assume that the client is still ambivalent and to continue using the motivation-building strategies of Phase 1 as well as the commitment-strengthening strategies of Phase 2.

There should be a clear sense of continuity of care. The four sessions of MET should be presented as progressive consultations and as continuous with the research protocol's schedule of followup sessions. The initial sessions build motivation and strengthen commitment, and subsequent sessions serve as periodic checkups of progress toward change.

It can be helpful during sessions 3 and 4 to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored:

- Situations in which the client drank
- Situations in which the client did not drink

Drinking Situations

If the client drank since the last session, discuss how it occurred. Remember to remain empathic and to avoid a judgmental tone or stance. Consistent with the MET style, do not prescribe coping strategies for the client. Rather, use this discussion to renew motivation, eliciting from the client further self-motivational statements by asking for the clients thoughts, feelings, reactions, and realizations. Key questions can be used to renew commitment (e.g., "So what does this mean for the future?" "I wonder what you will need to do differently next time?")

Nondrinking Situations

Clients may also find it helpful and rewarding to review situations in which they might have drunk previously or in which they were tempted to drink but did not do so. Reinforce self-efficacy by asking clients to clarify what they did to cope successfully in these situations. Praise clients for small steps, little successes, even minor progress.

Termination

Formal termination should be acknowledged and discussed at the end of the fourth session. This is generally accomplished by a final recapitulation of the client's situation and progress through the MET sessions. Your final summary should include these elements:

- Review the most important factors motivating the client for change, and reconfirm these self-motivational themes.
- Summarize the commitments and changes that have been made thus far.
- Affirm and reinforce the client for commitments and changes that have been made.
- Explore additional areas for change that the client wants to accomplish in the future.
- Elicit self-motivational statements for the maintenance of change and for further changes.
- Support client self-efficacy, emphasizing the client's ability to change.
- Deal with any special problems that are evident (see below).
- Remind the client of continuing followup sessions, emphasizing that these are an important part of the overall program and can be helpful in maintaining change.

Review, in session 4, the major points that have come up in the prior three sessions. It may be useful to ask clients about the worst things that could happen if they went back to drinking as before. Help clients look to the immediate future, to anticipate upcoming events or potential obstacles to continued sobriety.

Dealing With Special Problems

Special problems can arise during any treatment. The following are general troubleshooting procedures for handling some of the situations that may arise in delivering therapy in general as well as within a research context.

Treatment Dissatisfaction

Clients may report thinking that the assigned treatment is not going to help or wanting a different treatment. Under these circumstances, you should first reinforce clients for being honest about their feelings (e.g., "I'm glad you expressed your concerns to me right away."). You should also confirm that clients have the right to quit treatment at any time, seek help elsewhere, or decide to work on the problem on their own. In any event, you should explore the client's feelings further (e.g., "Whatever you decide is up to you, but it might be helpful for us to talk about why you're concerned"). Concerns of this kind that arise during the first session are probably reservations about an approach they have not yet tried. Typically, in randomized studies of multiple treatments, it is appropriate to assure the client that all of the treatments in the study are expected to succeed equally and that you will be offering all the help you can. No one can guarantee that any particular treatment will work, but you can encourage the client to give it a good try for the planned period and see what happens. You can add that should the problem continue or worsen, you will discuss other possible approaches.

If a client expresses reservations after two or three sessions, consider whether there have been new developments. Have new problems arisen? Did the plan for change that was previously developed with the client fail to work, and if so, why? Was it properly implemented? Was it tried long enough? Is there input or pressure from someone else for a change in approaches or for discontinuation of treatment? Is the client discouraged?

If the client's drinking problem has shown improvement but new problems, not previously identified, have appeared, these new problems can be discussed, following (and not departing from) the treatment procedures outlined above. The discussion of new problems and concerns, or a review of how prior implementation failed, can set the stage

for continuation in treatment. You can suggest that it may be too early to judge how well this approach will work and that the client should continue for the 12-week duration. After that, if the client still feels a need for additional treatment, he or she could certainly obtain it.

If other parties are concerned about this treatment and are pressuring the client, you can explore this problem by following the treatment guidelines outlined above. It is also permissible for you to telephone the concerned party (with written consent from the client) to discuss the concerns and provide assurances, along the same lines as those outlined above for similar client concerns.

In Project MATCH, a limit of no more than two additional “emergency” sessions may be provided at the therapist’s discretion. These must remain consistent with the MET guidelines provided in this manual and can be viewed as an extension or intensification of MET. The SO may be included in these sessions if appropriate, but the SO may never be seen alone. All sessions, including any emergency sessions, must be completed within 12 weeks of the first session. After that date, therapists are no longer permitted to see the client for any session, even if MET has not been completed.

A plan to provide a specific referral and help the client make contact was devised in Project MATCH in case all attempts to keep the client in treatment fail. Additional treatment may not be provided by any project therapist. Referral is made to an outside agency or to a therapist within the same agency who has no involvement in Project MATCH. A good procedure for accomplishing the referral is to telephone the agency or professional while the client is still in your office and make a specific appointment. For Project MATCH, this is discussed with the project coordinator or project director, because it has implications for the client’s continuation in the study. In any event, the client is urged to participate in followup interviews as originally planned.

Missed Appointments

When a client misses a scheduled appointment, respond immediately. First try to reach the client by telephone, and when you do, cover these basic points:

- Clarify the reasons for the missed appointment.
- Affirm the client—reinforce for having come.
- Express your eagerness to see the client again.
- Briefly mention serious concerns that emerged and your appreciation (as appropriate) that the client is exploring these.
- Express your optimism about the prospects for change.

- Reschedule the appointment.

If no reasonable explanation is offered for the missed appointment (e.g., illness, transportation breakdown), explore with the client whether the missed appointment might reflect any of the following:

- Uncertainty about whether or not treatment is needed (e.g., “I don’t really have that much of a problem”)
- Ambivalence about making a change
- Frustration or anger about having to participate in treatment (particularly with clients coerced by others into entering the program)

Handle such concerns in a manner consistent with MET (e.g., with reflective listening, reframing). Indicate that it is not surprising, in the beginning phase of consultation, for people to express their reluctance (frustration, anger, etc.) by not showing up for appointments, being late, and so on. Encouraging the client to voice these concerns directly may help to reduce their expression in future missed appointments. Use Phase 1 strategies to handle any resistance that is encountered. Affirm the client for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. It may be useful to elicit some self-motivational statements from the client in this regard. Reschedule the appointment.

In all cases, unless you regard it as a duplication of the telephone contact that might offend the client, *also* send a personal, individualized handwritten note with these essential points. This should be done within 2 days of the missed appointment. Research indicates that a prompt note and telephone call of this kind significantly increase the likelihood that the client will return (Nirenberg et al. 1980; Panepinto and Higgins 1969). Place a copy of this note in the clinical file.

This procedure should be used when any of the four appointments is missed. Three attempts (new appointments) should be made to reschedule a missed session.

Telephone Consultation

Some clients and their SOs will contact you by telephone between sessions for additional consultation. This is acceptable, and all such contacts should be carefully documented in the client’s file. An attempt should be made to keep such contacts brief, rather than providing additional sessions by telephone. All telephone contacts must also comply with the basic procedures of MET. Specific change strategies should not be prescribed. Rather, your approach emphasizes elicitation and reflection.

Early in a telephone contact, you should comment positively on the client's openness and willingness to contact you. Reflect and explore any expressions of uncertainty and ambivalence that are expressed with regard to goals or strategies discussed in a previous session. It can be helpful to "normalize" ambivalence and concerns; for example: "What you're feeling is not at all unusual. It's really quite common, especially in these early stages. Of *course* you're feeling confused. You're still quite attached to drinking, and you're thinking about changing a pattern that has developed over many years. Give yourself some time." Also, reinforce any self-motivational statements and indications of willingness to change. Reassurance can also be in order during these brief contacts, e.g., that people really do change their drinking, often with a few consultations.

Crisis Intervention

The Project MATCH protocol provides guidelines on actions to be taken if the therapist is contacted by the client or SO in a condition of crisis. Others using this manual can adopt these guidelines as needed for their own protocols. These guidelines permit offering up to two special emergency sessions with the client (and SO) within the 12-week treatment period.

If at any time, in the therapist's opinion, the immediate welfare and safety of the client or another person is in jeopardy (e.g., impending relapse, client is acutely suicidal or violent), the protocol instructs the therapist to intervene immediately and appropriately for the protection of those involved, with appropriate consultation from the therapy program supervisor. This may include your own immediate crisis intervention as well as appropriate referral. In Project MATCH, the therapist's involvement in crisis interventions cannot exceed two sessions above and beyond those prescribed by the treatment condition. If a client's urgent needs require more additional treatment than this, referral is arranged.

Cases where there appears to be a worsening of the drinking problems or evidence of other new and serious difficulties (e.g., suicidal thoughts, psychotic behavior, violence) are referred to the onsite Project MATCH study coordinator for further evaluation and consultation. Based on his/her own evaluation and the defined procedures of the study, the coordinator determines what action is warranted and whether the client should be continued in the study. If alternative treatments are warranted, the coordinator is involved in making this determination.

Recommended Reading and Additional Resources

Clinical Descriptions

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- Sanchez-Craig, M. Brief didactic treatment for alcohol and drug-related problems: An approach based on client choice. *British Journal of Addiction* 85:169–177, 1990.
- van Bilsen, H.P.J.G., and van Emst, A.J. Heroin addiction: Motivational milieu therapy. *International Journal of the Addictions* 21:707–713, 1986.

Demonstration Videotapes

- Miller, W.R. *Motivational Interviewing*. Albuquerque, NM: University of New Mexico, 1989. Available from William R. Miller, Ph.D., Department of Psychology, University of New Mexico, Albuquerque, NM, USA 87131-1161. European format videotape available from the National Drug and Alcohol Research Centre, P.O. Box 1, University of New South Wales, Kensington, NSW 2033, Australia.
- Motivation and Change*. Set of two training videotapes available from the Addiction Research Foundation, 33 Russell Street, Toronto M5S 2S1, Ontario, Canada.
- Rollnick, S. *I Want It But I Don't Want It: An Introduction to Motivational Interviewing*. Mind's Eye Video, 1989. European format only. Available from the Department of Psychology, Whitchurch Hospital, Cardiff, Wales, United Kingdom, CF4 7XB.
- van Bilsen, H.P.J.G., and Bennet, G. *Motivational Interviewing in the Addictive Behaviours*. East Dorset Health Authority and Matakana Video Productions, 1987. Contact Gerald A. Bennett, Ph.D., 20 Newstead Road, Bournemouth, Dorset, United Kingdom BH6 3HJ.
- van Emst, A. J., van Bilsen, H. P. J. G., and Schippers, G. M. *Motivation: A Demonstration Videotape on Motivational Interviewing. Part I: Problem Drinking; Part 2: Heroin Addiction*. Audi-Visuele dienst A-faculteiten, Catholic University, Nijmegen, the Netherlands, 1986.
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Appendix A: Assessment Feedback Procedures

by William R. Miller, Ph.D.

Preface

The instructions contained in appendix A refer to the assessment feedback components of Motivational Enhancement Therapy, as practiced in Project MATCH. It is not necessary, however, to use exactly the same assessment instruments as were employed in Project MATCH. The basic idea is to assess a range of dimensions, with particular emphasis on those likely to reflect early problems or risk. If you wish to replicate the exact procedures used in MATCH, information is provided at the end of this appendix for obtaining the needed instruments. You may, however, construct your own assessment battery and design a corresponding Personal Feedback Report (PFR) based on normative data for the instruments you have chosen. The PFR used in Project MATCH is reproduced following page 89.

In general, your assessment battery should sample a variety of potential problem and risk domains. Here is a brief list of pertinent domains, with examples of appropriate assessment approaches for each.

Alcohol Consumption

The volume of alcohol consumption is a primary dimension for assessment, because all other risk and problem domains are related to the quantity and frequency of use. There are four basic approaches for quantifying alcohol consumption.

Quantity/ Frequency Questionnaire

The simplest approach is to ask a few structured questions regarding the frequency (e.g., how many days per month does the person drink) and quantity of consumption (e.g., on a drinking day, how many drinks does the person have on average). Such questions can be aided by describing a standard drink unit (see Miller et al. 1991 for alternatives) or asking separately about different kinds of beverages (beer, wine, spirits, etc.). An advantage of this approach is that, unlike the others, it can be administered by paper and pencil questionnaire. This method appears to underestimate actual consumption, however, and reliability and validity parameters have not been established.

Grid Averaging

A second approach is to reconstruct, by structured interview, a typical drinking week and then account for episodes of drinking that deviate from this pattern. This approach was introduced by Miller and Marlatt (1984) and has been employed in a variety of studies.

***Timeline
Followback***

A third and still more detailed approach is to reconstruct drinking by filling in an actual calendar for the past few weeks or months. Day by day drinking data are obtained, taking advantage of the memory-prompting value of a calendar (Sobell et al. 1980). The Form 90 approach used in Project MATCH (see below) represents a hybrid of the timeline and grid averaging methods.

Drinking Diary

Finally, individuals can be asked to keep a daily diary of alcohol consumption. These records can then be converted into quantitative data. A freeware computer program for this purpose has been developed by Markham, Miller, and Arciniega (see resource list at the end of this appendix).

**Alcohol-Related
Problems**

As heavy drinking continues, life problems tend to accumulate. Some counting of such accumulation is a common measure of problem severity. Measures such as the Michigan Alcoholism Screening Test (MAST; Selzer 1971) combine life problems with other factors such as alcohol dependence symptoms and help seeking. Miller and Marlatt (1984) attempted to differentiate between common problematic consequences of heavy drinking and other life problems, which may or may not be alcohol related. The DRINC questionnaire (see below), developed for Project MATCH, is intended as a purer measure of negative consequences of drinking, apart from alcohol dependence signs.

**Alcohol
Dependence**

The alcohol dependence syndrome is currently a central diagnostic concept. Severity of dependence represents a third dimension to be tapped in comprehensive assessment. A variety of alcohol dependence scales have been published. Skinner's Alcohol Dependence Scale (Skinner and Horn 1984) has been a popular instrument in North America, with strong psychometric characteristics.

Physical Health

Heavy drinking also has predictable effects on physical health. The most common evaluation approach in this domain has been a serum chemistry profile, screening for elevations on variables commonly affected by excessive drinking. These include liver enzymes (SGOT, SGPT, GGT), mean corpuscular volume (MCV), and high-density lipoprotein (HDL). Blood pressure can also be screened, because heavy drinking contributes to hypertension.

**Neuro-
psychological
Functioning**

Knowledge of all of the above domains provides relatively little information about a person's cognitive functioning. Problem drinkers have been found to be impaired on a variety of neuropsychological tests (Miller and Saucedo 1983). Both Project MATCH and other checkup

and feedback interventions have included neuropsychological test results (see Miller and Sovereign 1989; Miller et al. 1988), although interventions can also be effective without the inclusion of neuropsychological testing (Bien and Miller submitted; Brown and Miller submitted). Tests that commonly show impairment include the Block Design and Digit/Symbol subtests of the Wechsler Adult Intelligence Scale, the Wisconsin Card Sorting Task, and Halstead-Reitan subtests including the Tactual Performance Test, the Trail-Making Test, and the Categories Test.

Risk Factors

Markers of high risk for alcohol problems can also be measured, apart from the individual's current level of use and its consequences. Family history of alcohol/drug problems can be obtained by a variety of methods (e.g., Cacciola et al. 1987; Miller and Marlatt 1984). Of personality scales designed to detect correlates of risk for substance abuse, the MacAndrew scale has fared best in research, though others are available (Jacobson 1989; Miller 1976). Beliefs about alcohol, as assessed by Brown's Alcohol Expectancy Questionnaire, have also been found to be predictive of risk (Brown 1985).

Motivation for Change

Various approaches are available for measuring the extent of an individual's motivation for changing drinking. Some consist of simple Likert scales assessing commitment to abstinence or other change goals (e.g., Hall et al. 1990). Self-efficacy scales can be constructed to ask about confidence in one's ability to change. Respondents can be asked to rate the extent to which alcohol is helping or harming them on a range of life dimensions (Appel and Miller 1984). Stages of change derived from the Prochaska and DiClemente (1984) theoretical perspective were used as the basis for construction of the University of Rhode Island Change Assessment (Prochaska and DiClemente 1992; DiClemente and Hughes 1990) and the alcohol-specific Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller).

Comprehensive Assessment Approaches

Several questionnaires and structured interview protocols provide a range of quantitative scores that can be compared with normative or diagnostic standards. None of these taps all of the above dimensions, but each provides a basis for judging status on several domains. The Alcohol Use Inventory (AUI; Horn et al. 1987) is a widely used and well-developed self-administered questionnaire that permits comparison of individual with normatived scores. The materials necessary to administer, score, and interpret the AUI are available from National Computer Systems, P.O. Box 1416, Minneapolis, MN 55440. The kit includes the AUI manual, forras, client test book, hand-scored answer key templates, and the AUI profile sheet, which summarizes the scores and can be given to the client. Structured interviews include the Addiction Severity Index (ASI; Cacciola et al. 1987), the Comprehen-

sive Drinker Profile (CDP; Miller and Marlatt 1984, 1987), and the Form 90 interview developed for Project MATCH (see below).

The crucial point is that the battery of assessment procedures to be used as a basis for feedback can be tailored to the needs, time demands, and client characteristics of a program. What follows is but one example—from Project MATCH—of how assessment feedback can be done within the context of Motivational Enhancement Therapy.

The Project MATCH Assessment Feedback Protocol and Procedures for Completing The PFR

Prior to the first session with an MET client, the Personal Feedback Report is prepared by obtaining the pertinent data from the client's file. The following information from the Project MATCH assessment battery is used:

- AUDIT score from the Quickscreen
- Form 90–I (Initial Intake)
- ASI family history section
- MacAndrew scale score
- DRINC questionnaire
- Serum chemistry profile
- Neuropsychological test results
- Alcohol Use Inventory

BACCuS, an IBM–PC software program, is used for converting alcohol consumption data into standardized measures (Markham et al. submitted).

Alcohol Consumption

The first datum to be presented to the client is the number of standard drinks consumed during a week of drinking. This calculation is available from Form 90–I, the Project MATCH interview protocol for quantifying alcohol consumption. Some degree of judgment is needed here, but remember that the goal is to provide clients with a fair picture of their alcohol consumption during a typical drinking week. If the Steady Pattern Chart has been completed (page 6), use line 38 as the number of standard drinks per week. If no Steady Pattern Chart has been completed, the client's drinking was too variable to provide a consistent weekly pattern. In this case, consult the Summary Statistics sheet. If the client abstained on fewer than 10 percent of days *during the 90-day window*, multiply the "Average SECs per drinking

day” by 7 to obtain the number of standard drinks per week. Be sure you are examining the 90-day window and not the whole current period. If abstinent days exceed 10 percent, examine the calendar to determine whether these abstinent days mostly occurred within drinking weeks (e.g., no drinking on Monday through Wednesday) or whether they occurred in blocks in between periods of drinking (i.e., periodic drinker). In the former case, determine the typical number of drinking days in an average week and multiply this number of days by the Average SECs per drinking day (from the Summary Sheet) to obtain the number of standard drinks per week. In the latter case—a purely periodic drinker—determine from the calendar whether drinking episodes are normally at least 7 days in length. If so, use the same procedure as for the Steady Pattern Chart: multiply the Average SECs per drinking day by 7 to describe the number of standard drinks consumed during a typical week of drinking. If drinking episodes are typically shorter than 1 week (e.g., 3 days), multiply the average number of days in an episode by the Average SECs per drinking day (from the Summary Statistics). Again, remember that the guiding principle is to describe the number of standard drinks that the client consumed, on average, in a drinking week.

When you have obtained the client’s average number of drinks per drinking week, use table 3 to obtain the client’s percentile among American adults. Note the separate norms for men and women.

Estimated Blood Alcohol Concentration Peaks

The second set of data presented to Project MATCH clients consists of computer-projected blood alcohol concentration (BAC) peaks, based on alcohol consumption patterns reported on Form 90–I. These projections are computed by BACCuS and will normally have been completed by the research assistant who conducted the Form 90–I interview. Nevertheless, you should check these calculations using BACCuS. Any projected peak over 600 mg% should be reported as 600 mg%. The reasoning here is that projections above this level are likely to be overestimates, because actual BAC peaks above 600 mg%, though possible, are relatively rare.

The BAC peak for a typical drinking week is obtained from line 39 of Form 90–I. This is the highest intoxication peak from the typical drinking week grid. Note that it may be necessary to use the BACCuS program (Menu #3, BAC Peak for an Episode) to estimate BAC peaks for several different days in order to determine which yielded the highest BAC. It is not always obvious, from visual inspection, which period will produce the highest BAC peak. Where a day contains at least two periods of drinking separated by several hours (e.g., 6 drinks from noon until 2:00 pm and then 8 drinks from 7:00–11:00 pm), it is wise to try the BAC level for each period within the day, as well as for the whole day. (In the above example, you would run 6 drinks in 2 hours, 8 drinks in 4 hours, and 14 drinks in 11 hours. The resulting BAC projections for a 160-pound male would be 109, 124, and 152,

Table 3. Alcohol consumption norms for U.S. adults, in percents

Drinks per week	Total	Men	Women
0	35	29	41
1	58	46	68
2	66	54	77
3	68	57	78
4	71	61	82
5	77	67	86
6	78	68	87
7	80	70	89
8	81	71	89
9	82	73	90
10	83	75	91
11	84	75	91
12	85	77	92
13	86	77	93
14	87	79	94
15	87	80	94
16	88	81	94
17	89	82	95
18	90	84	96
19	91	85	96
20	91	86	96
21	92	88	96
22	92	88	97
23-24	93	88	97
25	93	89	98
26-27	94	89	98
28	94	90	98
29	95	91	98
30-33	95	92	98
34-35	95	93	98
36	96	93	98
37-39	96	94	98
40	96	94	99
41-46	97	95	99
47-48	97	96	99
49-50	98	97	99
51-62	98	97	99
63-64	99	97	>99.5
65-84	99	98	>99.6
85-101	99	99	>99.9
102-159	>99.5	99	>99.9
160+	>99.8	>99.5	>99.9

Source: 1990 National Alcohol Survey, Alcohol Research Group, Berkeley.
Courtesy of Dr. Robin Room

respectively. In this case, the BAC of 152, from 14 drinks in 11 hours, would be used.) If the Steady Pattern Chart was not completed on 90–I, leave this line blank.

The BAC peak for a heavier day of drinking is obtained from the Highest Peak BAC line of the Summary Statistics sheet. This represents the *highest* BAC peak reached during the 90-day period. This will never be lower than line 39 but may be the same as line 39. In this case, the number on both lines of section 2 would be the same.

Risk Factors

The third feedback panel on the PFR reflects five risk factors. Higher scores on these scales are associated with greater risk and severity of alcohol-related problems.

Tolerance Level

Tolerance level is inferred from the BAC peaks reached during the 90-day window. The rationale is that the higher the projected BAC peak, the higher the individual's tolerance. Use the higher of the two numbers in Section 2 to arrive at the classification:

0–60 mg%	Low tolerance
61–120 mg%	Medium tolerance
121–180 mg%	High tolerance
181 mg% +	Very high tolerance

Other Drug Risk

Other drug risk is judged from the lifetime use of other drugs, as reported on page 10 of Form 90–I. The rationale is that more frequent use of other drugs, or any use of drugs with higher dependence potential, is associated with greater risk for serious consequences and complications. Use the following classification system:

HIGH RISK	Any use of cocaine or crack or Any use of heroin, methadone, or other opiates or Frequent use (more than 3 months of at least once per week) of any other drug class except tobacco: Marijuana, Hash, THC Amphetamines, Stimulants, Diet Pills Tranquilizers Barbiturates
MEDIUM RISK	Any lifetime nonprescription use, but not frequent use (i.e., 3 months or less of weekly use) of any drug class except tobacco, opiates or cocaine: Marijuana, Hash, THC Amphetamines, Stimulants, Diet Pills Tranquilizers Barbiturates
LOW RISK	No use of other drugs (Code = 0 for all 10 drug classes except tobacco)

Family Risk

Family risk is judged from the family history of alcohol and other drug problems obtained in the ASI interview. The following weighting

system is used to arrive at a total Family Risk score. Assign the designated number of points for *each* blood relative indicated to be positive for alcohol/drug problems:

If father positive	add 2 points
If mother positive	add 2 points
For each brother positive	add 2 points
For each sister positive	add 2 points
For each grandparent positive	add 1 point
For each uncle or aunt positive	add 1 point

Risk levels are judged according to the following classification system:

Family Risk Classifications

0–1	Low risk
2–3	Medium risk
4–6	High risk
7+	Very high risk

MacAndrew Scale The MacAndrew Scale score can be obtained directly from this scale. The following classification system is used for risk:

MacAndrew Scale Risk Levels

0–23	Normal range; lower risk
24–29	Medium risk
30+	High risk

Age at Onset

Age at onset is the fifth risk factor in this panel. The rationale is that younger onset of problems is associated with a more severe course and symptomatology. Age at onset is calculated by the following procedure, using three items obtained from the DRINC (Drinker Inventory of Consequences) scale.

Calculating Age at Onset

- Record these three numbers, if applicable, and sum them (from page 7 of Drinker Inventory of Consequences)

Age of first regular intoxication (item 17): _____

Age of first loss-of-control (item 18): + _____

Age of first alcohol problems (item 19): + _____

TOTAL _____

- Divide by the number of ages used in step 1:

Age at onset = _____

NOTE: If an age item was not recorded for the client (e.g., the client had never experienced loss of control), the average is based on the other two age items (divide by 2). If only one age item was completed, this constitutes the age at onset.

Risk level is judged according to this classification system:

Under 25.0	Higher risk
25.0–39.9	Medium risk
40.0 +	Lower risk

Problem Severity The *AUDIT* score is recorded directly from this scale within the Quickscreen. The *DRINC* alcohol severity score is recorded directly from this questionnaire and is the sum of scores for the 55 *lifetime* consequences. Print the client's raw score for each of these two scales under the corresponding severity range (e.g., a 19 on the *AUDIT* would be printed under the HIGH descriptor, below the 16–25 range designation.)

The other information reviewed in the fourth panel is the profile of results from the AUI. Use the AUI Profile form, published by National Computer Systems, for this purpose. Circle the client's raw scores for all scales and connect the circles with straight lines. Do not cross the solid lines that divide categories.

Serum Chemistry Obtain the client's serum chemistry scores on SGOT, GGTP, SGPT, uric acid, and bilirubin (total) from the lab report. Record these lab scores on the corresponding lines of the PFR. Interpretive ranges are shown on the PFR.

**Neuro-
psychological
Test Results**

A 5-point performance scale is used to interpret neuropsychological test results:

1	Well above average
2	Above average
3	Average
4	Below average
5	Well below average

The scoring systems below attempt to correct for effects of age and/or education level, based on available norms. The Shipley-Hartford Vocabulary test is used as a "hold" test that is less likely to be affected by alcohol, thus providing an estimate of the level of performance that would ordinarily be expected from an individual.

***Shipley-Hartford
Vocabulary Test
(SV)***

Use the *age-adjusted* score to obtain a normalized T-score, as specified in the revised Shipley-Hartford manual. Then use the following table to convert the T-score into our 1–5 scale:

≥ 63	1	Well above average
57–62	2	Above average
44–56	3	Average
38–43	4	Below average
≤ 37	5	Well below average

**Shipley-Hartford
Abstraction Test
(SHVA)**

Use the *age-adjusted* score to obtain a normalized T-score, as specified in the revised Shipley-Hartford manual. Then use the following table to convert the T-score into our 1–5 scale:

≥ 63	1	Well above average
57–62	2	Above average
44–56	3	Average
38–43	4	Below average
≤ 37	5	Well below average

**Trail-Making
Test, Form A
(TMTA)**

The score is the number of seconds to complete Form A.

	Age			
	20–39	40–49	50–59	60–69
1	≤ 21	≤ 22	≤ 25	≤ 29
2	22–26	23–28	26–29	30–35
3	27–41	29–44	30–48	36–66
4	42–49	45–58	49–66	67–103
5	≥ 50	≥ 59	≥ 67	≥ 104

Based on Lezak 1976, Table 17–6, page 558. Cutting points represent the 10th, 25th, 75th, and 90th percentiles.

**Trail-Making
Test, Form B
(TMTB)**

The score is the number of seconds to complete Form B.

	Age			
	20–39	40–49	50–59	60–69
1	≤ 45	≤ 49	≤ 55	≤ 64
2	46–55	50–57	56–75	65–89
3	56–93	58–99	76–134	90–171
4	94–128	100–150	135–176	172–281
5	≥ 129	≥ 151	≥ 177	≥ 282

Based on Lezak, 1976, Table 17–6, page 558. Cutting points represent the 10th, 25th, 75th, and 90th percentiles.

**Symbol Digit
Modalities Test
(SYDM)**

The score for the Symbol Digit Modalities Test is the number of correct digits associated with their respective symbols within the 90-second written testing period.

Use this table if client has 12 years or less of education.

Age	1	2	3	4	5
18–24	≥ 67	63–66	47–62	42–46	≤ 41
25–34	≥ 65	61–64	46–60	41–45	≤ 40
35–44	≥ 64	60–63	44–59	39–43	≤ 38
45–54	≥ 62	57–61	39–56	33–38	≤ 32
55–64	≥ 55	51–54	36–53	31–35	≤ 30
65+	≥ 47	42–46	25–41	20–24	≤ 19

Use this table if client has 13 years or more of education.

Age	1	2	3	4	5
18–24	≥ 72	67–71	53–66	47–52	≤ 46
25–34	≥ 67	62–66	50–61	44–49	≤ 43
35–44	≥ 65	60–64	44–59	37–43	≤ 36
45–54	≥ 61	57–60	45–56	40–44	≤ 39
55–64	≥ 56	52–55	40–51	35–39	≤ 34
65+	≥ 55	49–54	33–48	27–32	≤ 26

Interpreting the PFR to Clients

Project MATCH therapists follow a systematic approach in discussing the Personal Feedback Report with clients. The general therapeutic style in giving MET feedback is illustrated in Dr. Miller's "Motivational Interviewing" videotape.

The original copy of the PFR is given to the client and a copy is retained for the therapist's file. The PFR consists of two pages of data from interviews and questionnaires plus the client's Alcohol Use Inventory Profile sheet. When the therapist has finished presenting the feedback, the client may take home the PFR plus a copy of "Understanding Your Personal Feedback Report." If a session ends partway through the feedback process, however, the therapist retains the original PFR, sending it home with the client only after the review of feedback is completed. Clients are given a copy of *Alcohol and You* at the end of the first session (a copy is included at the end of appendix A).

Therapists need to be thoroughly familiar with each of the scales included on the PFR. "Understanding Your Personal Feedback Report" provides basic information for the client. Here are some additional points helpful in reviewing the PFR with clients.

Alcohol Consumption

The idea of a standard drink is an important concept. Explain that all alcohol beverages—beer, wine, spirits—contain the same kind of alcohol, ethyl alcohol. They just contain different amounts of this drug. Use the "Standard Drink" graphic depicted in the client handout "Understanding Your Personal Feedback Report" to explain this. We are using, as a standard drink, any beverage that contains half an ounce of ethyl alcohol. Thus, the following beverages are each equal to one standard drink:

Beverage	Usual %	x	Ounces	=	Alcohol content
Beer	.05	x	10 oz	=	0.5 oz
Table wine	.12	x	4 oz	=	0.5 oz
Fortified wine	.20	x	2.5 oz	=	0.5 oz
Spirits					
80 proof	.40	x	1.25 oz	=	0.5 oz
100 proof	.50	x	1 oz	=	0.5 oz

Explain that the number of standard drinks per week is calculated from the client's own report of regular and periodic drinking patterns, converted into standard units as shown in the graphic.

The normative table provides an estimate of the client's standing among American adults of the same sex with regard to alcohol consumption. The conversion table provides percentile levels for various numbers of standard drinks per week, based on data from the 1990 National Alcohol Survey, provided by Dr. Robin Room of the Alcohol Research Group at Berkeley. A good explanation of this percentile figure is that, "This means you drink more than __percent of American [men/women] do, or that (100-X) percent of American (men/women) drink as much or more than you do."

Estimated BAC Peaks

The number of drinks consumed is only part of the picture. A certain number of drinks will have different effects on people, depending on factors like their weight and sex. The *pattern* of drinking also makes a difference: having 21 drinks within 4 hours on a Saturday is different from having 21 drinks over the course of a week (3 a day).

Another way to look at a person's drinking, then, is to estimate how intoxicated he or she becomes during periods of drinking. Be clear here that we are discussing "intoxicated" in terms of the level of alcohol (a toxin) in the body and *not* the person's subjective sense of being drunk. It is common for alcoholics to be quite intoxicated (high BAC) but not to look or feel impaired.

The unit used here is milligrams of alcohol per 100 ml of blood, abbreviated "mg%." This is the unit commonly used by pharmacologists and has the additional convenience of being a whole number rather than a decimal (less confusing for some clients). If you or your client wish to compare this with the usual decimal expressions of BAC, simply move the decimal point three places to the left. Thus:

80 mg% = .08
100 mg% = .10
256 mg% = .256 and so on

Note that the "normal social drinking" range is defined as from 20–60 mg% in peak intoxication. In fact, the vast majority of American drinkers do not exceed 60 mg% when drinking.

Risk Factors

Introduce this section by explaining "risk." Elevated scores on risk factors are not predestination. A person with a family history of heart disease is not doomed to die of heart disease—but such a person needs to be extra careful about diet and exercise, for example, and to keep a careful eye for warning signs. The five scores in this section are markers of higher risk for serious problems with alcohol. They indicate a greater susceptibility to alcohol problems.

Tolerance

The behavioral effects as shown in “Understanding Your Personal Feedback Form” can be understood as the ordinary effects of various BAC levels. Because of tolerance, people may reach these BAC levels without feeling or showing the specific effects listed.

The presence of a high BAC level, especially if accompanied by a reported absence of apparent or subjective intoxication signs, is an indication of alcohol tolerance. This should be discussed with the client as a *risk factor*. That is, people with a high tolerance for alcohol have a *greater* risk of developing serious problems because of drinking! A few points to cover are—

- Tolerance is partly inherited, partly learned.
- For the most part, tolerance does *not* mean being able to get rid of alcohol at a faster rate (although this occurs to a small extent). Rather it means reaching high levels of alcohol in the body without feeling or showing the usual effects.
- Normal drinkers are sensitive to low doses of alcohol. They feel the effects of 1–2 drinks, and this tells them they have had enough. Other people seem to lack this warning system.
- A result of tolerance is that the person tends to take in large quantities of alcohol—enough to damage the brain and other organs of the body over time—without realizing it. Thus you damage yourself without feeling it. An analogy would be a person who loses all sensations of pain. While at first this might seem a blessing, in fact, it is a curse, because such a person can be severely injured without feeling it. The first sign that your hand is on a hot stove is the smell of the smoke. Similarly, for tolerant drinkers, the first signs of intoxication are felt at rather high BAC levels.

Other Drug Risk

A second risk factor to consider is other drug use. In essence, the more drugs the client is using, the greater the risk for problems, cross-tolerance, dependence, drug substitution (decreasing one but increasing another), and so forth. Discuss these risks with your client.

Family Risk

Evidence is now strong that alcohol problems run in families and are genetically influenced. Of course, many people develop alcohol problems without having a family history, but your risk is higher if you have blood relatives with alcohol problems. Any family history should be discussed with the client.

MacAndrew Score

Higher scores on the MacAndrew scale, a subscale of the MMPI, have been found for alcoholics than for normals or people with other psychological problems. Elevations on this scale have also been found to be predictive, in young people, of *later* development of alcohol prob-

lems. This personality scale taps a variety of personal characteristics that are associated with higher risk of serious alcohol problems.

Age at Onset

Alcohol problems tend to be more severe when they begin at a younger age. Three items from the Drinker Inventory of Consequences are averaged to obtain an “age of onset” for alcohol difficulties. The younger this age, the greater the risk for developing severe problems if drinking continues. Young emergence of “loss of control” (difficulty stopping once started or in keeping one’s drinking within planned limits), for example, may be an indicator of high risk for severe alcohol problems.

Problem Severity

Two measures from Project MATCH screening are used here to reflect overall alcohol problem severity. One is the AUDIT scale, developed by the World Health Organization and used in the Quickscreen. The other is the Drinker Inventory of Consequences. Explain that these scores are very broad, general measures of negative effects of drinking in an individual’s life. Notice that the AUDIT focuses on recent patterns, whereas the DRINC measures lifetime effects.

Your larger task here is to review with the client his or her scores from the Alcohol Use Inventory. To do this, you should be thoroughly familiar with the manual (Horn et al. 1987), particularly chapter 6. It is helpful, in understanding and interpreting scales, to be familiar with the items that constitute each scale (see page 71 of the manual). Refer to (and provide the client with a copy of) the AUI Profile Sheet, available from National Computer Systems, Minneapolis, MN. Remember when interpreting elevations on the AUI that the reference population is *people already seeking treatment for alcohol problems*. Thus, a “low” score in the white (decile 1–3) range is low relative to people entering treatment for alcohol problems. Scores in the middle deciles (4–7; light grey) are by no means average for the general population. General population norms on most scales would be expected to fall in deciles 1–2. A possible exception is GREGARIOUS, where high scores reflect drinking in social settings—a common style for young American men.

Serum Chemistry

These five serum assays can be elevated by excessive drinking and thereby reflect the physical impact of alcohol on the body. It is noteworthy that many heavy and problematic drinkers have normal scores on serum assays. The physical damage reflected by elevations on these scales may emerge much later than other types of problems. Also, normal scores on these tests *cannot* be interpreted as the absence of physical damage from drinking. The destruction of liver cells near the portal vein where blood enters, for example, can occur before liver enzymes reflect a warning. When these scales *are* elevated, then, it is information to be taken seriously.

Therapists should clarify that, as a nonmedical professional, you are not qualified to interpret these findings in detail. Clients who are concerned and want more information should be advised to discuss their results with a physician. If possible, referral should be made to a physician who is knowledgeable about alcohol abuse. A physician in general practice who is not familiar with alcohol abuse may advise a patient that their elevations are “nothing to worry about,” undermining the feedback process.

The following information will help explain to clients the basic processes underlying these assays and what they may mean.

SGOT/SGPT

Serum glutamic oxalacetic transaminase (SGOT; newer name: AST— aspartate aminotransferase) and serum glutamic pyruvate transaminase (SGPT; newer name: ALT—alanine transferase) are enzymes that reflect the health of the liver. The liver is important in metabolism of food and energy and also filters and neutralizes poisons and impurities in the blood. When the liver is damaged, as happens from heavy drinking, it becomes less efficient in these tasks and begins to leak enzymes into the bloodstream. These two are general indicators, reflecting overall health of the liver.

GGTP

Serum gamma glutamyl transpeptidase is an enzyme found in liver, blood, and brain, which is more specifically sensitive to alcohol's effects. Elevations of this enzyme have been shown to be predictive of later serious medical problems related to drinking, including injuries, illnesses, hospitalizations, and deaths. This enzyme is often elevated first, with SGOT and SGPT rising into the abnormal range as heavy drinking continues.

Bilirubin (Total)

The liver is also importantly involved in the recycling of hemoglobin, the molecule which makes the blood red. Bilirubin is one breakdown product of hemoglobin. When the liver is not working properly, it cannot recycle hemoglobin efficiently, and the byproducts back up into the bloodstream and eventually into the brain. High bilirubin levels over time result in jaundice—yellowing of the skin. Elevations of bilirubin are not common, even among heavy drinkers, and are indicative of severe physical impact from alcohol.

Uric Acid

Uric acid is a waste product that results from the breakdown of RNA. Alcohol's damage to the liver reduces the kidney's ability to excrete uric acid, which then builds up in the bloodstream. High levels of uric acid result in gout, the painful inflammation of joints, particularly fingers and toes. Uric acid is also an important component of a certain type of kidney stones.

If your site is including other relevant assays in your serum chemistry package (e.g., HDL, MCV), these could be included on your feedback form.

Neuro- psychological Test Results

Enzyme elevations can occur for reasons other than heavy drinking. GGTP, for example, can be elevated by cancer or hormonal changes. In this population, however, the most likely cause of an elevation is heavy drinking. In this case, these assays tend to return toward normal if the person ceases heavy drinking. Reductions in GGTP (by changed drinking) have been shown to be associated with dramatically reduced risk of serious medical problems.

The last panel of assessment results in the Project MATCH MET feedback is from the brief neuropsychological testing. Scores on these tests range from 1 (well above average) to 5 (well below average). Scores of 4 are often interpreted as “suggestive” of cognitive impairment, and scores of 5 as “indicative” of cognitive impairment.

The first (SV) result is from the Shipley-Hartford Vocabulary test. It is included as a “hold” test to indicate the approximate level of cognitive functioning that would be *expected* for a particular individual. Performance on this test is not commonly affected by alcohol use. This score, then, gives you an approximate reference point with which to compare other performances.

The other four tests appear to be sensitive to the effects of alcohol on the brain. They tend to be impaired in heavy drinkers and often show substantial improvement over the first weeks and months of sobriety. No judgment can be made about a client’s general neuropsychological functioning or “brain damage” from this brief set of tests. Rather, they are *indicators* of the types of cognitive impairment commonly related to heavy drinking.

The Trail-Making Test has two forms. Trails A is a follow-the-dot format that mainly tests psychomotor speed. Alcoholics tend to be impaired (slow) on this test, though normal scores are more common than on Trails B. Trails B requires not only test psychomotor speed but also a mental switching back and forth between two cognitive sets—numbers and letters. As a group, alcoholics are rather consistently impaired (slow) on this test.

The Symbol Digit Modalities test is a reversal of the more familiar Digit/Symbol subtest of the WAIS. It is a timed test requiring the copying of numbers that correspond to symbols. It is influenced not only by psychomotor speed but also by memory. Alcoholics tend to perform more poorly (complete fewer correct digits) than others on this scale.

Finally, the Abstraction scale of the Shipley-Hartford taps a cognitive capacity—verbal abstraction ability—that is commonly impaired in heavy drinkers. Lower scores are associated with more concrete thinking styles. The common observation in alcoholics is a poorer performance on Abstraction than on the Vocabulary scale of the Shipley.

Be aware of other factors that may have influenced performance. Speed on Trails and Symbol/Digit, for example, will be slowed by an injury to the writing hand or arm. Visual impairments will also slow performance on these tests.

The PFR form and the handout explaining the data on the PFR form as used in Project MATCH are provided as examples. These can be modified to suit the needs of other research studies.

Assessment Instruments Used in Project MATCH Feedback

Form 90

Both published and newly developed assessment instruments were employed in Project MATCH as a basis for providing client feedback in Motivational Enhancement Therapy. The sources from which these instruments can be obtained are provided below.

Form 90 is a family of assessment interview instruments designed to provide primary dependent measures of alcohol consumption and related variables. It is a structured interview procedure that yields quantitative indices of alcohol consumption, other drug use, and related variables during a specified period of time. These instruments were developed for use in Project MATCH, with the collaboration of all principal investigators in that project. A Form-90 manual and forms will be published when final protocols and initial psychometric data are available. While the instrument remains under development, a research citation should be in this form:

Miller, W.R. "Form 90: Structured Assessment Interview for Drinking and Related Behavior." Unpublished manual for Project MATCH, National Institute on Alcohol Abuse and Alcoholism.

Until publication, requests for use should be addressed to William R. Miller, Ph.D., Department of Psychology, University of New Mexico, Albuquerque, NM 87131.

DRINC

The alcohol research field has lacked a consensus instrument for assessing negative consequences of drinking. The DRINC was designed as a survey schedule for evaluating the occurrence of negative consequences related to drinking during a particular period of time. Items that are typically recognized as components of alcohol dependence syndrome (e.g., craving, blackouts) are intentionally omitted from this scale in an attempt to disaggregate dependence symptoms and negative life consequences. The DRINC also avoids the confounding, apparent in prior questionnaires (e.g., MAST), of recent consequences with lifetime ("ever") consequences or treatment experiences. The DRINC is therefore meant to be useful for parallel assessment of pretreatment and posttreatment consequences of drink-

ing. It yields problem scores for "ever" (lifetime) and for a specific timeframe (past 3 months), which can be adjusted.

The DRINC should be regarded as an experimental instrument, currently in development. An initial psychometric study with 299 drinkers found good internal consistency (Cronbach alpha = .92 for "ever" and .90 for past 3 months). Initial analyses further indicate the negative consequences as a construct is related to but not identical with alcohol dependence and alcohol consumption. Correlations with Skinner's Alcohol Dependence Scale were .58 for Ever and .56 for Past 3 Months. DRINC scores were correlated with recent quantity/frequency of drinking at .37 for Ever and .47 for Past 3 Months. Based on initial studies using this instrument (including NIAAA's Project MATCH), it will be modified to improve its reliability, validity, and utility.

A proper current citation, pending formal publication of the instrument, is:

Miller, W.R. "The Drinker Inventory of Consequences." Unpublished manuscript, University of New Mexico.

The DRINC is available for use and can be obtained from William R. Miller, Ph.D., Department of Psychology, University of New Mexico, Albuquerque, NM 87131.

MacAndrew Scale

The MacAndrew Scale is a subscale of the original Minnesota Multiphasic Personality Inventory. It is described in the following article:

MacAndrew, C. The differentiation of male alcoholic outpatients from nonalcoholic psychiatric outpatients by means of the MMPI. *Quarterly Journal of Studies on Alcohol* 26:238-246, 1965.

Addiction Severity Index

The Addiction Severity Index is a research instrument under ongoing development. For information regarding the current version, contact Dr. A. Thomas McLellan, VA Medical Center (116), Philadelphia, PA 19104.

AUDIT

The Alcohol Use Disorders Identification Test was developed for a large collaborative study of brief intervention conducted by the World Health Organization (Babor and Grant 1989; Saunders et al. in press).

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Handouts for Clients

Personal Feedback Report Form

This form is used in Project MATCH to summarize information obtained from the pretreatment assessment battery and is discussed with and given to the client in the early sessions of MET. It is an example of the type of form that may be adapted for use in other research studies involving MET.

Understanding Your Personal Feedback Report

Project MATCH clients receive a copy of this material to take home with them to read in conjunction with their PFR. It summarizes important information that helps the client understand the implications of their scores on the assessment instruments. Again, it is an example of the Project MATCH material that may be adapted for use in other research studies involving MET.

“Alcohol and You”

This pamphlet was developed by Dr. William R. Miller and is suitable for duplication and distribution to clients.



PERSONAL FEEDBACK REPORT

Location: _____

Name: _____ ID: _____

1. YOUR DRINKING _____

Number of standard "drinks" per week: _____ drinks

Your drinking relative to American adults (same sex): _____ percentile

2. LEVEL OF INTOXICATION _____

Estimated Blood Alcohol Concentration (BAC) peaks:

in a typical week: _____ mg %

on a heavier day of drinking: _____ mg %

3. RISK FACTORS _____

Tolerance Level:

_____ Low (0 - 60) _____ Medium (61 - 120) _____ High (121-180) _____ Very High (181 +)

Other Drug Risk:

_____ Low _____ Medium _____ High

Family Risk: _____

Low: 0 - 1 Medium: 2 - 3 High: 4 - 6 Very High: 7 +

MacAndrew Score: _____

Normal Range: 0 - 23 Medium Risk: 24 - 29 High Risk: 30 +

Age at onset: _____ years

Under 25 - Higher Risk 25 - 39 Medium Risk 40 + Lower Risk

4. NEGATIVE CONSEQUENCES _____

Severity of Problems

	Low	Medium	High	Very High
AUDIT	0 - 7	8 - 15	16 - 25	26 - 40

Your Score: _____

DRINC: Ever happened	Low 55 - 60	Medium 61 - 75	High 76 - 90	Very High 91 +
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Your Score: _____

(Additional information on attached sheet.)

5. BLOOD TESTS _____

SGOT (AST): _____ Normal range: 5 - 35

GGTP (GGT): _____ Normal range: 0 - 30 Low Normal 31 - 50 High Normal

51 + Elevated / Abnormal

SGPT (ALT): _____ Normal range: 7 - 56

Uric Acid: _____ Normal range: 2.6 - 5.6

Bilirubin: _____ Normal range: .2 - 1.2

6. NEUROPSYCHOLOGICAL TESTS _____

SV	Well Above Average 1	Above Average 2	Average 3	Below Average 4	Well Below Average 5
TMTA	1	2	3	4	5
TMTB	1	2	3	4	5
SYDM	1	2	3	4	5
SHVA	1	2	3	4	5

Therapist: _____

Understanding Your Personal Feedback Report

The Personal Feedback Report summarizes results from your pretreatment evaluation. Your therapist has explained these to you. This information is to help you understand the written report you have received and to remember what your therapist told you.

Your report consists of two sheets. The first sheet provides information from your pretreatment interviews. Attached to this is a second sheet summarizing your answers to a questionnaire, the Alcohol Use Inventory. The following information is presented section by section to help you understand what your results mean.

1. Your Drinking

The first line in this section shows the number of drinks that you reported having in a typical drinking week. Because different alcohol beverages vary in their strength, we have converted your regular drinking pattern into standard "one drink" units. In this system, one

drink is equal to:

10 ounces of beer	(5 percent alcohol)	or
4 ounces of table wine	(12 percent alcohol)	or
2.5 ounces of fortified wine (sherry, port, etc.)	(20 percent alcohol)	or
1.25 ounces of 80 proof liquor	(40 percent alcohol)	or
1 ounce of 100 proof liquor	(50 percent alcohol)	


All of these drinks contain the same amount of the same kind of alcohol: one-half ounce of pure ethyl alcohol.

This first piece of information, then, tells you how many of these standard drinks you have been consuming per week of drinking, according to what you reported in your interview. (If you have not been drinking for a period of time recently, this refers to your pattern of drinking before you stopped.)

To give you an idea of how this compares with the drinking of American adults in general, the second number in section 1 is a *percentile figure*. This tells you what percentage of U.S. men (if you


ONE STANDARD DRINK IS:

BEER




10 oz

WINE




4 oz

80 PROOF LIQUOR



1 1/4 oz

100 PROOF LIQUOR



1.0 oz

are a man) or women (if you are a woman) drink *less* than you reported drinking in a typical week of drinking. If this number were 60, for example, it would mean that your drinking is higher than 60 percent of Americans of your sex (or that 40 percent drink as much as you reported, or more).

How much is too much? It depends on many factors. Current research indicates that people who average *three* or more standard drinks per day have much higher risk of health and social problems. For some people, however, even 1–2 drinks per day would be too many. Pregnant women, for example, are best advised to abstain from alcohol altogether, because even small amounts of regular drinking have been found to increase risk for the unborn child. Certain health problems (such as liver disease) make even moderate drinking unsafe. Some people find that they are unable to drink moderately, and having even one or two drinks leads to intoxication.

Your total number of drinks per week tells only part of the story. It is *not* healthy, for example, to have 12 drinks per week by saving them all up for Saturdays. Neither is it safe to have even a few drinks and then drive. This raises the important question of level of intoxication.

2. Level of Intoxication

A second way of looking at your past drinking is to ask what level of intoxication you have been reaching. It is possible to estimate the amount of alcohol that would be circulating in your bloodstream, based on the pattern of drinking you reported. Blood alcohol concentration (BAC) is an important indication of the extent to which alcohol would be affecting your body and behavior. It is used by police and the courts, for example, to determine whether a driver is too impaired to operate a motor vehicle.

To understand better what BAC means, consider the list of common effects of different levels of intoxication.

Common Effects of Different Levels of Intoxication

20–60 mg%	This is the “normal” social drinking range. NOTE: Driving, even at these levels, is unsafe.
80 mg%	Memory, judgment, and perception are impaired. Legally intoxicated in some States.
100 mg%	Reaction time and coordination of movement are affected. Legally intoxicated in all States.
150 mg%	Vomiting may occur in normal drinkers; balance is often impaired.

200 mg%	Memory “blackout” may occur, causing loss of recall for events occurring while intoxicated.
300 mg%	Unconsciousness in a normal person, though some remain conscious at levels in excess of 600 mg% if tolerance is very high.
400–500 mg%	Fatal dose for a normal person, though some survive higher levels if tolerance is very high.

The two figures shown in section 2 are computer-calculated estimates of your highest (peak) BAC level during a typical week of drinking and during one of your heaviest days of drinking.

It is important to realize that there is no known “safe” level of intoxication when driving or engaging in other potentially hazardous activities (such as swimming, boating, hunting, and operating tools or machinery). Blood alcohol levels as low as 40–60 mg% can decrease crucial abilities. Adding to the danger, drinkers typically do not *realize* that they are impaired. The only safe BAC when driving is *zero*. If you must drive after drinking, plan to allow enough time for all of the alcohol to be eliminated from your body before driving. The tables below can be helpful in determining how long it takes to eliminate alcohol completely:

Approximate hours from first drink to zero alcohol concentration levels for men

		Your weight in pounds							
		120	140	160	180	200	220	240	260
Number of Drinks	1	2	2	2	1.5	1	1	1	1
	2	4	3.5	3	3	2.5	2	2	2
	3	6	5	4.5	4	3.5	3.5	3	3
	4	8	7	6	5.5	5	4.5	4	3.5
	5	10	8.5	7.5	6.5	6	5.5	5	4.5

One drink = 10 oz of beer or 4 oz of wine or 1 oz of liquor (100 proof)

Approximate hours from first drink to zero alcohol concentration levels for women

		Your weight in pounds							
		120	140	160	180	200	220	240	260
Number of Drinks	1	3	2.5	2	2	2	1.5	1.5	1
	2	6	5	4	4	3.5	3	3	2.5
	3	9	7.5	6.5	5.5	5	4.5	4	4
	4	12	9.5	8.5	7.5	6.5	6	5.5	5
	5	15	12	10.5	9.5	8	7.5	7	6

One drink = 10 oz of beer or 4 oz of wine or 1 oz of liquor (100 proof)

3. Risk Factors

It is clear that some people have a much higher risk of alcohol and other drug problems. This section provides you with some information about your own level of risk, based on your personal characteristics. "High risk" does not mean that one will definitely have serious problems with alcohol or other drugs. Neither does "low risk" mean that one will be free of such problems. High-risk people, however, have greater chances of developing serious problems.

Tolerance

Your peak BAC levels, given in section 2, are one reasonably good reflection of your level of *tolerance* for alcohol. If you are reaching BAC levels beyond the normal social drinking range (especially if you are not feeling some of the normal effects of lower BACs), it means that you have a higher tolerance for alcohol. This is partly hereditary and partly the result of changes in the body that occur with heavier drinking. Some people are proud of this tolerance—the ability "to hold your liquor"—and think it means they are not being harmed by alcohol. Actually, the opposite is true. Tolerance for alcohol may be a serious *risk factor* for alcohol problems. The person with a high tolerance for alcohol reaches high BAC levels, which can damage the brain and other organs of the body but has *no built-in warning* that it is happening. Tolerance is not a protection against being harmed by drinking; to the contrary, it makes damage more likely because of the false confidence that it encourages. It is a bit like a person who has no sense of pain. Pain is an important warning signal. People who feel no pain can seriously injure themselves without realizing it. It is the same with people who have a high tolerance for alcohol.

Many people believe that tolerance ("holding your liquor") means that a person gets rid of alcohol at a faster rate than others. Although people do differ in how quickly their bodies can clear alcohol, tolerance has more to do with actually *being* at a high blood alcohol level and not feeling it.

Other Drug Use

A person who uses other drugs besides alcohol runs several additional risks. Decreased use of one drug may simply result in the increased use of another. The effects of different drugs can multiply when they are taken together, with dangerous results. A tolerance to one drug can increase tolerance to another, and it is common for multiple drug users to become addicted to several drugs. The use of other drugs, then, increases your risk for serious problems. Based on the lifetime drug use that you reported during your interview, your risk in this regard was judged to be low, medium, or high.

Family Risk

People who have a family history of alcohol or other drug problems among their blood relatives clearly are at higher risk themselves. The exact reason for this higher risk is unknown, but it appears that the risk is inherited to an important extent. People may inherit a higher tolerance for alcohol or a body that is particularly sensitive to alcohol

in certain ways. In any event, a family history of alcohol problems increases personal risk.

Personality Pattern

Although there is no single personality style associated with alcohol and drug problems, certain patterns are linked to higher risk. One questionnaire you completed—the MacAndrew Scale—measures this particular kind of risk. People who score higher on this scale as teenagers, for example, have been found to have higher risk for developing serious problems with alcohol in adulthood.

Age at Onset

Recent research indicates that the younger a person is when drinking problems start, the greater the person's risk for developing serious consequences and dependence. Although serious problems can occur at any time of life, a younger beginning does represent a significant risk factor.

4. Negative Consequences

From your pretreatment interview, two scores were calculated to reflect the current overall severity of your negative consequences from drinking.

AUDIT

The AUDIT is a scale devised by the World Health Organization to evaluate a person's problematic involvement with alcohol. Higher scores reflect recent problems related to drinking.

DRINC

Another way to look at risks and effects of drinking is to add up alcohol's negative effects throughout one's lifetime. Your score on this scale reflects the extent to which your drinking has had negative effects over the course of your life thus far. The higher your score, the more harm has resulted from your drinking.

5. Blood Tests

Your pretreatment evaluation also included a blood sample. These particular blood tests were chosen because they have been shown in previous research to be negatively affected by heavy drinking. You should realize that normal results on these tests do not guarantee that you are in good health (for example, that your liver is functioning completely normally). An abnormal score on one or more of these tests, however, probably reflects unhealthy changes in your body resulting from excessive use of alcohol and/or other drugs.

Research indicates that modestly abnormal scores on the blood tests reported here will often show improvement and a return to normal range when harmful drinking and other drug use patterns are changed. The longer one continues drinking, however, the more difficult it is to reverse the physical damage.

These tests are directly related to how the liver is working. Your liver is extremely important to your health. It is involved in producing energy, and it filters and neutralizes impurities and poisons in your bloodstream. Alcohol damages the liver, and after a long period of heavy drinking, parts of the liver begin to die. This is the process of cirrhosis, but physical changes in the liver can be caused by drinking long before cirrhosis appears. As the liver becomes damaged, it begins to leak enzymes into the blood and is less efficient in doing its work. This can be reflected in abnormally elevated values on the tests reported in this section.

Elevated values on any of these tests should be taken seriously. They do not happen by chance and are very likely related to physical changes in the body caused by excessive drinking. Consult a physician who is knowledgeable about the effects of alcohol on the body.

6. Neuro-psychological Tests

Some of the earliest damaging effects of drinking may be seen in certain types of abilities that are affected by alcohol. Certain patterns of brain impairment have been shown to be especially related to heavy drinking. The brain is very vulnerable to alcohol, and over a long span of time, a substantial amount of damage can occur in a heavy drinker. (Brain impairment from the use of certain other drugs has also been shown.)

Such damage occurs gradually. In later stages, it can be seen in x rays of the brain, which show actual shrinkage and other changes in shape and density. Long before this occurs, however, harmful changes in brain functioning can be measured by psychological tests, several of which you completed. Research indicates that such negative effects can often be reversed, sometimes completely, if the individual stops or reduces drinking.

The four tests included in section 6 have been found to be related to heavy drinking. For comparison purposes, we include one test (SV) that is not usually affected by drinking to give you an idea of where your scores might normally be expected to fall. People who are heavy drinkers tend to score more poorly (higher) on the four alcohol-sensitive tests (TMTA, TMTB, SYDM, and SHVA) than on SV.

A high score on any one scale is not necessarily reason for concern. There are many reasons why a single score might be elevated. A *pattern* of elevated scores, however, resembles the kinds of problems that emerge among excessive drinkers. Studies of individuals currently in treatment for alcohol problems consistently show impairment on these measures.

Alcohol's effects on the brain have sometimes been described as "premature aging." The abnormal changes in the brain of a heavy drinker

do resemble normal changes that occur with advanced age. For this reason, your scores reflected above take into account your present age. Scores of 4 or 5 represent below-average performance relative to others in your age group.

The Alcohol Use Inventory

You completed a longer questionnaire that asked in detail about your drinking. This questionnaire has been given to thousands of people seeking treatment for alcohol problems. Based on your answers, 24 scores were obtained, and these are shown on the Alcohol Use Inventory Profile section of your Personal Feedback Report .

Notice that each score falls into one of three ranges. The *white* range indicates a low score, the *light grey* range is for medium scores, and the *dark grey* range reflects high scores—*compared to other people in treatment for alcohol problems*. If, for example, your score for the “Quantity” scale (#13) was in the medium (light grey) range, it would mean that you drink about an average amount *for people already receiving treatment for alcohol problems*. This would be far above the average amount of drinking for Americans in general.

Here are brief reminders of what each scale means. If you want to discuss your results in more detail, contact your therapist.

Benefits

The first four scales reflect possible *reasons* for excessive drinking. A high score on one of these scales may indicate a way in which you have come to depend on alcohol. In order to be free of alcohol problems, it would be important to find other ways of dealing with these areas of your life.

Social Improvement Drinking

People who score in the medium or high range on this scale tend to be social drinkers. They may use alcohol to relax and feel more comfortable around others, to be friendly, or to enjoy social events more. They might have difficulty knowing how to handle their social lives without alcohol.

Mental Improvement Drinking

Those who score medium or high on this scale tend to like the way alcohol changes their *thinking* or *mental* state. They indicate that when they drink they feel more creative or alert, work better, or see the world in more enjoyable ways.

Managing Mood With Drinking

On this scale, medium or high scores indicate people who use alcohol to change how they feel. They drink to forget, to feel less anxious or depressed, or to escape from unpleasant moods. Without alcohol, they might experience difficulty coping with their own emotions.

Marital Coping by Drinking

(If you are not married, you will have no score here.) People who score in the medium or high range on this scale report that they drink because of problems in their marriage.

Styles of Drinking

The next three scales reflect different *styles* of using alcohol. Low scores on these scales describe a different style of drinking but do not mean that there are no problems.

Gregarious Drinking

A medium or high score indicates a preference for drinking around other people. Those who prefer to drink alone score low on this scale.

Compulsive Drinking

Medium and high scores on scale 6 indicate a close attachment to alcohol. Such people tend to think about alcohol a lot, keep a supply handy, and drink in a "compulsive," predictable style.

Sustained Drinking

People who score in the medium and high range on this scale tend to be regular, steady drinkers, drinking every day or most days. Those who score lower on this scale are not such steady drinkers but have periods of drinking and nondrinking.

Consequences

Scales 8–12 reflect possible negative consequences of drinking. Higher scores on these scales reflect more problems, *compared with people already in treatment for alcohol problems*. Thus, a person with a lower score may still have some problems but fewer than most people now in treatment for alcohol problems.

Loss of Control

One kind of difficulty that people can have is that they lose control of themselves when drinking. They get into trouble, arguments, or fights. They may do embarrassing things or hurt themselves or other people. They may not remember things that happened while drinking (black-

outs) or may drink until they become unconscious. Medium and high scores indicate these kinds of problems.

Role Problems

Drinking can also cause social difficulties, such as problems at work or school, and conflicts with the law. Medium and high scores indicate that alcohol is seriously interfering with social functioning.

Delirium

If people continue to drink heavily over a period of time, they may develop a pattern of physical *dependence* on alcohol. A number of changes occur, usually gradually, that make it more difficult for a person to live without alcohol. This can include actual addiction to alcohol, so that the person becomes uncomfortable or even ill when stopping or cutting down drinking. Medium to high scores on this scale reflect some of the more serious signs of addiction to alcohol. For example, stopping drinking can result in hallucinations (seeing, hearing, or feeling things that are not really there) or fuzzy thinking.

Hangover

Hangovers are actually a form of alcohol withdrawal, the body's "rebound" reaction to alcohol. Medium or high scores on scale 11 reflect some of these signs of addiction to alcohol: feeling shaky or sick to the stomach, feeling your heart racing, having a seizure, or feeling hot or cold flashes when sobering up.

Marital Problems

People who score in the medium or high range of scale 12 report that they are having problems in their marriage because of their drinking. (If you are not married, this scale will be blank.)

Personal Concern

How much do you recognize and acknowledge problems with drinking? This is what scales 13–17 describe.

Quantity of Drinking

Scale 13 is a rough indicator of the *amount* you said you have been drinking. (Section 1 of your Personal Feedback Report is a more accurate indication.) Remember that this is in comparison to other people seeking treatment for alcohol problems.

Guilt/Worry

To what extent have you felt guilty about your drinking or worried about what it is doing to you and those around you? Medium and high scores reflect more of this kind of concern.

Help Before

To what extent have you sought help for your drinking before coming to this program? The more things you have tried before, the higher this score will be.

Receptiveness

To what extent do you feel ready and willing to receive help for your drinking? Medium and high scores reflect greater willingness to accept help.

Awareness

To what extent are you aware of problems being caused by your drinking? Medium and high scores indicate recognition of more serious problems.

Second Order Scales

Scores A through F are summaries. They do not contain new information but rather combine information from scales 1–17. Nevertheless, they are useful as overall problem indicators.

Enhancement Drinking

Medium and high scores on this scale reflect drinking to cope, to enhance your life, or to get what you perceive to be the benefits of drinking. To the extent that this score is high, there would be some challenges to face in changing your drinking, because you have relied on alcohol for these purposes. Scales 1–5 show you where you may have relied most on alcohol to enhance your life.

Obsessive Drinking

Medium and high scores on this scale indicate what are often thought of as classic “alcoholic” drinking patterns. The drinking of high scorers on this scale tends to be steady and “driven,” occupying much of the person’s time and energy. High scorers think about drinking quite a bit and will go to considerable lengths to make sure they can drink. It has become a central part of their lives.

Disruption

Both of these two scales report the extent to which life has been disrupted by drinking. Medium and high scores indicate serious symptoms and problems resulting from drinking.

Anxious Concern

Medium and high scores on this scale indicate worry, anxiety, or concern about drinking, as well as alcohol's negative effects on the person's emotional life.

Recognition and Awareness

Medium and high scores here indicate a recognition of a need for change in drinking and/or willingness to get help with drinking.

General

Finally, the Alcohol Involvement Scale is one general indicator of the overall severity of alcohol problems. The higher this score, the more serious and severe the alcohol problems. Remember that scores are low, medium, or high in relation to people already in treatment for alcohol problems.

Summary

Your Personal Feedback Report summarizes a large amount of information that you provided during your pretreatment interviews. Sometimes this information can seem surprising or even discouraging. The best use of feedback like this is to consider it as you decide what, if anything, you will do about your drinking. Many of the kinds of problems covered in your Personal Feedback Report do improve when heavy drinking is stopped. What you do with this information is up to you. Your report is designed to give you a clear picture of where you are at present so that you can make good decisions about where you want to go from here.

Alcohol And You

William R. Miller, Ph.D.

Have you ever wondered:

*Whether you drink too much?
Whether alcohol is harming you or putting you at risk?
How heavy drinking affects your health?
How much is too much?*

Drinking

Drinking alcohol is certainly common in our society. About two-thirds of American adults have a drink at least occasionally, while the other one-third don't drink at all. Of those who do drink, the vast majority use alcohol very moderately, and will never have serious problems with it. For them, alcohol beverages are simply that: *beverages* to be enjoyed now and then as part of a meal or a social occasion.

Yet it is important to remember that alcohol is also a *drug*, and a potentially dangerous one. People who use it beyond moderate levels have a much greater risk for a wide variety of illnesses and problems. Overdrinking results in up to 200,000 deaths each year in the United States alone — about 550 every day — and many more people than that are ill or injured because of their drinking.

Drinking is such a serious health problem in our country, in part, because many people who drink too much don't think of themselves as problem drinkers, or even heavy drinkers. They see themselves as normal, moderate drinkers. Although they may realize that their drinking has negative consequences now and then, they also enjoy drinking, and aren't sure they need to make a change. Heavy drinking can seem quite normal if one has friends who drink just as much, or even more.

This booklet explains some of the risks associated with heavy drinking, based on current scientific knowledge. Of course no one person will experience all, or even most of the risks and problems discussed here. Some are relatively rare, while others happen to many people who drink too much.

The point is that it is important to *know* about alcohol, just as a doctor or pharmacist informs you about the effects of drugs that are prescribed. When you know the facts, you can make better choices. What you decide to do with this information, of course, is up to you.

Heavy Drinking

How much is too much? It is difficult to say exactly. Studies suggest that people who have no more than 1 or 2 drinks per day have no higher risk in general than non-drinkers. ("One drink" here means a 10-ounce glass of beer, or a 4-ounce glass of wine, or one ounce of 100 proof spirits.) Only 8% of American adults (and only 4% of women) average 3 drinks or more per day, and those who do so suffer many more diseases, injuries, and problems than do light drinkers or nondrinkers.

Surprisingly few Americans are aware of the risks of heavier drinking. Most know that drunk driving is dangerous, and that alcoholics may get liver disease. Yet

few really understand how many areas of life and health can be harmed by alcohol, and how quickly and easily this can happen. Over time, heavy drinking can damage one's relationships, job, intelligence, and emotional and physical health. Often the damage is gradual, occurring slowly over a period of years, so that one may not even notice that it is happening. Other kinds of alcohol-related damage and problems happen suddenly.

What kinds of problems can happen because of overdrinking? Health risks will be considered first; then social and psychological risks will be discussed.

Health Risks

Heart and Fitness

Is alcohol good for the heart? Although light drinkers (no more than 1-2 drinks per day) seem to be at least as healthy as abstainers, heavier drinkers can do serious damage to their health and fitness. Alcohol weakens heart muscle, decreasing cardiovascular fitness, and heavy drinkers have much higher risk of heart disease. Heavy drinking also increases blood pressure, and can contribute to hypertension. The electrical control patterns of the heart can be disrupted by an episode of heavy drinking, which can cause the heart to race or skip beats, even in young people with no previous history of heart disease.

The Brain and Nervous System

The human brain is sometimes the first organ to be damaged by heavy drinking. Alcohol kills nerve cells, and many heavy drinkers show evidence of brain damage. If this process continues for a period of years, the brain literally shrinks in size, due to the destruction of so many brain cells. Such shrinkage can be observed (by special X-rays known as a "CAT scan") in about half of people in treatment for alcohol problems.

It is not surprising, then, that heavy drinkers also show significant decreases in their mental abilities. Alcohol damages the ability to learn and remember new material, to think abstractly, and to adjust flexibly to changes. One recent study found a strong relationship between amount of drinking and grades in college students: the more they drank, the lower their grade point average. After years of heavy drinking, a disease known as Wernicke-Korsakoff syndrome can occur, permanently damaging the person's ability to remember things from one day to the next. The damaging effects of alcohol have been likened to a premature aging of the brain. The mental abilities of a 30-year-old heavy drinker may resemble those of an 80-year-old nondrinker.

Nerve cells outside the brain are also damaged by heavy drinking. Usually the first effects are experienced in the legs and feet, or arms and hands. The signs include muscle weakness, pain, tingling, or numbness. These result from "peripheral neuropathy," the dying off of nerve channels that serve the legs and arms.

The good news is that the nervous system, including the brain, can repair itself to some extent if a heavy drinker stops drinking. Although once dead, brain cells are not replaced, the brain has a remarkable ability to make new connections, and former drinkers often show significant improvement in their mental abilities during their first year or so without alcohol.

The Digestive System

Alcohol can irritate and damage the sensitive tissue of the digestive system. Perhaps the most direct experience of this is to take a drink of straight liquor. It burns — all the way down. It irritates the lining of the lips, mouth, throat and stomach. Alcohol also releases digestive acid in the stomach, which adds to the irritating effect of the alcohol itself. Heavy drinkers experience higher rates of gastritis, ulcers, and bleeding of the digestive system. Pancreatitis, an extremely painful and sometimes fatal inflammation of the pancreas, also occurs at higher rates in heavy drinkers.

Cancers of the digestive system are much more common in heavy drinkers — some occurring at more than 40 times the normal rate. Heavy drinkers account for a majority of head and neck cancers: those in the mouth, tongue, throat, and esophagus.

Because alcohol contains a high level of empty calories — those with no nutritional value — heavy drinkers also tend not to eat properly. They may drink up to half of their daily calories. This can result in both weight gain and nutritional deficits. To make matters worse, alcohol prevents the body from fully absorbing and using even those vitamins and other nutrients that are available.

The Liver

The liver is the body's main defense against poisons and impurities in the blood. It is also important in manufacturing energy for the whole body, including the brain, muscles, and heart. Because alcohol is a toxic chemical, it is the liver's job to remove it from the bloodstream. When alcohol is present, the liver gives priority to getting rid of it, and in the process does not perform some of its normal work, such as getting rid of fats and body waste products.

As a result, heavy drinkers tend to pile up fat in the liver and bloodstream. The liver itself becomes fatty and enlarges, contributing to the "beer belly" appearance.

This condition is reversible, but if the heavy drinking continues a different kind of damage occurs. Liver cells begin to die off, and are replaced by scar tissue. The beginnings of this irreversible process can be seen long before it reaches the disease stage known as cirrhosis. As living liver tissue is replaced by scars, the liver is less and less able to produce energy and filter impurities (including alcohol) from the bloodstream.

The Immune System

Alcohol decreases the body's ability to fight off diseases and infections. The immune system — the body's defense — works less efficiently whenever a person drinks, and over a period of heavy drinking the body's defenses can be greatly weakened. As a result, the person becomes more vulnerable to infections, cancers, and other illnesses. The risk of cancers in general among heavy drinkers is twice that of other people. Sores and injuries tend to heal more slowly, and it becomes harder to shake off sickness.

The Reproductive System

Alcohol has clear negative effects on the reproductive system. In men, drinking decreases the body level of testosterone, the primary male hormone. If a man drinks heavily for a period of time, this loss of testosterone can result in a "feminization" of his body — the loss of body hair, enlargement of fatty tissue in the breasts, and a shrinking of the testicles. Heavy drinking can also contribute to sexual problems such as impotence.

In women, heavy drinking has been linked to increased rates of sexual, menstrual and other gynecological problems. Alcohol also changes sex hormone balances in women, and can promote a loss of feminine body characteristics. Heavy drinking during pregnancy has been clearly linked to increased rates of miscarriage and stillbirth, and to birth defects, behavior problems, and mental retardation of children exposed to alcohol in the womb. Alcohol consumed by a pregnant woman directly affects the fetus, and there is no known safe level of drinking during pregnancy.

Summary

In short, once alcohol is consumed, it is rapidly distributed throughout the body, where it affects virtually every organ system. There are no proven beneficial health effects of drinking, but there are many proven harmful effects of heavy drinking. Many of these damaging effects can be reversed, at least partly, when a heavy drinker stops drinking. In general, the longer the period of heavy drinking, the less reversible the damage, but quitting usually results in improved health and fitness, even after many years of excess.

Social and Psychological Problems

The damaging physical effects of heavy drinking are only part of the picture. Heavy drinkers are also at risk for many other kinds of problems.

Risk-Taking and Accidents

Alcohol-related accidents and violence are the leading cause of death among Americans under the age of 35. How can this be?

There are several reasons. First, as many people know, drinking makes a person less in control. Alcohol, even at levels well under the "legal limit" can cause dangerous changes in a person's ability to react, to control muscles, and to perceive the world accurately.

These changes are made all the more dangerous by something else that happens when a person drinks. Among the first things to be changed by alcohol is a person's *judgment*. Experienced race drivers, for example, become much poorer drivers after even a few drinks, but may actually perceive themselves to be *better* drivers under the influence of alcohol. In short, a person cannot tell how much he or she is being affected. You can't judge when your judgment is affected!

These judgment changes, in turn, often make a person overconfident, and more likely to take foolish risks. After a few drinks, people are less able to make good decisions, and are more likely to do things they would never do while sober. Sometimes the result is only embarrassment, but other times it is much more serious. A majority of people in prison, for example, committed their crimes while under the influence of alcohol. When drinking, people are more likely to misjudge others as threatening or challenging them, and to react impulsively, aggressively, even violently. Other misjudgments can be disastrous as well. Tens of thousands of deaths and hundreds of thousands of injuries happen each year because people drink before driving vehicles, using power tools or firearms, or engaging in fun but hazardous sports such as swimming, boating, or skiing — activities where even a small misjudgment can be very dangerous.

Mood

Drinking also affects mood. After one or two drinks, some people feel happier, more relaxed, less tense and anxious. Interestingly, these same changes happen when people *believe* they are drinking alcohol, even if they are not. Alcohol itself is a *depressant* drug, and its effects, in heavier doses at least, are to turn good feelings bad, and to make bad feelings worse. After several drinks, mood tends to take a turn for the worse. It is around this same point, however, that alcohol also affects memory, so people tend not to remember the

depressing effects of drinking — only the seemingly positive effects of the first drink or two.

Among heavy drinkers, depression is common. There are many possible reasons for this. Yet when heavy drinkers get treatment and quit, usually their depression goes away after a few weeks. Alcohol is not a stimulant or an upper. It is a downer.

Relationships

Heavy drinking can damage close relationships. "You always hurt the one you love" seems to be especially true for people who drink too much. Heavy drinkers have, on average, more problems in their marriages and other relationships, and higher rates of separation and divorce. One's ability to be a good parent can also be harmed by overdrinking, resulting in family problems. Child abuse and neglect are more common among heavy drinking parents.

Problems and Coping

One reason why heavy drinkers' relationships may get into trouble is that the person begins to drink alcohol as a *solution* to problems, as a way of trying to cope. Drinking takes the place of talking and working out difficulties in other ways. It can be a tempting trap. Alcohol dulls memory, and makes the problems seem to go away — at least for the time being.

Yet while people are drinking to ease cares and worries, the troubles aren't really going away. In fact, they often get worse, because the drinker makes little or no attempt to find better ways to handle things. It's just easier to let things go, to take a break, to forget. So things begin to fall apart — sometimes a little at a time, sometimes in bigger shocks — and it happens in different ways for different people:

- Friends pull back or drift away
- Problems start showing up on the job or at school: coming in late, missing days, not working up to your abilities, making more mistakes, missing opportunities, having accidents, putting off responsibilities
- Tension builds up in the family: more complaints, problems, and arguments, less fun and closeness
- Health and fitness begin to be affected
- Money problems increase: too much is spent on alcohol, and on paying for problems or poor decisions related to drinking

Because alcohol can make it hard to see what is really happening, heavy drinkers often feel misunderstood, unfairly treated, harassed, or just unlucky. And as things get worse, the temptation is — to drink.

Personal Risk

Many people drink alcohol moderately without ever experiencing significant problems. Why is it that some people have trouble with alcohol while others do not?

Part of the answer, of course, lies in *how much* a person drinks. The more one drinks, the greater the risk of suffering the negative health, psychological and social consequences. Yet that is not the whole picture. Certain people have a greater risk than others. Here are a few factors that have been shown to increase a person's danger for overdrinking and running into significant problems with alcohol:

- Having a family history of relatives with alcohol or other drug problems
- Drinking to get drunk
- Being able to "hold your liquor" — seeming to be less affected by alcohol than most people
- Having one or more memory "blackouts" due to drinking
- Drinking to relieve bad feelings or to escape from problems
- Having friends who are heavy drinkers
- Thinking of alcohol as a positive life influence, which helps people be more friendly, happy, relaxed, successful, etc.
- Using other drugs which, when combined with alcohol, increase the effects and dangers of drinking

People with these characteristics seem to have higher risk for the kinds of problems described earlier. A person doesn't *have* to have any of these in order to be harmed by alcohol, of course. It's just that these are risk factors, which increase one's chances for harm from overdrinking.

Alcohol and You

Probably most of the things mentioned earlier have not happened to you. Even heavier drinkers can sometimes go for many years without piling up too many of these problems. Yet maybe you do see yourself in some of these descriptions, or perhaps you see what might happen to you if your drinking continues as it is.

Is it time for you to make a change? That is your choice. In fact, no one else can decide about your drinking, or change your drinking for you, not even if they want to. To be sure, other people may be able to help quite a bit if you let them, but still in the end it's your decision.

If you want to change your drinking, there are many ways to do it. Some people just decide, and go ahead. Others find that it's easier with some help from friends, professionals, or other people who have been through it. There's no one approach that is best for all. The truth is that there are many different ways, and you keep trying until you find what works for you. If one approach isn't working, try something else. There are books, self-help groups, skilled counselors and psychologists and physicians, spiritual approaches, medications, clinics, and hospitals. There's no one magic answer for everybody, but there are many helpful people and approaches to try.

And in the long run, the chances for change are very good. If you do try to change your drinking and you're like most people, you may not succeed the very first time. It is common to have some setbacks, and it can be tough to make an important change in your life. One try may not do it. Or two, or five. Yet each try brings you closer to getting free, to succeeding in change. Studies show that most people who have problems with alcohol do get better in the long run. For those who decide to do something about their drinking, there is hope.

Appendix B: Motivational Enhancement Therapy in the Aftercare Setting

The manual to this point has focused on the application of the MET model to individuals presenting for treatment at an outpatient facility. The same principles and techniques can be applied effectively in the aftercare clinic. In the aftercare situation, the client has already completed a comprehensive abstinence-oriented inpatient treatment program, and the general focus of treatment will differ. Aftercare clients are more likely to be further along in the change cycle than clients first presenting for treatment. Many of these individuals will have thus far successfully negotiated the precontemplation, contemplation, and determination stages. They will have begun to take action at least in the hospital setting and possibly on several home visits. The real task for these clients is to return to their home environment and successfully sustain their abstinence from alcohol. They will need to transfer learning to be aware of possible pitfalls and remain committed to abstinence in the face of new and challenging situations. Although they can be assumed to be motivated to change if they have spent 14 to 28 days in the hospital, often the hospitalized client is unprepared for the posthospital environment and the challenge to their motivation that going home will provide.

While the basic principles and techniques of MET remain the same, the overall focus of treatment will be somewhat different. This section briefly outlines variations in the MET sessions when applied to aftercare clients.

Scheduling

Prior to discharge and before the first session, the Project MATCH client will have completed the initial screening, informed consent procedures, and the comprehensive assessment battery. Following completion of the assessment battery and before the client's discharge, project therapists contact the client to introduce themselves and schedule the first aftercare session. Regardless of the details of the particular research protocol being followed, it is desirable to schedule the first session as close as possible to the client's date of discharge.

As noted previously (see “Initial Session”), the therapist stresses the importance of having the spouse or significant other along to the first two sessions and also explains the importance of coming to appointments sober. In the aftercare setting, attempt to have the first appointment immediately prior to discharge so therapist and client will connect before leaving the hospital. This schedule may make spouse attendance problematic without adequate planning.

Structuring (see “The Structure of MET Sessions”) the therapy sessions is particularly important for aftercare clients. These clients already have completed lengthy inpatient treatment and have well-developed expectations for what therapy sessions should be like. In most cases, these therapy expectations will differ considerably from the nondirective style of MET. Here is an example of what you might say to an aftercare client at the beginning of the first session:

Before we begin, I'd like to talk a little bit about how we will be working together over the next 3 months. You've already successfully completed the treatment program here, and these aftercare sessions are aimed at helping you maintain the changes that you've begun during your stay in the hospital. Also, we'll be trying to help you deal with new problems that might come up in these first few months following your discharge.

My approach may be different from what you were used to during your stay in the hospital. For one thing, I'm not going to be *telling* you what you should or shouldn't do. I can help you to think about your present situation or new problems and consider what, if anything, you might want to do, but if there are any decisions to be made or any changing to be done, *you* will be the one doing it. When it comes right down to it, nobody can tell you what to do and certainly nobody can make you change. I'll be giving you a lot of information about yourself, and maybe some advice, but what you do with all of it is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether or how to change is *you*. How does that sound? (Explore client's and significant other's reactions as previously discussed.)

Now, you spent a lot of time completing tests and questionnaires for us just before you were discharged. I appreciate the time you spent on those. Today we are going to make good use of the information you gave to us. We'll be going over the results of some of those tests in detail. As you may know, this is the first of four sessions that we will be having. During these sessions, we will take a close look at your situation and help you adjust now that you're out of the hospital. I think you'll find these sessions interesting and helpful.

Reviewing Progress

Since the client has already completed a treatment program and presumably made some commitment for change, it is important to monitor the client's progress in meeting his/her goals. The client's judgment of progress can be assessed with an open-ended question such as, "Well, before we go any further, tell me how things have been going since you came to the hospital?" When asking this question, the therapist may want to look at both the client and the client's SO and allow either one to respond. Allow the client or SO to volunteer information. If the client answers only briefly (e.g., "Oh, fine"), ask for elaboration (e.g., "When you say fine, what do you mean?"). The therapist should use empathic reflection, affirmation, or reframing as discussed previously in responding to the client or SO. If the response of the client or SO does not touch on drinking or urges to drink, it is appropriate to ask direct questions or make statements to elicit this information. As with anything in the MET approach, however, these questions/statements should be asked in a nonjudgmental manner. For example, the statement, "You haven't mentioned anything about your plans for discharge, return to work..." will often prompt a reason.

During the second through the fourth sessions, in response to either reports of drinking or reports of abstinence in the time since discharge, the therapist should attempt to explore the clients' own attributions regarding their behavior. For example, in response to a report of no drinking, the therapist might say, "Well, Joe, it sounds as though you've been doing extremely well. I was wondering what you see yourself doing differently now that's helped you to remain sober?" To the client's response, the therapist should use empathic reflection, affirmation, and reframing as a means of exploring and reinforcing changes the client has made. As noted previously, the goal here is to enhance the attitude of self-responsibility, reinforce effort, and support the client's self-esteem.

In response to a report of drinking since discharge, it is important for the therapist to remain nonjudgmental. At the same time, however, the therapist should explore more carefully the circumstances surrounding the slip or relapse and the client's feelings about it. For example, "Can you tell me more about what was happening at the time you decided to take a drink? How were you feeling?" or "What led up to you deciding to take a drink?" Again, the therapist should use empathic reflection and reframing in discussing the relapse episode. Overall, the therapist should encourage the client to discuss the circumstances leading up to the relapse, the relapse, and how the client felt afterward. The therapist should also explore what the client should do differently in the future to reduce the risk of relapse. For example, "Joe, given this experience you had, what do you think you would do differently in the future to prevent this from happening?" As is basic to the self-motivational approach, the goal here is to allow the client to generate and decide on self-change strategies.

The exploration of relapse situations may lead into several relevant areas of further discussion and exploration. For example, for individuals experiencing considerable guilt over a relapse, the therapist can offer supportive statements and information. "It is not unusual for people to have a slip when they first get out of the hospital. What is important is that they try to evaluate what happened and what changes they need to make to reduce the risk of it happening again. You deserve a lot of credit for catching that slip before it got too far out of hand." Discussion of a relapse episode may also unveil a client's uncertainty over abstinence as their intended goal. In such instances, the therapist should emphasize that while we advise and encourage abstinence as a goal, it is ultimately up to the client to decide (see "Emphasizing Abstinence"). A related issue may be slips in which the client consumes light or moderate levels of alcoholic beverage. In these cases, it is important to reinforce the client's restraint but also, where appropriate, advise the client of the potential risk of even moderate consumption levels. Finally, exploration of relapse situations may reveal considerable resistance (see "Handling Resistance"). It is very important that the therapist not be seen as a judge so the client would be willing to return to talk about the frustrating and embarrassing experience of slipping or relapsing.

Generating Self- Motivational Statements

The discussion of relapses (or abstinence) during the time since discharge provides a gateway into discussing the client's motivation for wanting to change (see "Eliciting Self-Motivational Statements"). For abstinent clients or clients functioning well with respect to drinking, the therapist can elicit the perceived differences they have noted in their life now compared to when they were drinking. This discussion can lead to the client's reviewing reasons for wanting to change. Clients who are doing well sometimes become overconfident, and a review of negative events which occurred before they quit drinking and positive events occurring since quitting can make their initial motivations for change more salient. In most cases, eliciting self-motivational statements from aftercare clients may be easier than eliciting statements from individuals first presenting for treatment.

For individuals who have relapsed, the generation of self-motivational statements is particularly important. In fact, some of these individuals may have reverted to (or never left) the precontemplation or contemplation stage in the cycle of change. Self-motivational statements to bring the client back to the determination and action stages should be elicited (see "Eliciting Self-Motivational Statements").

Providing Personal Feedback

Once the therapist has reviewed the client's progress and elicited self-motivational statements, attention should be turned to giving feedback from the client's predischarge assessment (see "Presenting Personal Feedback"). The personal feedback form and the assessment

battery used in Project MATCH is provided in appendix A, with suggestions on how it may be modified to fit the needs of other research protocols. Rather than being abrupt, the therapist should try to make a smooth transition and may want to incorporate feedback with the elicitation of self-motivational statements. For example, in responding to a client's reasons for wanting to quit, the therapist may say, "That's very consistent with what you were telling us on the tests and questionnaires that you completed. Maybe this would be a good time for us to discuss the results of those now." Another transition statement might be, "I think it is important to discuss changes which you think you need to make to prevent a relapse from happening again. In doing that, it might be helpful for us to review the results of the tests and questionnaires you completed just before discharge. This might give you some perspective on where you're at now and maybe what you want to work on."

Feedback for aftercare clients will be similar to that described in previous sections of the manual. Reviewing the level of addiction, quantity/frequency of drinking, patterns of use, and consequences of drinking can be quite helpful in motivating continued commitment to change. Some clients may only now, after several weeks of sobriety, be capable of understanding their destructive pattern of drinking. This information can also be important for helping them develop a solid postdischarge plan. Feedback on family history of drinking and neuropsychological assessments can provide additional information for discussion with client and significant other.

The focus of the feedback with the aftercare client is not so much the need for change as it is the need for continued effort. It would be important to tie in the work and progress the client has made during the hospital stay. In fact, reviewing hospital progress can be a valuable additional topic during the first session of treatment. However, be careful not to get into a discussion that is simply a critique of the hospital or some staff. Encourage them to bring up complaints to the hospital staff if necessary. Keep the focus on the discharge and where do we go from here.

Developing a Plan

With few exceptions, most of the aftercare clients will have already made some commitment for change and have a plan for change. Reviewing this plan in concert with their progress since discharge is important. Once the personal feedback has been provided, the therapist should summarize the main points (see "Summarizing") for the client and elicit the client's perceptions of the information provided (if this has not been done already). For example,

Just to summarize what we've been talking about, Joe, you indicated that one of your main reasons for seeking treatment was your concern about your health. Certainly, this appeared to

be a wise decision since, as we saw, your liver tests were elevated way above normal when you entered the hospital. Your drinking was negatively affecting your liver and could have led to permanent damage. This is common for individuals with moderate to severe alcohol problems and, as we saw, you seem to fit in this group. We also saw that with abstinence during your time in the hospital your liver tests basically returned to normal. This is very encouraging and indicates that if you remain off alcohol, your health will continue to improve or, at least, not deteriorate further. You also indicated in the tests that one of your most difficult situations with respect to drinking is when you find yourself at home with nothing to do and feeling lonely. This appears to be the problem you ran into last weekend in which you said you had a strong urge to have a drink. You also express some difficulty turning down drinks when you're around some of your old buddies. Based on your discussion here, it certainly sounds like you are committed to staying off alcohol. In fact, since discharge you have been doing extremely well. At this point then, it may be helpful for us to talk about what you feel you need to do or need to continue doing in order to maintain the important change you've already made.

Although it is not necessary to complete the plan for change by the end of the first session, some plan elements should be completed in order to give closure to the first session.

In the second and subsequent sessions, the therapist should complete the plan for change, if it has not been done already. The majority of these sessions will be spent reviewing progress as discussed above, reinforcing the client's change and modifying the plan for change as needed.

The first two sessions of MET are scheduled to occur within a week of each other. Feedback and spouse involvement are scheduled during these sessions. If significant others cannot come in during these sessions, they can be invited to later sessions.

The final two sessions are times when clients can check in and reflect on their progress and problems. If they have lost momentum or have encountered serious problems, this is the time to reflect, empathize, summarize, and offer advice. Followthrough on the plans and modifying plans would be a major focus of these sessions. In Project MATCH, as with the other therapies, ME therapists have available up to two emergency sessions to use if there are crises for the client. These would be used similarly to those in the outpatient condition.

Integrating MET Aftercare With Inpatient Programing

Experiences with Motivational Enhancement Therapy in the aftercare setting have been quite positive. Many patients view the support for *taking personal responsibility* for their aftercare plan to be quite helpful. Although this message may be somewhat at variance with the information given during the inpatient stay, clarification of the MET philosophy and perspective can be an important first step to engaging the patient. The focus on discharge and life after hospitalization is critical for the aftercare patient. Focus not only on the plans for sobriety, which may have been heavily influenced by inpatient staff and other patients, but also on plans for establishing routines and goals postdischarge. Several key issues can arise in this context.

The Prepackaged Plan

Most aftercare patients will have a postdischarge plan that is developed during the hospital program. At times, these plans are rather standardized, depending on the type of inpatient program, and can include AA, group therapy, or disulfiram. They often include messages about employment, relationships, leisure, exercise, and a variety of other activities or life situations. *Exploring this plan* is a critical first step in assisting clients in developing their own unique plan to which they can commit. It is important to explore which elements the clients really believe will work and will fit with their unique situation. *Be careful to have clients be as specific as possible in discussing the plan.* Elicit the details of the plan and how it will work.

In some cases, the discharge plan may not be well formulated or may change as the client leaves the hospital. It is important to check with the *client about how the plans are developing*. From one week to the next, the client's plan can undergo substantial revisions. This would be particularly true during the time between the final two MET sessions.

Should the prepackaged discharge plan serve as the action plan of Motivational Enhancement Therapy? In each case, the MET therapist works with the client to answer this question. In the aftercare condition, the therapists help the clients evaluate prehospital problems, the feedback, and the hospital discharge plan to develop a unique action plan. This plan can include all or part of the prepackaged plan if the motivation elicited during the first sessions focuses on these elements. However, as clients consider their particular situation and address personal issues and situations, the MET action plan can be quite different from the prepackaged plan.

Disulfiram

Some clients will be discharged from the hospital on disulfiram, which must be taken regularly. There are several important considerations about disulfiram and ME therapy. Disulfiram can be a very helpful aid in promoting sobriety in clients who are impulsive and may need some built-in delays and deterrents to drinking. However, clients can see disulfiram as the sole cause of their sobriety. This can undermine

self-motivation and self-efficacy. If clients are planning to use disulfiram as part of their postdischarge plans, it is *important to explore how the disulfiram will help and what role it will play in sobriety*. It is also helpful to elicit self-motivational statements that make clients the agents in the use of disulfiram. It is their decision to take disulfiram and their evaluation of the need for disulfiram that will help them to follow through with the prescription that makes disulfiram work. Ownership of the disulfiram plan and daily commitment to the prescription can certainly be a valuable part of the MET action plan and promote successful sobriety. Do not be afraid to include disulfiram in the plan, but only include it if the client endorses it and has a personal commitment to it. Often, disulfiram is the decision of the doctor and not the client. In this case, it is important not to undermine or sabotage the inpatient prescription but not to endorse or push it if the client does not demonstrate any commitment to the disulfiram. Focus your attention on other behaviors and ideas that can engage the client's interest and commitment.

Alcoholics Anonymous

It will be difficult, if not impossible, for any client to complete an inpatient stay without having a prescription to attend AA or to participate in the 12-Step recovery process. AA involvement is often a major element in the discharge plan prepared in the hospital and part of the hospital regimen. Thus, in the aftercare condition, it would be impossible to simply ignore AA involvement. However, because of the overlap with other treatment conditions, you need to be careful not to become an independent promoter of AA involvement. In the MET condition, it seems best to handle AA involvement the same as other aspects of the client's plan. Therapists do not originate or promote any one measure or method of achieving sobriety. Therapists do help clients to explore and evaluate both problems and solutions as indicated by the client or the feedback information.

Specifically, this approach would mean that AA involvement is examined if it is proposed by the client or has been a part of the client's experience. In this examination, the therapist explores the specifics, uses reflective listening, elicits motivational statements, and summarizes the client's plans and commitment with regard to AA involvement and 12-Step work. Some clients may simply be reflecting a party line, others may be convinced of the value of meetings, and still others may be committed to working with a sponsor and completing each of the 12 Steps of recovery. Understanding the client's level of understanding and commitment is the first step. If any level of AA involvement is included as an integral part of the action plan postdischarge, it needs to be monitored and examined as the therapist would do with any other method or measure decided by the client.

Motivational Enhancement Therapy attempts to identify motivations and maximize the client's commitment to a personal, individual plan of action. For clients who identify AA as a viable part of their plan, the

task of MET is to enhance the personal motivation and commitment to follow through with that part of the plan. From this perspective, there is no conflict between AA involvement and MET. In fact, they can be quite compatible, particularly in the aftercare condition where the social support and philosophy of AA, if freely chosen by the client, can provide substantial assistance in achieving the goal of sobriety.

Feedback

Even after an inpatient stay, clients appear genuinely interested in the results and can gain information, insight, and motivation from the specific feedback given to them about their condition. Several cautions need to be heeded in giving feedback in the aftercare condition that may differ from the outpatient condition.

At times, the feedback on liver functioning and neuropsychological functioning will appear to be nonproblematic. This can be interpreted by a client as a sign that there are no problems or no damage. It is important to remember that the tests given provide only gross indicators and are not designed to assess subtle signs of damage or dysfunction. In other words, these tests do not give the client a clean bill of health and, if negative, need to be contrasted with the significance of the problem that needed hospital treatment. Having few indicators of damage can also be reframed to convey the message that the client is fortunate to not yet be showing gross symptoms. This message can be used to increase motivation for sobriety, since sobriety can ensure protection from any further alcohol-related damage.

Clients may be quite interested in having additional information and explanation of their physical condition. Since they are coming from a hospital setting, they may address the therapist as one who is well versed in medical conditions and problems. It is important for therapists to clarify specific issues, to acknowledge when they do not know an answer, and to obtain an answer for the next session or refer clients to the physician in charge of their case in the hospital. Issues of credibility and accuracy of information are important considerations in the feedback process.

Ambivalence and Attribution

ME therapists in aftercare settings should not be surprised to find ambivalence about drinking, and particularly about abstinence, among their clients. Many individuals who enter hospital treatment are motivated by external pressures or by current problems or concerns at the time of the hospitalization. The hospital stay can be a time of respite and even one of eroding motivation as the pressures or concerns recede. Therefore, it is critical not to assume motivation for sobriety postdischarge. Often, clients are motivated not to go back to the hospital, never to get to that prehospital state again, and not to have as many problems that drove them to drink. If you listen care-

fully, you will hear that these are not motivations about drinking but about the problems drinking caused.

In exploring the drinking problem, it is often helpful to get a clear understanding of what led to the prehospital pattern of drinking and the reason for hospitalization. It would be important to continue to connect psychosocial problems with drinking whenever this can clearly be done. Understanding how the postdischarge plan will address both drinking and other lifestyle, relationship, and employment issues can be a fruitful avenue of discussion. Listen carefully for what abstinence from drinking will mean for this client and what it will entail. Many of these clients have been living in alcohol-saturated environments. In fact, this may be part of the reason for hospitalization. Discharge from the protected setting of the hospital will severely test plans and ideas about abstinence. Even a firmly motivated stance during the first session in the hospital can be shaken to the foundations at the second session after the client is discharged. The first few weeks can be quite volatile with respect to motivations about sobriety and plans for using certain coping measures to ensure sobriety. Aftercare ME therapists need to be aware of these issues, probe for the ambivalence, and listen carefully to the client. Using reflective listening, supportive and empathic statements, and accurate, sensitive feedback will be particularly needed to handle the ambivalence of the aftercare client.

The hospital setting provides a safe environment for helping clients initiate an alcohol-free existence. The restricted setting, however, can have a deleterious effect on client attributions of success. Since access to alcohol cues is quite limited during detox and hospital stays, clients have to attribute some of their successful abstinence to external control. Part of the task of the aftercare ME therapist is to assist the client in reattributing the success to internal causes. After all, the client chooses to enter and stay in the hospital and must choose the level of participation in the program as well as the level of commitment to sobriety. Thus, although it is true that the restricted setting is helpful, attribution to personal goals, effort, and achievement is important to increase self-efficacy. Since MET puts the responsibility for sobriety squarely on the client, it would be helpful to explore and assist in the attribution of success to the client rather than the hospital. This is an ongoing process that becomes more salient as the client is discharged and during the later sessions of MET.

Motivational Enhancement Therapy can be an effective aftercare treatment for clients discharged from various types of inpatient treatment. This aftercare approach can enhance the work accomplished by the clients during their inpatient program and can assist them in developing a solid plan for achieving and maintaining sobriety.

Appendix C: Therapist Selection, Training, and Supervision in Project MATCH

by Kathleen Carroll, Ph.D.

Specifications of treatment in manuals is intended to define and differentiate psychotherapies, to standardize therapist technique, and to permit replication by other investigators. However, it is essential that manual-guided therapies be implemented by qualified therapists who are trained to perform them effectively. Project MATCH uses extensive procedures to select, train, and monitor therapists in order to promote delivery of study treatments that are specific, discriminable, and delivered at a consistently high level of quality. These include (1) selection of experienced therapists committed to the type of therapy they would be performing, (2) extensive training to help therapists modify their repertoire to meet manual guidelines and to standardize performance across therapists and across sites, and (3) ongoing monitoring and supervision of each therapist's delivery of treatment during the main phase of the study to assure implementation of study treatments at a high and consistent level.

Therapist Selection

All MATCH therapist candidates are required to meet the following selection criteria: (1) completion of a master's degree or above in counseling, psychology, social work, or a closely related field (some exceptions to this requirement were made in individual cases), (2) at least 2 years of clinical experience after completion of degree or certification, (3) appropriate therapist technique, based on a video-taped example of a therapy session with an actual client submitted to the principal investigator at each site and to the Yale Coordinating Center, and (4) experience in conducting a type of treatment consistent with the MATCH treatment they would be conducting and experience treating alcoholics or a closely related clinical population.

These criteria are intended to facilitate (1) selection of appropriate therapists for the training program, as training is *not* intended to train novice therapists, but to familiarize experienced therapists with man-

ual-guided therapy, and (2) implementation of MATCH treatments by experienced and credible therapists. For example, therapists selected for the Cognitive-Behavioral Coping Skills Therapy (CB) are experienced in cognitive and behavioral techniques; thus, the CB therapists are predominantly doctoral or masters-level psychologists. Therapists for the Twelve-Step Facilitation Program are predominantly individuals who have gone through 12-step recovery themselves, have been abstinent for several years, and are typically masters-level or certified alcoholism counselors. Therapists selected for the recently developed Motivation Enhancement Therapy (MET) have worked extensively with alcoholics and typically have experience in systems theory, family therapy, and motivational counseling.

Therapist Training

Training, supervision, and certification of therapists was centralized at the Yale Coordinating Center to facilitate consistency of treatment delivery across sites. Each therapist came to New Haven for a 3-day intensive training seminar, which included background and rationale for Project MATCH, extensive review of the treatment manual, review of taped examples of MATCH sessions, and practice exercises. Each therapist then returned to their clinical site and was assigned a minimum of two training cases, which were conducted following the MATCH protocol (e.g., weekly individual sessions, a maximum of two emergency and two conjoint sessions, truncated sessions for patients who arrived for a treatment session intoxicated).

All sessions from training cases were videotaped and sent to the Coordinating Center for review of the therapists' (1) adherence to manual guidelines, (2) level of skillfulness in treatment delivery, (3) appropriate structure and focus, (4) empathy and facilitation of the therapeutic alliance, and (5) nonverbal behavior. Yale Coordinating Center supervisors review all training sessions and provide weekly individual supervision to each therapist via telephone. Supplemental onsite supervision is delivered weekly by the project coordinator at each Clinical Research Unit.

Therapists were certified by the Yale Coordinating Center supervisors following successful completion of training cases. Therapists whose performance on initial cases was inadequate were assigned additional training cases until their performance improved. The average number of training cases was three, and therapists completed an average of 26 supervised sessions before certification.

Ongoing Monitoring

To monitor implementation of Project MATCH treatments, facilitate consistency of treatment quality and delivery across sites, and prevent therapist "drift" during the main phase of the study, all sessions are videotaped and sent to the Coordinating Center, where a proportion of each subject's sessions (one-third of all sessions for Cognitive-

Behavioral and Twelve-Step Facilitation, one half of all MET sessions) are reviewed by the supervisors. Telephone supervision is provided on a monthly basis by the Coordinating Center supervisors and supplemented with weekly onsite group supervision at each Clinical Research Unit.

All sessions viewed are rated for therapist skillfulness, adherence to manual guidelines, and delivery of manual-specified active ingredients unique to each approach. These ratings are sent monthly to the project coordinators at each site to alert local supervisors to therapist drift. Therapists whose performance deviates in quality or adherence to the manual are “redlined” by the Coordinating Center, and the frequency of sessions monitored and supervision is increased until the therapist’s performance returns to acceptable levels.



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Catalogue of effective and cost-effective intervention programmes (CAT - IP)

“The HELPS Collection”

- Part 1: “Weight Management”
(reverse or prevent weight gain; antipsychotic-induced weight-gain;
nutritional intervention / exercise)
- Part 2: “Health Promotion, Lifestyle, Wellness, Empowerment”
(incl. Oral Health, Stress Management; Psychoeducation)
- Part 3: “Smoking”
- Part 4: “Alcohol and Illicit Drug Abuse”
- Part 5: “IPs for the general population”

PART 1: "Weight Management – Medication, Nutrition, Exercise"

Medication

- 1 -	
Title	Attenuation of antipsychotic-induced weight gain with early behavioural intervention in drug-naïve first-episode psychosis patients: A randomized controlled trial
Reference	Alvarez-Jimenez M et al., J Clin Psychiatry, 67:8, 2006, 1253- 1260
Study characteristics	
Country	Spain
Patient population	61 patients with a DSM-IV diagnosed psychotic disorder were first randomly assigned to 3 different antipsychotic treatments and subsequently randomly assigned to the intervention condition "Early Behavioral Intervention" (EBI: N = 35) or "Routine Care Intervention" (RCI: N = 27).
Method / Intervention	<p>→ prevention of weight gain</p> <p>EBI and RCI were offered for a 3-month period and were undertaken in a community setting.</p> <p>EBI comprised 10 -14 individual sessions and incorporate several modules which can be flexibly offered:</p> <ul style="list-style-type: none"> - engagement and assessment (2 sessions) - psychoeducation (2 sessions) - dietary specialized counselling (1 to 4 sessions) - exercise programme (1 to 4 sessions) - behaviour therapy (1 to 4 sessions)
Results	<p>All 61 participants completed the study.</p> <p>Patients in the EBI group gained significantly less weight than those allocated to the RCI group during the 3-month follow-up period. Similar findings were obtained when both groups were compared on treatment-induced change in body mass index, which was significantly less in the EBI group than in the RCI group.</p> <p>Conclusions: EBI was effective in attenuating antipsychotic-induced weight gain in a drug-naïve first-episode psychosis cohort. Patients displayed good adherence in this type of preventive intervention.</p>
Comments	The early behavioural intervention manual is available from the authors on request.

- 2 -	
Title	A program for treating olanzapine-related weight gain
Reference	Ball MP et al., Psychiatric Services, 52:7, 2001, 967- 969
Study characteristics	
Country	USA
Patient population	7 men, 4 women
Method / Intervention	<p>This study evaluated the effectiveness of a Weight Watchers Programme for patients with schizophrenia who had olanzapine-related weight gain.</p> <p>Intervention: → participants attended Weight Watchers meetings and were offered supervised exercise sessions.</p>
Results	Only the men experienced significant weight loss.

- 3 -	
Title	A double-blind, placebo-controlled trial of sibutramine for clozapine-associated weight gain
Reference	Henderson D, Acta Psychiatr Scand, 115, 2006, 101- 105
Study characteristics	
Country	USA
Patient population	Ten patients were enrolled into the placebo group and 11 patients into the sibutramine group. There were no significant baseline differences between the two groups on age, gender, education, ethnicity, diagnosis, weight, body mass index (BMI), and blood pressure.
Method / Intervention	This was a 12-week double-blind, placebo controlled, randomized trial of sibutramine for weight loss in obese clozapinetreated schizophrenia or schizoaffective disorder subjects.
Results	<p>At week 12, there were no significant differences in changes in weight, BMI, abdominal and waist circumferences, Hba1c, fasting glucose, or cholesterol levels.</p> <p>Significant outcomes:</p> <ul style="list-style-type: none"> • Sibutramine treatment did not result in statistically significant weight loss, compared with placebo, in clozapine-treated, obese schizophrenia subjects. • Sibutramine treatment did not result in worsening of clinical symptoms. • Sibutramine treatment did not result in significant elevations in heart rate and blood pressure. <p>Conclusion: Sibutramine treatment did not show significant weight loss compared with placebo in clozapine-treated patients with schizophrenia or schizoaffective disorder. Further research with a larger sample size and longer follow-up duration is warranted.</p>

- 4 -	
Title	Effects of behavioural therapy on weight loss in overweight and obese patients with schizophrenia or schizoaffective disorder
Reference	Brar J et al., J Clin Psychiatry, 66:2, 2005, 205- 212
Study characteristics	
Country	USA
Patient population	The study evaluated the effects of a group-based behavioural treatment (BT) for weight loss in overweight and obese stable patients with DSM-IV schizophrenia or schizoaffective disorder who had been switched from olanzapine to risperidone.
Method / Intervention	<p>→ weight loss</p> <p>14-week multicenter, open-label, rater-blinded, randomized, study.</p> <p>A: group-based behavioural treatment (BT): → 20 sessions during which patients were taught to reduce caloric intake.</p> <p>B: control group (usual clinical care, UC) The primary outcome measure was change in body weight.</p>
Results	BT may be an effective method for weight reduction in patients with chronic psychotic illness.
Comments	Authors have contact to pharmaceutical inst.: e.g. Eli Lilly, Pfizer, Janssen, Bristol-Myers Squibb.

- 5 -	
Title	Behavioral treatment of obesity in patients taking antipsychotic medications
Reference	Kalarchian M et al., J Clin Psychiatry, 66:8, 2005; 1058- 1063
Study characteristics	
Country	USA
Patient population	Outpatients receiving psychiatric care at a university medical center who had a body mass index ≥ 30 and were currently taking antipsychotic medication. N = 35 (start).
Method / Intervention	<ul style="list-style-type: none"> - 12-week group behavioural weight control programme. - A medical chart review was conducted for each participant's body weight over the 10 months prior to beginning the programme. - Also assessed were self-reported eating-behaviour, physical activity, and health-related quality of life.
Results	Among 35 patients who began the programme, 29 completed treatment, with mean weight loss of 5.04 (sd=+7.52) pounds ($p = .001$) and improvements in eating, activity, and quality of life. At 3-month posttreatment follow-up (N = 27), total mean weight loss was 7.14 (sd=11.47) pounds ($p = .003$). Results of a longitudinal model based on general estimating equations indicated that BMI decreased significantly during treatment and remained stable through 12-month posttreatment follow up.

- 6 -	
Title	Nutritional intervention to prevent weight gain in patients commenced on olanzapine: a randomized controlled trial
Reference	Evans S, Newton R, Higgins S. Australian and New Zealand Journal of Psychiatry, 2005, 39, 479-486
Study characteristics	
Country	Australia
Patient population	<p>Fifty-one individuals (29 females, 22 males) who had started on olanzapine in the previous 3 months (mean length of 27 days +/- 20) were recruited through Peninsula Health Psychiatric Services (= outpatients when commencing the study) and were randomly assigned to either the intervention (n=29: 11 males; 18 females) or the control group (n=22).</p> <p>But: 6 withdrawals before the 3-month follow-up. Before 6-month data collection, 12 patients from the intervention group were withdrawn. This left 11 in the interv. group & 8 in the control group.</p>
Method / Intervention	<p>→ prevention of weight gain</p> <p>Individuals in the intervention group received six 1 hour nutrition education sessions over a 3-month period. Weight, waist circumference, body mass index (BMI) and qualitative measures of exercise levels, quality of life, health and body image were collected at baseline at 3 and 6 months.</p> <p>Nutrition intervention:</p> <ul style="list-style-type: none"> • Passive nutritional education from the booklet <i>Food for the Mind</i>, a publication produced by the manufacturers of Zyprexa. • 6 one-on-one individual nutrition education sessions over a 3-month period. • The sessions were carried out by a pool of dietitians and were 1 hour duration. • The content of the sessions included discussions between the participants and the dietitian on: <ul style="list-style-type: none"> - healthy eating - exercise - label reading - energy density - high fibre diets - non-hungry eating - lifestyle goals. <p>Weight, waist circumference and BMI were assessed at baseline and at 3 months (end of the nutritional intervention) and 6 months. At 3 months, the subjects were also asked to complete self-report scales based on the Clinical Global Impressions (CGI) to assess their subjective view of their own quality of life, health, body image and assessment of their activity levels.</p>
Results	<p>After 3 months, the control group had gained significantly more weight than the treatment group (6.0 kg vs 2.0 kg, $p \leq 0.002$). Weight gain of more than 7% of initial weight occurred in 64% of the control group compared to 13% of the treatment group. The control group's BMI increased significantly more than the treatment group's (2 kg/m² vs 0.7 kg/m², $p \leq 0.03$). The treatment group reported significantly greater improvements in moderate exercise levels, quality of life, health and body image compared to the controls. At 6 months, the control group continued to show significantly more weight gain since baseline than the treatment group (9.9 kg vs 2.0 kg, $p \leq 0.013$) and consequently had significantly greater increases in BMI (3.2 kg/m² vs 0.8 kg/m², $p \leq 0.017$). Conclusion: Individual nutritional intervention provided by a dietitian is highly successful at preventing olanzapine-induced weight gain.</p>
Comments	Study funded by Eli Lilly

- 7 -	
Title	A Double-Blind, Placebo-Controlled Trial of Sibutramine for Olanzapine-Associated Weight Gain
Reference	Henderson D, Am J Psychiatry, 162:5, 2005, 954- 962
Study characteristics	
Country	USA
Patient population	<p>Patients were included in the study if they met the following criteria: DSM-IV diagnosis of schizophrenia or schizoaffective disorder, age of 18–65 years, well-established compliance with outpatient medication regimens, stable dose of olanzapine for at least 4 months, and no exposure to tricyclic, selective serotonin reuptake inhibitor (SSRI), or monoamine oxidase inhibitor antidepressants for 1 month. Additionally, the patients were required to have a body mass index of ≥ 30 kg/m² or a body mass index of 27 kg/m² plus another risk factor for cardiovascular disease (hypertension, lipid abnormality, diabetes mellitus). [study group: N = 37]</p> <p>Subjects were excluded from the study if they were unable to provide informed consent, had current substance abuse or significant medical illness (including hepatic or renal disease), had untreated hypertension, had a history of intolerance of sibutramine, were pregnant or breast-feeding, were receiving treatment with agents that induce weight loss, had a history of glaucoma, had heart disease or an abnormal electrocardiogram, or were being treated with antimigraine agents containing serotonin agonists.</p>
Method / Intervention	<p>This 12-week double-blind, placebo-controlled, randomized placebo-controlled trial was conducted in the adult outpatient clinic of an urban mental health center. 37 subjects received placebo or sibutramine (up to 15 mg/day).</p> <p>For the first 8 weeks all subjects participated in weekly group sessions focused on nutrition and behavioural modification. Each subject was given a 1-week supply of 5-mg sibutramine capsules or identical-appearing placebo capsules and instructed to take two capsules daily. Research psychiatrists were allowed to decrease the dose of the study medication to one capsule a day, as indicated for intolerable side effects. After 4 weeks, the dose was increased to three capsules, as tolerated. For the first 8 weeks, the participants attended a weekly 1-hour group meeting that incorporated weight education, behaviour modification, and group support to facilitate healthy dietary changes. Videotapes covered the "Food Guide Pyramid" and "Dietary Guidelines for Americans" from the U.S. Department of Agriculture.</p> <p>Weekly goals for meal planning, portion control, food preparation, healthy snacking, and exercise were discussed in the group sessions and followed up in individual meetings with the group leader.</p>
Results	<p>The sibutramine and placebo groups had no significant baseline differences on age, gender, education, ethnicity, diagnosis, weight, body mass index, and blood pressure. At week 12 the sibutramine group had significantly greater losses than the placebo group in weight (mean=8.3 lb, SD=2.4, versus mean=1.8 lb, SD=1.6), waist circumference, body mass index, and haemoglobin A1c. There were no significant differences on most side effects, although the sibutramine group exhibited a mean increase in systolic blood pressure of 2.1 mm Hg (SD= 8.5), and anticholinergic side effects and sleep disturbances were at least twice as common in the sibutramine group.</p>
Comments	<p>Supported by a Young Investigator Award from the National Alliance for Research on Schizophrenia & Depression and by an investigator-initiated independent research grant from Eli Lilly and Co. Drug and placebo were provided by Knoll Pharmaceuticals (Abbott Laboratories).</p>

- 8 -	
Title	Appropriate Intervention Strategies for Weight Gain Induced by Olanzapine: A Randomized Controlled Study
Reference	Milano W et al., Advances in Therapy, 24:1, 2007, 123- 134
Study characteristics	
Country	Italy
Patient population	<p>Study group: 18 patients (9 female, 9 male) affected by manic episodes in bipolar disorder, received olanzapine (10–20 mg/d), jogged lightly for 30 min 3 times a week, and complied with a diet that consisted of 500 kcal/d less than usual.</p> <p>Control group: 10 patients (4 female, 6 male) with schizophrenia received only olanzapine (10–20 mg/d).</p>
Method / Intervention	<p>The goals of this study were to evaluate weight gain in a group of patients treated with olanzapine, diet modifications, and moderate physical activity and to compare the findings with those from a second group of patients who were given only olanzapine treatment. For 8 wk, investigators followed 2 groups of patients suffering from schizophrenia and hypomania in bipolar disorder, according to the nosographic criteria of The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). The first group (A) of 18 patients (9 female, 9 male) affected by manic episodes in bipolar disorder received olanzapine (10–20 mg/d), jogged lightly for 30 min 3 times a week, and complied with a diet that consisted of 500 kcal/d less than usual. The second group (B) of 10 patients (4 female, 6 male) with schizophrenia received only olanzapine (10–20 mg/d).</p> <p>Proposed Physical Activity: 1st and 2nd wk: 5 min of fast step walking alternated with 3 min of slow running for a total of 30 min 3rd, 4th, and 5th wk: 5 min of fast step walking alternated with 5 min of slow running for a total of 30 min 6th, 7th, and 8th wk: 4 cycles of 4 min of fast step walking alternated with 6 min of slow running for a total of 40 min 9th, 10th, 11th, and 12th wk: 4 cycles of 4 min of fast step walking alternated with 8 min of slow running for a total of 48 min → Stretching exercises were performed at the beginning and end of activity</p> <p>Essential Points of Weight Loss Intervention: - Frequent monitoring - Nutritional and lifestyle counseling - Skills training that focuses on exercise, diet, health education, and behavioral techniques</p> <p>Example of Aerobic Running Program: → see paper</p>
Results	<p>After 2 month of observation, group A showed a mean weight gain of 1.47 kg, whereas group B exhibited a mean weight gain of 3.5 kg; the difference between the 2 groups was almost 2 kg ($P < .005$). Group A showed a statistically significant reduction in weight gain compared with group B, clearly demonstrating the effectiveness of moderate physical activity and diet therapy in reducing weight gain in atypical antipsychotic treatment. Therefore, patient weight and body mass index must be monitored during the first weeks of antipsychotic treatment, with the goals of avoiding significant weight gain and treatment interruption.</p>

- 9 -	
Title	Cognitive behavioural therapy for weight gain associated with antipsychotic drugs
Reference	Khazaal Y et al., Schizophrenia Research, 91, 2007, 169- 177
Study characteristics	
Country	Switzerland
Patient population	<p>61 patients treated with an antipsychotic drug who reported weight gain following treatment.</p> <p>Inclusion criteria were: that patients be between 18 and 65 years of age, able to give informed consent, undergoing antipsychotic treatment for a minimum of 2 months and with a reported weight gain during AP treatment >2 kg over 6 months following inclusion into the study.</p> <p>Exclusion criteria were: anorexia, bulimia nervosa, opiate, alcohol or cocaine dependence, mental retardation, diabetes mellitus.</p>
Method / Intervention	<p>→ weight loss</p> <p>A randomized controlled study (12-week CBT vs. Brief Nutritional Education) was carried out on 61 patients treated with an antipsychotic drug who reported weight gain following treatment. Binge eating symptomatology, eating and weight-related cognitions, as well as weight and body mass index were assessed before treatment, at 12 weeks and at 24 weeks.</p> <p>CBT group: (Cognitive behavioural treatment)</p> <p>The "Apple-pie group" was conceived as a handbook for a CBT treatment for severe psychiatric patients and adopts techniques such as Socratic questioning suited for patients with psychotic disorders. Twelve two-hour group treatment sessions were held weekly. The first session consisted of a motivational group interview. The principles of this interview were then integrated in subsequent sessions in order to promote self-determination of eating behaviour. Other components of the proposed treatment were: self-observation of eating behaviour, cognitive restructuring of maladapted cognitions related to weight and eating behaviour (through 59 specific questions), a behavioural treatment aiming at making more moderate weekly food intake through meal tasting, paying particular attention to sensations, as well as better recognizing satiety (i.e. negative alliesthesia). Tasting sessions began with a presentation of the history, the composition, the taste and the nutritional characteristics of the presented food, ranging from food cognitively associated with images of health (i.e. apple), to food cognitively linked to weight gain (i.e. chocolate.). Food intake moderation was prescribed without any specific food prohibition and occasional eating excesses were considered acceptable in order to reduce guilt and risk of relapse. One session was dedicated to psychoeducation on links between weight gain and antipsychotic drugs. Finally, moderate physical activity was encouraged, not so much to modify the energetic balance, but mainly to promote self-care of the patient's body.</p> <p>BNE group: (Brief Nutritional Education)</p> <p>The BNE group consisted of an informative two hour group session in which patients received information on different types of foods, the food pyramid, daily nutritional needs as well as recommendations for a successful moderate calorie-restricted diet. At the end of the session, patients were given nutritional recommendations in the form of a written summary and were encouraged to refer frequently to these guidelines and maintain their effort to lose weight.</p>
Results	<p>The CBT group showed some improvement with respect to binge eating symptomatology and weight-related cognitions, whereas the control group did not. Weight loss occurred more progressively and was greater in the CBT group at 24 weeks.</p> <p>Conclusion: The proposed CBT treatment is particularly interesting for patients suffering from weight gain associated with antipsychotic treatment.</p>

- 10 -	
Title	Weight change in treatment with olanzapine and a psychoeducational approach
Reference	Scocco P et al., Eating Behaviour, 7, 2006, 115- 124
Study characteristics	
Country	Italy
Patient population	18 subjects affected by schizophrenic-spectrum disorders treated with olanzapine.
Method / Intervention	<p>→ prevention of weight gain</p> <p>This study assesses the efficacy of an educational and dietary approach in preventing olanzapine-induced weight gain.</p> <p>→ psychoeducational intervention and referral to a nutritionist</p>
Results	Results showed that after 8 weeks of olanzapine treatment, weight gain was contained in the subjects receiving "preventive intervention" (group 1) unlike patients without preventive intervention (group 2). At the end of the trial these patients partly shed their gain, presenting a final weight which was not significantly different from baseline.

- 11 -	
Title	Managing atypical antipsychotic-associated weight gain: 12 month data on a multimodal weight control program
Reference	Menza M et al., J Clin Psychiatry, 65:4, 2004, 471- 477
Study characteristics	
Country	USA
Patient population	31 subjects with schizophrenia or schizoaffective disorder (DSM-IV) on treatment with atypical antipsychotics.
Method / Intervention	52-week, multimodal weight control program that incorporated nutrition, exercise, and behaviour interventions.
Results	<p>The program resulted in clinically significant reductions in weight, BMI, other risk factors for long-term poor health.</p> <p>In contrast, patients who did not receive weight control intervention continued to gain weight.</p>
Comments	Authors have connections to: Pfizer, Lilly, Cephalon, GlaxoSmithKline, Bristol-Myers Squibb, Forest, Bayer, AstraZeneca, Johnson & Johnson.

- 12 -	
Title	Weight management program for treatment-emergent weight gain in olanzapine-treated patients with schizophrenia or schizoaffective disorder: A 12-week randomized controlled clinical trial
Reference	Kwon J S et al., J Clin Psychiatry, 67:4, 2006, 547- 553
Study characteristics	
Country	Korea
Patient population	Outpatients with schizophrenia or schizoaffective disorder (DSM-IV) taking olanzapine (5-20 mg/day). N = 48: Intervention group: n = 33; control group: n = 15 ; age: 19- 64
Method / Intervention	<p>→ weight loss</p> <p>The main components of this study were diet and exercise, which were based on cognitive and behavioural therapy.</p> <p>The weight management programme was carried out in an individual format:</p> <p>Diet management included the keeping of a food diary and nutritional education. A dietician discussed the food diaries with the patients and helped with diet planning at every visit. In addition, subjects were educated about important nutritional concepts, including the food exchange table, using food models, the importance of regular eating behaviour, healthy snacking, low-calorie cooking preparation, food shopping, and reading food labels.</p> <p>Exercise management included the keeping of an exercise diary and education regarding daily lifestyle modification for weight control. Subjects were urged to keep an exercise diary. An exercise coordinator discussed the exercise diaries with the patients, evaluated their exercise protocols, and helped patients with exercise planning at every visit. The education regarding daily lifestyle modification in the exercise management programme included checking waist/hip ratio, explanations of calorie consumption in daily activities, correct aerobic/anaerobic exercise, choosing exercise suitable for the patient, correcting common misconceptions about diet, the "yo-yo phenomenon", and using the community health centre.</p> <p>The treatment period was 12 weeks.</p>
Results	The weight management programme was effective in terms of weight reduction and was also found to be safe in terms of psychiatric symptoms, vital signs, and laboratory data. In addition, the weight management programme might improve quality of life with respect of their physical well-being.
Comments	Study was supported by Lilly Korea

- 13 -	
Title	The effect of nutritional education on the shopping and eating habits of a small group of chronic schizophrenic patients living in the community
Reference	McDougall S., British Journal of Occupational Therapy, 1992, 55:2, 62- 68

- 14 -	
Title	Management of antipsychotic-induced weight gain: prospective naturalistic study of the effectiveness of a supervised exercise programme
Reference	Poulin M et al., Australian & New Zealand Journal of Psychiatry, 41, 2007, 980- 989
Study characteristics	
Country	Canada
Patient population	110 patients with schizophrenia, schizoaffective or bipolar disorders (DSM-IV), on treatment with atypical antipsychotics
Method / Intervention	<p>A prospective, comparative, open and naturalistic study was carried out for a total of 110 patients with schizophrenia, schizoaffective or bipolar disorders (DSM-IV), on treatment with atypical antipsychotics. Of these, 59 patients participated in an 18 month weight control programme that included an educational activity about dietary and physical activity counselling as well as a structured, supervised, facility-based exercise programme. The control group consisted of 51 patients with the same baseline characteristics who did not receive the clinical programme. Anthropometric measurements, plasma lipid-lipoprotein profile, and fasting plasma glucose concentrations were assessed at 11 timepoints over the study. In addition, serum concentrations of prolactin, thyrotropin-stimulating hormone (TSH), and glycated haemoglobin (HbA1c) were assessed at four time-points. Finally, the Clinical Global Impression scale (CGI), the Brief Psychiatric Rating Scale (BPRS) and the Short Form (SF)-36 Health Survey were used.</p> <p>This prospective, comparative, open and naturalistic study aimed to determine the potential effectiveness of a behavioural weight control programme in the prevention of antipsychotic-induced weight gain and associated comorbid conditions in outpatients with schizophrenia and mood disorders. The patients included in the active group (nutritional recommendations and physical exercise) were compared to those who were not included in this clinical programme. In this regard, the programme offered to the experimental group included a small group educative activity about dietary and physical activity counselling. This educative activity of 90 min length was given once at the beginning of the study for the active group and was delivered by a nutritionist and a psychiatric nurse. The focus here was that the patient understands the role of nutrition and exercise as a vital therapeutic goal in preventing many risk factors. The Canada's food guide to healthy eating was a useful tool for this nutrition education counselling. In addition, the active group was involved in a structured, supervised, facility-based exercise programme in a small gymnasium of the hospital. A kinesiologist supervised small groups (8-10 subjects) who were devoted to exercise sessions including cardiovascular workouts on treadmills and stationary cycles. Strength-training exercises included use of free weights and resistance bands as well as flexibility and balance drills. Music was used to maintain enthusiasm for exercise sessions. Rates of perceived exertion and heart rate were closely monitored. Special attention was given to subjects with medication-related impaired balance and coordination. This individualized fitness training was performed for 60 min twice a week over the 18 month period.</p>
Results	The adherence rate of patients was 85%, both in the active and in the control group. Whereas the control group experienced a significant increase in bodyweight (4.1%), body mass index (BMI; 5.5%) and waist circumference (WC; 4.2%), the active group significantly reduced their bodyweight (_3.5%), BMI (_4.4%), and WC (_4.6%) at the study end-point. In addition, a significant increase in low-density lipoprotein (LDL)- cholesterol (14.8%) and in triglyceride concentrations (12.3%) was observed at month 18 in the control group. In contrast, high-density lipoprotein-cholesterol (HDL) significantly

	<p>increased (21.4%), and LDL cholesterol (\downarrow 13.7%), triglycerides (\downarrow 26.2%), total cholesterol (\downarrow 12.1%), fasting glucose concentrations (\downarrow 12.0%), and HbA1c (\downarrow 11.4%) significantly decreased compared to baseline in the active group. No significant changes were observed regarding serum concentrations of prolactin and TSH during the study. In regard to the changes observed in psychological measures, no between-group differences were seen in the clinical ratings of CGI and BPRS. However, the SF-36 showed that physical health was improved only for subjects in the active group at months 12 and 18 compared to baseline (p<0.05), and mental health was significantly improved for both groups at months 12 and 18 compared to baseline.</p> <p>Conclusion: Bodyweight and metabolic risk profile in patients receiving atypical antipsychotic medications can be effectively managed with a weight control programme including physical activity.</p>
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- 15 -	
Title	Lifestyle intervention and metformin for treatment of antipsychotic-induced weight gain. A randomized controlled trial
Reference	Wu R et al., Jama, 299:2, 2008, 185- 193
Study characteristics	
Country	China
Patient population	A randomized controlled trial (October 2004-December 2006) involving 128 adult patients with schizophrenia in the Mental Health Institute of the Second Xiangya Hospital, Central South University, China. Participants who gained more than 10% of their predrug weight were assigned to 1 of 4 treatment groups.
Method / Intervention	<p>Patients continued their antipsychotic medication and were randomly assigned to 12 weeks of placebo, 750 mg/d of metformin alone, 750 mg/d of metformin and lifestyle intervention, or lifestyle intervention only.</p> <p>Main Outcome Measures Body mass index, waist circumference, insulin levels, and insulin resistance index.</p>
Results	<p>All 128 first-episode schizophrenia patients maintained relatively stable psychiatric improvement. The lifestyle-plus-metformin group had mean decreases in body mass index (BMI) of 1.8 (95% confidence interval [CI], 1.3-2.3), insulin resistance index of 3.6 (95% CI, 2.7-4.5), and waist circumference of 2.0 cm (95% CI, 1.5-2.4 cm). The metformin-alone group had mean decreases in BMI of 1.2 (95% CI, 0.9-1.5), insulin resistance index of 3.5 (95% CI, 2.7-4.4), and waist circumference of 1.3 cm (95% CI, 1.1-1.5 cm). The lifestyle-plus-placebo group had mean decreases in BMI of 0.5 (95% CI, 0.3-0.8) and insulin resistance index of 1.0 (95% CI, 0.5-1.5). However, the placebo group had mean increases in BMI of 1.2 (95% CI, 0.9-1.5), insulin resistance index of 0.4 (95% CI, 0.1-0.7), and waist circumference of 2.2 cm (95% CI, 1.7-2.8 cm). The lifestyle-plus-metformin treatment was significantly superior to metformin alone and to lifestyle plus placebo for weight, BMI, and waist circumference reduction.</p> <p>Conclusions: Lifestyle intervention and metformin alone and in combination demonstrated efficacy for antipsychotic-induced weight gain. Lifestyle intervention plus metformin showed the best effect on weight loss. Metformin alone was more effective in weight loss and improving insulin sensitivity than lifestyle intervention alone.</p>

- 16 -	
Title	A program for managing weight gain associated with atypical antipsychotics
Reference	Vreeland B et al., Psychiatric Services, 54:8, 2003, 1155- 1157
Study characteristics	
Country	USA
Patient population	31 patients with schizophrenia or schizoaffective disorder; compared with 15 patients in a control group
Method / Intervention	This study assessed the efficacy of a weight control program for patients taking atypical antipsychotics. Thirty-one patients with schizophrenia or schizoaffective disorder participated in a 12-week weight control program that incorporated nutrition, exercise, and behavioral interventions. Changes in patients' weight and in body mass index (BMI) were recorded and compared with those of 15 patients in a control group.
Results	The intervention group had a mean weight loss of 2.7 kg (six pounds) and a mean reduction of .98 BMI points, compared with a mean weight gain of 2.9 kg (6.4 pounds) and a mean gain of 1.2 BMI points in the control group. These data suggest that the intervention was effective in this group of patients.

- 17 -	
Title	A cognitive/behavioural group intervention for weight loss in patients treated with atypical antipsychotics
Reference	Weber M & Wyne K., Schizophrenia Research, 83, 2006, 95- 101
Study characteristics	
Country	USA
Patient population	N = 17; Cognitive/behavioural treatment: n = 8; Treatment as usual: n = 9. Diagnosis: schizophrenia or schizoaffective disorder (DSM IV) Ages of 18 – 65; BMI equal to or greater than 25.
Method / Intervention	<u>16-week cognitive(behavioural group intervention:</u> Week 1: getting started being active and losing weight Week 2: move those muscles Week 3: being active: a way of life Week 4: be a fat detective Week 5: three ways to eat less fat Week 6: healthy eating Week 7: take charge of what's around you Week 8: tip the calorie balance Week 9: problem solving Week 10: 4 keys to healthy eating out Week 11: talk back to negative thoughts Week 12: the slippery slope of lifestyle change Week 13: jump start your activity plan Week 14: make social cues work for you Week 15: you can manage stress Week 16: ways to stay motivated
Results	This pilot study has demonstrated that weight loss is possible with cognitive/ behavioural interventions in a population with a psychotic disorder.

- 18 -	
Title	Outcome of obese, clozapine-treated inpatients with schizophrenia placed on a six-month diet and physical activity program
Reference	Wu M-K et al., Psychiatric Services, 58:4, 2007, 544- 550
Study characteristics	
Country	Taiwan
Patient population	53 clozapine-treated obese patients with schizophrenia (DSM IV) in a veterans hospital in eastern Taiwan who has a BMI greater than 27; study group: n = 28; control group: n = 25.
Method / Intervention	→ weight loss The study group was placed on a diet that reduced calorie intake and a six-month regimen of regular physical activity.
Results	The study group showed a significant decrease in body weight, BMI, waist circumference and hip circumference after 3 months and after 6 months. Triglyceride and insulin-like growth factor-binding protein-3 decreased significantly only after 6 months.

Nutrition

- 19 -	
Title	PROMOZIONE DELLA SALUTE FISICA un intervento con i pazienti psichiatrici
Reference	L Chioffi, S Morgante, L Berti, L Costa, L De Noni, N De Paoli, G Faggionato, V Rebonato, D Soave, L Valenari, M Valsecchi, L Burti – Dialogo sui farmaci • n. 5/2008
IP Criteria	
Country	Italy
Area of use/Application	Psychiatric patients (day centre users) and day centre mental health workers
Method	<p>Education on diet and promotion of physical activity</p> <p>ASSESSMENT (BMI and waist measurement, Blood pressure, Smoking habits, Dietary habits (consumption of fruits and vegetables: frequency assessed with a self administered questionnaire), Physical activities (weekly diary)</p> <p>INTERVENTION</p> <ul style="list-style-type: none"> - 4 Training sessions for day-centre mental health workers (MHWs) only; - 2 educational sessions on the importance of diet and fitness for both MHWs and patients (all) - 2 Educational group-activities for patients attending the day-centre ("dietetics by volumes") (all) - 2 Cooking sessions in collaboration with the local school of professional cuisine (all) - Group walking program (patients with one MHW)
Reliability	
Validity	<ul style="list-style-type: none"> - Menu preferences at the day-centre substantially changed (and persisted) according to dietary advice provided in educational sessions - Both workers and patients expressed appreciation and satisfaction for the initiative - The walking program has continued ever since
Norm(alization)/Standardization	Not available
Execution time	12 months
Accessibility/Availability	PARTICIPANTS: 17 users, 14 mental health workers
Procurement costs	Internal resources and free participation of the local department of Prevention

- 20 -	
Title	Cognitive behavioural weight-loss program for individuals with psychotic mental diseases
IP Criteria	
Area of use/Application	
Method	<p>Intervention Group (n=7, 3 female, 3 male) Control Group (n=8, 4 female, 4 male).</p> <p>Intervention programme: 12 sessions, 1 session per week of 90 minutes. Sessions given by a psychologist Programme Modules: 1) information about the condition; 2) nutritional education; 3) modification of type of food and eating style; 4) cognitive changes; 5) modification of physical activity; 6) relapse prevention</p> <p>Variables studied: 1) BMI (Body Mass Index); 2) Eating between meals; 3) Consumption style; 4) Sessions (number) of physical activity /week; 5) Negative thoughts; 6) Frequency of eating sweets; 7) Freq. of eating fats, fried foods; 8) Freq. of eating fruits; 9) Freq. of eating vegetables; 10) Freq. of eating prepared food; 11) Freq. of eating fat foods (pepperoni,); 12) freq. of eating salads</p>
Reliability	Non specified
Validity	Non specified
Norm(alization)/Standardization	Non specified
Execution time	12 sessions, 1 session per week of 90 minutes
Accessibility/Availability	
Procurement costs	Non specified
Further comments	<p>Results: Intervention group: all variables except 2 (eating between meals) were statistically significant at 12 week follow-up Control group: only variable 8 (eating fruits) was significant at 12 weeks Several limitations are discussed</p>
Reference	<p>Programa de control de peso en personas con enfermedad mental grave del espectro psicótico Ana Maria Gaitero Calleja, Miguel Angel Santed Germán, Margarita Rullas Trincado, Araceli Grande de Lucas Psicothema 2007, vol 19, nº4, 640-645 Cognitive behavioural weight-loss program for individuals with psychotic mental diseases. Overweight derived from the intake of new antipsychotic medication in order to treat schizophrenia is a growing problem. The main purpose of this study is to launch a cognitive behavioural program in outpatients. It is focused on the weight control of patients with chronic mental diseases, especially those diagnosed as psychotic, and who are under treatment in a Psychosocial Rehabilitation Centre. In this study, the results of an experimental group and a control group were compared. The experimental group was made up of 7 individuals, 3 males and 4 females, and the control group comprised 4 males and 4 females. The program had duration of twelve sessions administered over a period of three months. Three months after concluding the program, both groups were followed up. The data obtained indicate the efficiency of the cognitive-behavioural treatment in the patients. The achievements of this project were, on the one hand, to significantly reduce the patients' weight and, on the other, to modify their nutritional and physical exercise habits.</p>

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IP Criteria	
Country	Austria/Germany
Area of use/Application	All psychiatric diagnoses
Method	Psychoeducation and practical training
Reliability	No data available
Validity	No data available
Norm(alization)/Standardization	No data available
Execution time	No data available
Accessibility/Availability	Distributed by Eli Lilly Company
Procurement costs	Free
Further comments	Developed on behalf of Eli Lilly Company

- 22 -	
Title	Healthy living group programme (PhD thesis, not yet submitted but summary of results are available on the web)
IP Criteria	
Country	United Kingdom
Area of use/Application	Patients recruited from a local mental health service (Not sure whether this is community or inpatient services)
Method	single group pre-test post-test design and qualitative interviews
Reliability	Not reported
Validity	Not reported
Norm(alization)/Standardization	Due to methodological limitations only speculative conclusions can be made regarding the causality of effect.
Execution time	7 health education group sessions
Accessibility/Availability	Not stated – 58 referrals made, 45 service users were eligible. 29 service users (65%) attended 5 or more sessions
Procurement costs	Not stated
Further comments	45 participants were offered the intervention. 87% (n=39) attended the health education groups. Post-intervention results showed a significant increase in levels of exercise ($Z = -2.77$, $p = 0.006$) and the number of portions of fruit and vegetables consumed ($t = -5.38$, $p < 0.001$). Changes remained significant for both exercise ($Z = -2.31$, $p = 0.021$) and fruit and vegetable intake ($t = -3.77$, $p = 0.002$) at follow up and effect sizes were large. Small but non significant changes were shown in the amount of fried food eaten ($F = 4.70$, $df = 2$, $p = 0.09$) and the number of cigarettes smoked per day ($F = 0.83$, $df = 2$, $p = 0.66$). The feasibility of the intervention was good and results of focus groups indicated that health education delivered in a group format was acceptable to the participants of the study.

- 23 -	
Title	Weight change in treatment with olanzapine and a psychoeducational approach
Reference	Paolo Scocco, Raffaella Longo, Federico Caon Eating Behaviors 7 (2006) 115–124
IP Criteria	
Country	Italy
Area of use/Application	
Method	Eighteen patients affected by schizophrenic disorders were treated with olanzapine and weighed twice-weekly for 24 weeks. A psychoeducational intervention and referral to a nutritionist was introduced from the beginning of olanzapine treatment in 9 patients, and from the 9 th week of therapy in 8 patients.
Reliability	
Validity	Results showed that after 8 weeks of olanzapine treatment, weight gain was contained in the subjects receiving intervention unlike patients without preventive intervention (+0.99F3.34 kg vs. +2.96F3.08 kg; p b.03). At the end of the trial these patients partly shed their gain (–1.77 kg), presenting a final weight which was not significantly different from baseline (+1.19 kg). Subjects receiving the psychoeducational approach from the beginning were significantly heavier than at baseline (+3.4 kg). Poor dietary compliance correlated significantly with an increase in bodyweight, while higher mean dosages of olanzapine correlated with better weight-gain control.

- 24 -	
Title	Nutritional Education Group
IP Criteria	
Country	Scotland
Area of use/Application	Schizophrenic patients living in the community
Method	Quasi experimental comparing nutritional education group vs treatment as usual.
Reliability	Measures not reliable
Validity	Measures not valid
Norm(alization)/Standardization	Diagnosis and measures not standardised
Execution time	8 weeks
Accessibility/Availability	Convenience sample of 11 people
Procurement costs	Not stated
Further comments	Results are inconclusive as both groups showed changes with no superior advantage for the experimental group. Increase in knowledge about healthy eating was not associated with a change in behaviour.

Exercise

- 1 -	
Title	Sport, Physical Health and lifestyle in psychiatric illness
Reference	L. Ferrannini* C. Venturino* C. Pitto* M. Ferrari** P. Greco ** * ASL 3 Genovese, Mental Health Department, Genoa, Italy ** ASL 3 Genovese, Sports Medicine Unit, Genoa, Italy
Purpose of the study	<p>Serious mental illness is a trouble whose impact is concretized both in elevated costs produced by patients' and relatives' loss of productivity and quality of life, and in the huge resources addressed to its treatment. An important element in delaying or making less heavy the consequences of psychiatric illness is also the recovery of the value of health, departing from the management of one's own body and one's wellness.</p> <p>The importance of preventive and therapeutic effects of competitive sports activity on individual physical and psychic health is known and proved. Sport is also important in terms of secondary prevention, meant as rehabilitation and re-education for an earlier social reintegration.</p>
Method	<p>A survey was conducted in 2007 by the Mental Health Department and Sports Medicine Unit of ASL 3 Genovese, involving a group of 30 people in care for psychiatric illnesses (schizophrenia, bipolar disorder, serious personality disorders), aged 18 to 45, involved in a sports rehabilitation project. Sports activities include: sailing, training in a gym and in a athletic field, and a gym preparation with motor programs aimed to improve motor resistance, coordination and strength. Before starting activities, all subjects have been submitted to a competitive sports suitability screening. That was a specialistic visit, which included ECG, spirometry and urines test.</p>
Summary of results	<p>Tests results have shown a high rate of subjects overweight e/o with tendency of gaining weight, with incorrect styles of life with sedentariness, alcohol and smoke. Particularly:</p> <p>70% of visited subjects are overweight.</p> <p>90% have a level of absent or light (less than 20' a day) physical activity.</p> <p>90% conduct dysfunctional styles of life regarding diet, smoke, alcohol, abuse of medicines.</p> <p>85% was used to practice sport activity before the outset of mental illness, and then stopped it due to their psychic conditions.</p> <p>All these components can lead to that condition defined "Metabolic Syndrome" by WHO (World Health Organization). It is the contemporary presence of three risk factors among overweight, hypertension, dislipidemy, diabetes, sedentariness, high BMI, abdominal obesity, waist circumference > 105 in males and > 90 in women. Metabolic syndrome can also lead to general serious cardiovascular and medical problems, even in young age, and it makes treatment compliance more difficult too.</p> <p>Presence of risk factors in many visited subjects has brought us to set up a structured protocol of physical activity, directed to monitoring the parameters of health's risk factors. These goals integrate those classical aims of sports rehabilitation, which help autonomy, social relationships, contact with natural environmental contexts, and contribute to reduce costs of mental illness treatments.</p>

- 2 -	
Title	The psychoeducation on healthy lifestyle, exercising and healthy nutrition (the name of programme in Slovenian: Pot k dobremu počutju)
IP Criteria	
Country	Slovenia
Area of use/Application	The psychoeducation on healthy lifestyle, exercising and healthy nutrition programme is an educational programme and it teaches basics of physical health such as nutrition, relaxation and physical exercise. It's directed toward introducing a healthy lifestyle
Method	The psychoeducation on healthy lifestyle, exercising and healthy nutrition programme takes place 1 times a week and it lasts 12 weeks. The programme takes place 1-3 a year. It's implemented in groups (the number of participants is 5-12) and sometimes also individually.
Reliability	NA
Validity	NA
Normalization)/ Standardization	Carol Sowers and Carol D. Peabody. Adaptation of programme in Slovenia by Andreja Jerič
Execution time	12 weeks (available through the whole year).
Accessibility/availability	In all 6 national psychiatric hospitals, 2 community health centres, 1 social care centre and all NGO organisations for mental health: Center za izvenbolnišnično psihiatrijo LJ, Ljubljana Klinični oddelek za klinično psihiatrijo LJ, Ljubljana Ozara Ljubljana, Ljubljana ŠENT Ljubljana, Ljubljana ŠENT Trbovlje, Trbovlje, ŠENT Maribor, Maribor Ozara Maribor, Maribor SB Maribor, oddelek za psihiatrijo, Maribor Ozara Ptuj, Ptuj Psihiatrična bolnica Ormož, Ormož ŠENT Celeia, Celje Psihiatrična bolnica Vojnik, Vojnik Senatorij Ravne, Šoštanj Ozara Kranj, Kranj ZD Kranj, Kranj Psihiatrična bolnišnica Begunje, Begunje Ozara Nova Gorica, Nova Gorica ŠENT Ajdovščina, Ajdovščina Psihiatrična bolnica Idrija, Idrija ŠENT – Šentmar, Koper ŠENT – Kočevje, Kočevje VEZI – Društvo za duševno zdravje, Sežana VEZI – Društvo za duševno zdravje, Štanjel VEZI – Društvo za duševno zdravje, Postojna VEZI – Društvo za duševno zdravje, Ilirska Bistrica Ozara Izola, Izola Ozara Novo Mesto, Novo Mesto ZD Brežice, Brežice Ozara Murska Sobota, Murska Sobota CSD Koper, Koper
Procurement costs	NA (for the patients the programs are free of charge)

- 3 -	
Title	MUSCEL project (Meeting up for social contact, sport, exercise and leisure)
IP Criteria	
Country	United Kingdom
Area of use/Application	Service users with mental health problems living in the community
Method	Service evaluation (questionnaires and interviews with service users)
Reliability	Not assessed – questionnaire designed specifically for the study therefore results cannot be compared with any other studies
Validity	Not assessed – questionnaire designed specifically for the study therefore results cannot be compared with any other studies
Norm(alization)/Standardization	Small sample- All participants were volunteers therefore may be positive bias.
Accessibility/Availability	Service users living in the community in an urban centre of the UK (Leeds). Results based on a sample of 17
Procurement costs	None given
Further comments	Participants stated that the project increased self confidence and self esteem, perceived fitness levels and perceived habitual physical activity levels.

- 4 -	
Title	Pilot Study: Access to Fitness Facility and Exercise Levels in Olanzapine-Treated Patients
Reference	Archie S et al., Can J Psychiatry, 48:9, 2003, 628 – 632

- 5 -	
Title	Integrated weight management and fitness programme
IP Criteria	
Country	United Kingdom
Area of use/Application	High Security Hospital
Method	Service evaluation (pre-post intervention)
Reliability	Programme developed based on Diabetes guidelines
Validity	Programme developed based on Diabetes guidelines
Norm(alization)/Standardization	
Execution time	10-12 weeks
Accessibility/Availability	145 patients referred, 102 accepted, 95 started the programme and 46 completed five or more sessions
Procurement costs	£250,000 in the first year of operation, with a saving of £15,000 in the second year
Further comments	Mean weight loss was 1.3kg (s.d.= 3.73, range 12kg gain to 9kg loss) and mean waist reduction size was 2cm (s.d. = 3.73, range 8cm gain to 8cm loss).

- 6 -	
Title	SportivaMENTE (sportingly)
IP Criteria	
Country	Italy
Area of use/Application	Psychiatric patients, treated with antipsychotic drug, less than 35 years old
Method	Specialised physical examination, ECG (stress and at rest), spirometry, urine examination, weight monitoring. Gym activity two hours a week with exercise improving muscle power, psychomotor coordination and agility. 30 participants
Reliability	Not available
Validity	Good observed effect on psychomotor coordination (not evaluated) To be study effects on metabolic parameters and on changing in lifestyles. Good positive effects of group activity.
Norm(alization)/Standardization	Not available
Execution time	First phase from April 2008 to April 2009. It will start again in autumn 2009
Accessibility/Availability	ASL3 GENOVESE Mental Health Unit 12 th district) Dott. Luigi Ferrarini (Head of Mental Health Dep) luigi.ferrannini@asl3.liguria.it Clara.Pitto@asl3.liguria.it
Procurement costs	Participants directly contributed with 40€ for physical examination and 15€ for insurance; Other costs are covered by the service (4 hour a week of mental health workers).
Further comments	A better psychomotor coordination could improve cognitive impairments in schizophrenia.

- 7 -	
Title	Wissen – Genießen – Besser leben
IP Criteria	
Country	Austria/Germany
Area of use/Application	Schizophrenia
Method	Psychoeducation
Reliability	No data available for this module
Validity	No data available for this module
Norm(alization)/Standardization	No data available for this module
Execution time	No data available for this module
Accessibility/Availability	Sold as book by Psychiatrie-Verlag
Procurement costs	Sold as book by Psychiatrie-Verlag
Further comments	Developed by Amering M. and a research group of the Department of Psychiatry and Psychotherapy, Medical University of Vienna.

- 8 -	
Title	Evaluation of an integrated weight management and fitness programme in a high-security psychiatric setting
Reference	Cormac I et al., Psychiatric Bulletin, 32, 2008, 95 – 98

- 9 -	
Title	The role of a fitness intervention on people with serious psychiatric disabilities
Reference	Skrinar G et al., Psychiatric Rehabilitation Journal, 29(2), 2005

Reviews

- 1 -	
Title	Review: Healthy living interventions and schizophrenia: a systematic review
Reference	Bradshaw T et al., J of Advanced Nursing, 49:6, 2005, 634 – 654

- 2 -	
Title	Review: Schizophrenia and weight management: a systematic review of interventions to control weight
Reference	Faulkner et al., Acta Psychiatr Scand, 108, 2003, 324 – 332

- 3 -	
Title	Review: Efficacy of behavioural interventions in managing atypical antipsychotic weight gain
Reference	Gabriele JM et al. Obesity Reviews, 2009, 10, 442 – 455

- 4 -	
Title	Review: Behavioural management of antipsychotic-induced weight gain: a review
Reference	Werneke et al., Acta Psychiatr Scand, 108, 2003, 252 – 259

ELI LILLY**- 1 -**

Title	Weight management in a cohort of Irish inpatients with serious mental illness using a modular behavioural programme. A preliminary service evaluation
Reference	Bushe C et al., BMC Psychiatry, 8, 2008
Comments	Eli Lilly "Solutions of Wellness programme"

- 2 -

Title	A meaningful day group approach to weight gain from antipsychotics medication
Reference	O'Melia J et al., J of Psychiatric & Mental Health Nursing, 2004, 11, 112 – 116
Comments	Eli Lilly "Solutions of Wellness programme"

- 3 -

Title	The effects of an educational intervention on antipsychotic-induced weight gain
Reference	Littrell KH et al., Journal of Nursing Scholarship, 2003; 35:3, 237-241
Study characteristics	
Country	USA
Patient population	70 outpatients with a DSM IV diagnosis of schizophrenia or schizoaffective disorder (age 18 years or older)
Method/Intervention	<p>→ prevention of weight gain</p> <p>The intervention group attended a weekly, 1-hour psychoeducation class using the "Solutions of Wellness" modules for 16 weeks.</p> <p>The programme consists of two written modules: (1) "Nutrition, Wellness, and Living a Healthy Lifestyle" and (2) "Fitness and Exercise"</p> <p>(1): Learning objectives of the first module are: (a) recognizing health problems that can be reduced or avoided with a healthy diet and lifestyle (b) knowledge of the Dietary Guidelines for Americans (c) setting and achieving realistic goals (d) learning appropriate serving sizes (e) developing support systems that that maintain a healthy diet & lifestyle (f) reducing food costs</p> <p>(2): Learning objectives of the second module are: (a) a familiarity with healthy body weight (b) monitoring resting and target heart rates (c) recognizing the benefits of regular exercise (d) initiating and maintaining an exercise program (e) knowledge of the different types of exercise programs (f) learning low.cost and no-cost exercise strategies.</p>
Results	A significant difference in weight change between the intervention group and the control group was observed post-treatment and at endpoint.
Comments	Educational materials were provided by Eli Lilly & Company

PHYSICAL EXERCISE		- 4 -
Title	Health promotion intervention based on the Lilly ‘meaningful day’ manual (tailored to individual needs)	
IP Criteria		
Country	United Kingdom	
Area of use/Application	Service users accessing West Southampton community mental health team	
Method	Randomized controlled trial	
Reliability	Not given	
Validity	The package has ‘good face validity’ Lifestyle factors assessed using validated instruments.	
Execution time	6 weeks (six minute sessions)	
Accessibility/Availability	According to the authors this is a package devised by a pharmaceutical company and is the basis for most local health promotion work. It is a multimedia package	
Procurement costs	None given	
Further comments	The intervention produced small but statistically significant health gains in exercise and weight loss with a trend to improved subjective well being. There was a high drop out rate (17 out of 28 participants completed the study).	

NUTRITION		- 5 -
Title	PROGETTO BENESSERE (supported by ELY LILLY)	
IP Criteria		
Country	Italy	
Area of use/Application	Psychiatric patients treated with antipsychotic drug	
Method	Psychoeducational group, weekly sessions for 6 months To achieve healthy lifestyles 10 participants for group 2 groups completed the program (2008-2009) Next group in going will begins in September 2009	
Reliability	Not available	
Validity	Fairly good, reduced weight for 1/3 of participants. All participants improved their lifestyles	
Norm(alization)/Standardization	Not available	
Execution time		
Accessibility/Availability	ASL3 GENOVESE Psychiatric Day Centre FIUMARA Dott. Alessandro Fasce ✉lessandro.fasce@asl3.liguria.it	
Procurement costs	Sponsored by Ely Lilly	
Further comments	Very good participation, (no drop-out), creation of autonomous sub-groups for physical activities and free time	

- 6 -	
Title	A randomized controlled trial of a brief health promotion intervention in a population with serious mental illness
Reference	Brown S & Chan K. Journal of Mental Health, 15(5), 543 – 549, 2006
Study characteristics	
Country	UK
Patient population	Patients with "severe and enduring mental illness", Age: 18-65
Method/Intervention	A randomized controlled trial of a particular health promotion package using physiological measures and validated research instruments to measure outcome.
Results	The intervention produced small but statistically significant gains in exercise and weight loss with a trend to improve subjective well being. There was a high drop out rate.
Comments	The Lilly "Meaningful Day" package is well designed, has good face validity and is attractive to local services as it relieves them of the need to develop their own resource packages.

- 7 -	
Title	Programme for good health (Program pro dobré zdraví)
IP Criteria	
Country	Czech Republic
Area of use/Application	Weight gain prevention and weight reduction for patients with schizophrenia spectrum disorders
Method	The 16-week structured educational programme with behavioral components (diet and exercise) is delivered by trained psychiatric nurses in 10 sessions lasting one-hour, with first eight sessions held weekly and the last two sessions monthly in consecutive groups consisted of 5-8 participants. The programme is designed to deliver relevant information about healthy lifestyle and to teach participants techniques to control appetite and weight. The program is available in two different types of settings: 1) Outpatient treatment course (OTC) for highly motivated patients who get the knowledge about wellness programme from mental health professionals, from peers, or through the internet (www.ppdz.cz), and 2) as a regular part of more complex Day treatment programmes (DTP).
Reliability	The data are collected by instructors. No external check.
Validity	No double-blind studies available. Observational data available on 732 patients who entered the programme between 2005-2007, out of those 499 participated at least in seven lessons. At the end of the programme the weight loss was significant in both settings (82.04 vs. 80.97 kg; $p=0.004$ in DTP and 92.19 vs. 89.90 kg; $p=0.001$ in OTC) as well as the improvement in knowledge. These results suggest that the programme has both weight-reduction and weight-gain preventive potential.
Norm(alization)/Standardization	Normalization/standardization: To become instructors, psychiatric nurses attend regular seminars. Also, all instructors and participants have to use the same workbooks.
Execution time	The 16-week programme; 10 sessions lasting one-hour, with first eight sessions held weekly and the last two sessions monthly.
Accessibility/Availability	The programme started in 2005. Good availability all over the country in 23 centers (see the map on www.ppdz.cz).

PART 1: "Weight Management – Medication, Nutrition, Exercise"

Procurement costs	The instructors are paid by Eli Lilly, CR; 2500 CZK per course (~ 100 €)
Further comments	Between 2005 and June 2009, 1242 patients with the diagnosis of schizophrenia-spectrum disorder participated.

PHYSICAL EXERCISE		- 8 -
Title	A meaningful day group approach	
IP Criteria		
Country	United Kingdom	
Area of use/Application	Service users accessing community mental health teams	
Method	Programme evaluation	
Reliability	Adapted intervention seems rather arbitrary!	
Validity		
Norm(alization) / Standardization		
Execution time	8 weeks initially. The programme was then adapted to last for 25 weeks	
Accessibility/Availability	CD package available from Lilly drug reps visiting community mental health teams. All clients accessing community mental health teams appear to be eligible	
Procurement costs	CD package available from Lilly drug reps visiting community mental health teams.	
Further comments	Very small sample (5 patients in first intervention, 6 patients in second intervention). 8 week intervention ineffective – did not produce profound change in body weight and weight gain occurred. The 25 week intervention saw weight loss in three clients	

NUTRITION		- 9 -
Title	Solutions for Wellness group programme	
IP Criteria		
Country	United Kingdom	
Area of use/Application	Patients with SMI in Ireland	
Method	Service evaluation	
Reliability	Not assessed	
Validity	Not assessed	
Norm(alization)/ Standardization	Not assessed	
Execution time	Weekly group sessions and an 8-week rotational cycle of educational topics over 2 years	
Accessibility/Availability	55 patients from 6 centres accessed the programme	
Procurement costs	None given	
Further comments	55% of patients completed one year while 22% completed 2 years. Baseline mean weight = 98.6kg (SD 19.2) decreased to final visit weight 96.9kg (SD 18.4) paired t test , p = 0.0030; CI mean 2,53 (0.9 – 4.159) Weight increased in 11/55 patients, maintained 7/55 and decreased 37/55. Solutions for Wellness = Eli Lilly	

PART 2: "Health Promotion, Lifestyle, Wellness, Empowerment"

- 1 -	
Title	To your health: implementation of a wellness program for treatment staff and persons with mental illness
Reference	Camann, Archives of Psychiatric Nursing, Vol. XV(4), 2001, 182 – 187

- 2 -	
Title	Development and Evaluation of a Health Promotion Group for individuals with severe psychiatric disabilities
Reference	Gretchen-Doorty D et al., Psychiatric Rehabilitation Journal, 33(1), 2009, 56-59

- 3 -	
Title	Wellness intervention for patients with serious and persistent mental illness
Reference	Hoffmann V. et al., J Clin Psychiatry, 66:12, 2005, 1576 – 1579

- 4 -	
Title	A lifestyle intervention for older schizophrenia patients with diabetes mellitus: A randomized controlled trial
Reference	McKibbin Ch. Et al., Schizophrenia Research, 86, 2006, 36 – 44

- 5 -	
Title	The illness management and recovery program: Rationale, development, and preliminary findings
Reference	Mueser K et al., Schizophrenia Bulletin, 32, 2006, 32 – 43

- 6 -	
Title	A well-being programme in severe mental illness. Reducing risk for physical ill-health: A post-programme service evaluation at 2 years
Reference	Smith, A et al., European Psychiatry 22, 2007, 413 – 418

- 7 -	
Title	A wellness class for inpatients with psychotic disorders
Reference	Wirshing D et al., Journal of Psychiatric Practice, 12(1), 2006

MIXED INTERVENTION		- 8 -
Title	Well being support programme (WSP)	
IP Criteria		
Country	United Kingdom	
Area of use/Application	966 outpatients with SMI in seven geographical areas in the UK	
Method	Service evaluation	
Reliability	N/A	
Validity	N/A	
Norm(alization)/Standardization	Population is drawn form a diverse geographical and socio-economic areas and therefore findings may be generalisable to the UK population	
Execution time	2 years	
Accessibility/Availability	764 outpatients accessed the service	
Procurement costs	Not mentioned	
Further comments	Prior to WSP less 31% of patients had regular physical health checks. Within WSP 100% had regular physical health checks and basic lifestyle advice. Significant improvements were observed in levels of physical activity (p<0.0001), smoking (p<0.05) and diet (p<0.0001). there were no changes in mean BMI although 42% lost weight over two years	

Oral Health**- 1 -**

Title	The effects of an oral health promotion program for people with psychiatric disabilities
Reference	Almomani F et al., Psychiatric Rehabilitation Journal, 29 :4, 2006, 274 – 281

- 2 -

Title	Effects of an Oral Health Promotion Program in People with Mental Illness
Reference	Almomani F et al., J Dent Res, 88:7, 2009, 648 – 652

- 3 -

Title	A one-year follow-up of an oral health care programme for residents with severe behavioural disorders at special nursing homes in Denmark
Reference	Vigild M et al., Community Dental Health, 15, 1998, 88 – 92

- 4 -

Title	A one-year follow-up of an oral health care programme for residents with severe behavioural disorders at special nursing homes in Denmark
Reference	Community Dent Health. 1998 Jun;15(2):88-92
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Vigild M, Brinck JJ, Hede B.</p> <p>Department of Community Dentistry, Faculty of Health Sciences, University of Copenhagen, Denmark.</p> <p>OBJECTIVES: To describe a one-year follow-up study of an oral health care programme in special nursing homes for citizens with severe behavioural disorders. METHODS: An oral health care programme for residents (n = 264) at special nursing homes, which included an initial oral examination, subsequent dental treatment based on the principles of realistic treatment need and visits by a hygienist every three months, was evaluated one year after implementation. RESULTS: The follow-up data revealed a significant decrease in the mean number of teeth with primary decay and periodontal treatment need. Also less calculus and visible</p>

PART 2: "Health Promotion, Lifestyle, Wellness, Empowerment"

	<p>plaque were present. Regarding denture related conditions, a decrease was found in the presence of traumatic ulcers, denture stomatitis and the need for prosthodontic treatment. Finally, an improvement in denture hygiene was observed. A high rate of participation in the programme was obtained. CONCLUSION: Professional dental intervention has an effect on oral health indicators even when introduced to rather unapproachable recipients of dental care services.</p>
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PART 3: "Smoking"

- 1 -	
Title	Smoking Cessation Treatment for Patients With Schizophrenia
Reference	Addington J et al., Am J Psychiatry, 155:7, 1998, 974 – 978

- 2 -	
Title	Tabakabhängigkeit und Raucherentwöhnung bei psychiatrischen Patienten
Reference	Batra A, Fortschr Neurol Psychiat, 68, 2000, 80 – 92

- 3 -	
Title	The acceptability of physical activity programming within a smoking cessation service for individuals with severe mental illness
Reference	Faulkner G, Patient Education and Counseling, 66, 2007, 123 – 126

→ More findings (4 – 19) → see folder "smoking"

- 20 -	
Title	West Surrey Stop Smoking Service (WSSS)
IP Criteria	
Article	Edmonds N, Bremner J. Improving access to stop smoking support for people with mental health problems. Journal of public mental health, 2006;vol 6 (1) pp 10-19.
Country	United Kingdom
Area of use/Application	Community based stop smoking support service provided through primary care services and stop smoking support groups in west surrey (WSSS). The programme was adapted from an existing generic local stop smoking training programme for health professionals accredited by the Royal College of Nursing Level 2
Method	Service evaluation and qualitative study
Reliability	N/A – evaluation and qualitative methods
Validity	N/A – evaluation and qualitative methods
Norm(alization)/Standardization	N/A – evaluation and qualitative methods
Execution time	8 months
Accessibility/Availability	Available in the West Surrey area to mental health service users living in the community
Procurement costs	Not mentioned
Further comments	Results: 10/12 service users who requested the service had quit at four weeks (verified by carbon monoxide reading). The remaining two did not finish the course and did not quit

- 21 -	
Title	FUMO MENO PER STAR MEGLIO”- “LESS SMOKING FOR WELL BEING
IP Criteria	
Area of use/Application	Residential and semi-residential psychiatric patients
Method	Preventive questionnaire on smoking related risk Half an hour sessions with: pulmonary, cardiologist, psychologist Final questionnaire Objectives: reduction of environmental risk (ie fire risk), reduction of risk of smoking related illnesses, reduction of health care costs (specialised examinations, drugs...) From 8 to 10 patient for group
Reliability	Not available
Validity	Not available
Norm(alization)/Standardization	Not available
Execution time	2 months
Accessibility/Availability	ASL1 Impereriese: Mental Health Department IMPERIA Dott.ssa Maccagno m.maccagnoasl1.liguria.it Dott. Fabrizio D'Arienzo f.darienzo@asl1.liguria.it
Procurement costs	No costs (personnel from the public health service)
Further comments	Not studied. Health education procedure by the Health Promotion and Education Unit off the local Health Authority.

PART 4: "Alcohol and Illicit Drug Abuse"

- 1 -	
Title	Alliance Program
IP Criteria	
Country	Austria / Germany
Area of use/Application	Patients with a diagnosis of schizophrenia
Method	Psychoeducation
Reliability	No data available
Validity	No data available
Norm(alization)/Standardization	No data available
Execution time	No data available
Accessibility/Availability	Distributed by Pfizer Company
Procurement costs	Free
Further comments	Developed by psychiatrists on behalf of Pfizer Company

- 2 -	
Title	GOAL – Gesund und Ohne Abhängigkeit Leben (Healthy Life without dependence)
Reference	D'Amelio Roberto, Behrendt B, Wobrock Th. Psychoedukation Schizophrenie und Sucht. Manual zur Leitung von Patienten- und Angehörigengruppen.
Study characteristics	
Country	Germany
Patient population	Patients with schizophrenia or schizoaffective disorder (DSM-IV) and illicit drug abuse.
Method / Intervention	Duration: 5 weeks Topics: <ul style="list-style-type: none"> - Education ("passive learning") (10 sessions) - Skill training (via "role playing") (5 sessions) - Lifestyle (Life without illicit drugs) (5 sessions) - Sport activities: cardio training, work out, strength training (20 sessions)
Results	"significant & effective"
Comments	Personal contact ; training workshops for treatment staff

- 3 -	
Title	Training in dual diagnosis interventions (the COMO Study): Randomised control trial
Reference	Hughes E et al., BMC Psychiatry, 8:12, 2008

PART 5: "IPs for the general population"

Nutrition

- 1 -	
Title	Overweight men's motivations and perceived barriers towards weight loss
Reference	Eur J Clin Nutr. 2007 Apr;61(4):526-31. Epub 2006 Sep 20
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>OBJECTIVE: To explore motivation and perceived barriers towards weight loss among Danish men. DESIGN: The study was of an explorative nature, using qualitative focus group interviews as a method. SETTING: Copenhagen, Denmark. SUBJECTS: Twenty-two overweight men, at the age of 25-44 years and motivated for weight loss, were recruited and distributed into four focus groups. The men were primarily unskilled workers. Overall 13 men participated and each group contained three or four participants. INTERVENTION: The interview guide was partly structured, partly unstructured and the themes of the interviews were motives and perceived barriers towards weight loss. RESULTS: Main barriers for losing weight appeared to be lack of motivation and the perception of the slimming diet. The men had a desire to have a lean appearance and avoid illness, but in all the interviews it appeared that the strongest motive for losing weight was a strong desire to become more effective and a greater asset for one's workplace. Overweight subjects were considered less effective and attractive for the labour market. CONCLUSION: This study indicates that if men from lower socioeconomic backgrounds are to be motivated to weight loss the focus should not be on leanness and good health but rather on increased effectiveness and performance, and the arena should include the working place. Sponsorship: The Royal Veterinary and Agricultural University supplied the necessary equipment and conference rooms.</p>

- 2 -	
Title	How to maintain a healthy body weight
Reference	Int J Vitam Nutr Res. 2006 Jul;76(4):208-15 Astrup A
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Research Department of Human Nutrition, LMC, The Royal Veterinary and Agricultural University, Denmark. ast@kvl.dk</p> <p>The epidemic of both obesity and type 2 diabetes is due to environmental factors, but the individuals developing the conditions possess a strong genetic predisposition. Observational surveys and intervention studies have shown that excess body fatness is the major environmental cause of type 2 diabetes, and that even a minor weight loss can prevent its development in high-risk subjects. Maintenance of a healthy body weight in susceptible individuals requires 45-60 minutes physical activity daily, a fat-reduced diet with plenty of fruit, vegetables, whole grain, and lean meat and dairy products, and moderate consumption of calorie containing beverages. The use of table values to predict the glycemic index of meals is of little--if any--value, and the role of a low-glycemic index diet for body weight control is controversial. The replacement of starchy carbohydrates with protein from lean meat and lean dairy products enhances satiety, and facilitate weight control. It is possible that dairy calcium also promotes weight loss, although the mechanism of action remains unclear. A weight loss of 5-10% can be induced in almost all obese patients providing treatment is offered by a professional team consisting of a physician and dietitians or nurses trained to focus on weight loss and maintenance. Whereas increasing daily physical activity and regular exercise does not significantly effect the rate of weight loss in the induction phase, it plays an important role in the weight maintenance phase due to an impact on daily energy expenditure and also to a direct enhancement of insulin sensitivity.</p>

- 3 -	
Title	Short-term effects on bone turnover of replacing milk with cola beverages: a 10-day interventional study in young men
Reference	Osteoporos Int. 2005 Dec; 16(12):1803-8. Epub 2005 May 11
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>In the Western world, increased consumption of carbonated soft drinks combined with a decreasing intake of milk may increase the risk of osteoporosis. This study was designed to reflect the trend of replacing milk with carbonated beverages in a group of young men on a low-calcium diet and studies the effects of this replacement on calcium homeostasis and bone turnover. This controlled crossover intervention study included 11 healthy men (22-29 years) who were given a low-calcium basic diet in two 10-day intervention periods with an intervening 10-day washout. During one period, they drank 2.5 l of Coca Cola per day and during the other period 2.5 l of semi-skimmed milk. Serum concentrations of calcium, phosphate, 25-hydroxycholecalciferol, 1,25-dihydroxycholecalciferol (1,25(OH)2D), osteocalcin, bone-specific alkaline phosphatase (B-ALP) and cross-linked C-telopeptides (CTX), plasma intact parathyroid hormone (PTH) and urinary cross-linked N-telopeptides (NTX) were determined at baseline and endpoint of each intervention period. An increase in serum phosphate ($P<0.001$), 1,25(OH)2D ($P<0.001$), PTH ($P=0.046$) and osteocalcin ($P<0.001$) was observed in the cola period compared to the milk period. Also, bone resorption was significantly increased following the cola period, seen as increased serum CTX ($P<0.001$) and urinary NTX ($P<0.001$) compared to the milk period. No changes were observed in serum concentrations of calcium or B-ALP. This study demonstrates that over a 10-day period high intake of cola with a low-calcium diet induces increased bone turnover compared to a high intake of milk with a low-calcium diet. Thus, the trend towards a replacement of milk with cola and other soft drinks, which results in a low calcium intake, may negatively affect bone health as indicated by this short-term study.</p>

- 4 -	
Title	Effect of healthy school meal on selection of blood parameters
Reference	Horn PB, Brandslund I, Schmedes A, Thygesen K, Hey H. Klinisk Biokemisk Afdeling, Vejle Sygehus, DK-7100 Vejle. Peer.Horn@vgs.regionsyddanmark.dk
IP Criteria	
Area of use/Application	Block-randomized, controlled trial in which 145 pupils delivered blood before (week 39) and after the intervention (week 49)
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	The intervention group showed significant alterations in TSH, CA, HB, COBA and CREA values from the start to the end of the intervention period compared with the control group. The results should be confirmed in a study with more participants over a longer period of time. The teenagers in the study did not have sufficient vitamin D. Treating adolescents with a daily dose of vitamin D should be considered

Physical Exercise

- 5 -	
Title	Exercise on prescription: a randomized study on the effect of counseling vs counseling and supervised exercise
Reference	Scand J Med Sci Sports. 2008 Jun; 18(3): 288-97
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Sørensen JB, Kragstrup J, Skovgaard T, Puggaard L.</p> <p>Centre of Applied and Clinical Exercise Sciences, Institute of Sports Science and Clinical Biomechanics, University of Southern Denmark, Odense M, Denmark. jbs@aarhus.dk</p> <p>The aim of this study was to compare short- (0-4 months) and long-term (0-10 months) effects of high-intensive Exercise on Prescription (EoP) intervention (counseling and supervised exercise) implemented in primary healthcare in a number of Danish counties with a low-intensive intervention (counseling) using maximal oxygen uptake (VO₂max) as the primary outcome. The study was conducted as a randomized trial in 2005-2006 with a high and a low-intensive group. All the patients referred to the EoP scheme by their GP in the counties of Vejle and Ribe, Denmark, were eligible for the trial. The high-intensive EoP group received 4 months of group-based supervised training and attended five motivational counseling sessions. The low-intensive group only attended four motivational counseling sessions. Three hundred and twenty-seven patients entered the EoP scheme, and 52 (16%) volunteered for the randomized trial. No short- or long-term differences were found between the high and the low-intensive groups for VO₂max (short-term 95% CI -1.1; 4.4 mL O₂/(kg min), long-term 95% CI -1.6 to 2.1). The present study did not demonstrate any significant clinical outcome for the high-intensive EoP intervention as opposed to the low-intensive intervention.</p>

- 6 -	
Title	Associations between overall physical activity level and cardiovascular risk factors in an adult population.
Reference	Eur J Epidemiol. 2007; 22(6):369-78. Epub 2007 Feb 28
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Aadahl M, Kjaer M, Jørgensen T. Research Centre for Prevention and Health, Glostrup University Hospital, Ndr Ringvej 57, Building 84/85, 2600, Glostrup, Denmark. metaad01@glostruphosp.kbhamt.dk</p> <p>BACKGROUND: It is well established that physical activity level is inversely associated with cardiovascular morbidity and mortality, and with all-cause mortality. However, the dose-response relationship between physical activity and other cardiovascular disease risk factors is not fully understood. The aim of the present study was to explore the dose-response relationship between daily physical activity, as measured by a metabolic equivalent score, and BMI, waist circumference, waist hip ratio, total cholesterol, HDL, LDL, triglycerides, systolic and diastolic blood pressure. METHODS: A total of 1693 men and women, 33-64 years of age, from the 3 year follow-up of a population-based intervention study, were included in this cross-sectional study. Information on physical activity and other lifestyle factors was obtained by self-report questionnaire. Associations between activity level and biological variables were explored by general linear regression. RESULTS: Data from 835 (51%) men and 805 (49%) women were included. Mean age was 50.8 years (33-64). A significant inverse association between average 24-hour physical activity level ≤ 45 METs and waist circumference (men $p = 0.012$, women $p = 0.011$), BMI ($p = 0.0004$), waist-hip-ratio ($p = 0.002$) and triglycerides ($p = 0.0001$) was found as well as a positive association with HDL ($p = <0.0001$). In those with an activity level above 45 METs there were no associations. No association was found with total cholesterol, LDL, systolic or diastolic blood pressure. CONCLUSION: This study suggests a linear dose-response relationship between activity level and certain biological cardiovascular risk factors up to a threshold of a daily 24 h MET-score of 45, which corresponds to a moderate physical activity level.</p>

Oral Health

- 7 -	
Title	A one-year follow-up of an oral health care programme for residents with severe behavioural disorders at special nursing homes in Denmark
Reference	Community Dent Health. 1998 Jun;15(2):88-92
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Vigild M, Brinck JJ, Hede B.</p> <p>Department of Community Dentistry, Faculty of Health Sciences, University of Copenhagen, Denmark.</p> <p>OBJECTIVES: To describe a one-year follow-up study of an oral health care programme in special nursing homes for citizens with severe behavioural disorders. METHODS: An oral health care programme for residents (n = 264) at special nursing homes, which included an initial oral examination, subsequent dental treatment based on the principles of realistic treatment need and visits by a hygienist every three months, was evaluated one year after implementation. RESULTS: The follow-up data revealed a significant decrease in the mean number of teeth with primary decay and periodontal treatment need. Also less calculus and visible plaque were present. Regarding denture related conditions, a decrease was found in the presence of traumatic ulcers, denture stomatitis and the need for prosthodontic treatment. Finally, an improvement in denture hygiene was observed. A high rate of participation in the programme was obtained. CONCLUSION: Professional dental intervention has an effect on oral health indicators even when introduced to rather unapproachable recipients of dental care services.</p>

- 8 -	
Title	Lack of compliance of staff in an intervention study with focus on nutrition, exercise and oral care among old (65+ yrs) Danish nursing home residents
Reference	Aging Clin Exp Res. 2009 Apr;21(2):143-9
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	Lack of compliance by staff rather than residents seemed to be the main problem. In order to improve compliance in future studies, more focus should be put on the effect of practical implementation on staff. Insight into these matters may give valuable information to counteract staff problems, facilitate implementation in long term, and hence improve the benefits of nutrition interventions.

Smoking Cessation

- 9 -	
Title	High risk strategy in smoking cessation is feasible on a population-based level. The Inter99 study
Reference	Prev Med. 2008 Jun;46(6):579-84. Epub 2008 Mar 10
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Pisinger C, Glümer C, Toft U, von Huth Smith L, Aadahl M, Borch-Johnsen K, Jørgensen T.</p> <p>Research Centre for Prevention and Health, The Capital Region of Denmark, Denmark. chpi@glo.regionH.dk</p> <p>INTRODUCTION: A high risk strategy is one of more strategies in public health. Smoking remains the most important contributor to the burden of disease in developed countries. METHODS: A population-based multi-factorial intervention study, Inter99 (1999-2006), Copenhagen, Denmark, using a high risk strategy. All 2408 daily smokers were repeatedly offered individual face-to-face lifestyle counselling. Smokers in the high-intensity group were offered participation in smoking cessation groups. We measured point abstinence at 1, 3 and 5-year follow-up and compared with a control group, using adjusted intention-to treat analyses. RESULTS: Compared with the control group it was twice as likely to be self-reported abstinent at 5-year follow-up in the high-intensity intervention group (OR: 2.19; 95%CI: 1.7-2.8; $p<0.001$). The effect of the intervention was significant, even when comparing validated abstinence in the intervention groups with self-reported abstinence in the control group (OR: 1.38; 95%CI: 1.1-1.8; $p=0.014$). Male gender, vocational training, higher age at onset of smoking, high knowledge of harm of smoking and lower tobacco consumption predicted abstinence. CONCLUSION: A high risk strategy showed a significant effect on smoking in the long term. Proactive recruitment, face-to-face setting, repeated offer of assistance to quit and a multi-factorial approach may explain the success of the intervention.</p>

- 10 -	
Title	Acceptance of the smoking cessation intervention in a large population-based study: the Inter99 study.
Reference	Scand J Public Health. 2005;33(2):138-45
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Pisinger C, Vestbo J, Borch-Johnsen K, Thomsen T, Jørgensen T. Research Centre for Prevention and Health, Nordre Ringvej, Glostrup University Hospital, Glostrup, Denmark. chpi@glostruphosp.kbhamt.dk</p> <p>AIMS: Potential exists for improving the impact of quit-smoking programmes, by recruiting smokers in early motivational stages, by using active recruitment strategies, and by offering professional assistance to quit. METHODS: This was a randomized population-based intervention study, in Copenhagen, Denmark. A total of 2,408 daily smokers in all motivational stages were included. All participants completed a questionnaire, and underwent a health examination and a lifestyle consultation. Smokers in the high-intensity intervention were offered assistance to quit smoking in smoking cessation groups. RESULTS: Before the lifestyle consultation only 11% of the smokers stated that they planned to quit within one month. After the lifestyle consultation 27% accepted smoking cessation in groups and an additional 12% planned to quit without assistance. Of the smokers who accepted smoking cessation groups 23% had not been planning to quit before the lifestyle consultation. Being a woman, having high tobacco consumption, having a long smoking history, having tried to quit within the previous year, and having a higher motivation to quit predicted participation in smoking cessation groups. CONCLUSIONS: It was possible to recruit a large number of smokers in early motivational stages by using active recruitment strategies and by offering assistance to quit. Lifestyle consultations markedly increased the number of smokers willing to try to quit. Smokers preferred assistance to quit in a smoking cessation group to quitting on their own; therefore, it is important to improve recruitment strategies for smoking cessation programmes.</p>

- 11 -	
Title	Essential communication skills in individual smoking cessation
Reference	Chron Respir Dis. 2004;1(4):221-7
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Tønnesen P.</p> <p>Department of Pulmonary Medicine, Gentofte University Hospital, Hellerup, Copenhagen, Denmark. philipt@dadlnet.dk</p> <p>When dealing with smokers it is important to realize that nicotine addiction plays a major role. Minimal clinic smoking cessation advice by a physician is a powerful motivation to quit and even short intervention (<3 minutes) is effective especially when repeated. There is a dose-response relationship between the number and duration of sessions and quit rate. The optimum programme contains 4-5 sessions of 10-15 minutes duration during the first six weeks after quit day. It is essential that smokers select a target quit day and stop smoking completely on that day as even a few cigarettes per day in the first weeks are strongly related to relapse. Administration of nicotine replacement products or bupropion may double success rates. The communication with smokers should be emphatic and adjusted to the level of change. Barriers to successful smoking cessation and structured interventions are described. The use of the five As to motivated smokers and the five Rs to smokers not ready to quit is recommended. Telephone and written material may supplement clinic visits in the follow-up period.</p>

Alcohol and Illicit drug prevention
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- 12 -	
Title	Screening and brief intervention targeting risky drinkers in Danish general practice--a pragmatic controlled trial.
Reference	Alcohol Alcohol. 2007 Nov-Dec; 42(6):593-603. Epub 2007 Sep 11
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Research Unit and Department for General Practice, University of Copenhagen, Centre for Health and Community, Oster Farimagsgade 5, DK-1014 Copenhagen K, Denmark. ab@gpract.ku.dk</p> <p>AIMS: Recommendations for routine alcohol screening and brief counselling intervention in primary health care rest on results from intervention efficacy studies. By conducting a pragmatic controlled trial (PCT), we aimed at evaluating the effectiveness of the WHO recommendations for screening and brief intervention (SBI) in general practice. METHODS: A randomized PCT (brief counselling intervention vs no intervention) involving 39 Danish general practitioners (GPs). Systematic screening of 6897 adults led to inclusion of 906 risky drinkers, and research follow-up on 537 of these after 12-14 months. Outcome measures focused on patients' acceptance of screening and intervention and their self-reported alcohol consumption. RESULTS: Patient acceptance of screening and intervention -10.3% (N = 794) of the target population (N = 7,691) explicitly refused screening. All intervention group subjects (N = 442) were exposed to an instant brief counselling session while only 17.9% of them (79/442) attended a follow-up consultation that was offered by their GP. Consumption Changes At one-year follow-up, average weekly consumption had increased by 0.7 drinks in both comparison groups. As secondary findings, we observed an indiscriminate absolute risk reduction (ARR = 0.08 (95% CI: -0.02; 0.18)) in male binge drinking, but adverse intervention effects for women on the secondary outcomes (binge drinking ARR = -0.30 (95% CI: -0.47; -0.09)). CONCLUSIONS: The results of brief interventions in everyday general practice performed on the basis of systematic questionnaire screening may fall short of theoretical expectations. When applied to non-selected groups in everyday general practice SBI may have little effect and engender diverse outcome. Women may be more susceptible to defensive reactions than men.</p>

- 13 -	
Title	Personality-guided treatment for alcohol dependence: a quasi-randomized experiment.
Reference	Am J Addict. 2007 Sep-Oct; 16(5):357-64
IP Criteria	
Area of use/Application	
Method	
Reliability	
Validity	
Norm(alization)/Standardization	
Execution time	
Accessibility/Availability	
Procurement costs	
Further comments	<p>Nielsen P, Røjskjaer S, Hesse M. Centre for Treatment of Addictive Behaviors, Middelfart, Denmark. Personality disorders are highly prevalent among alcohol-dependent populations and result in a seriously elevated risk for non-responding to treatment; therefore, they represent a major challenge for professionals providing treatment for alcohol dependence. Personality-guided Treatment for Alcohol Dependence (PETAD), an approach that integrates cognitive therapy for addictive behaviors with strategic intervention for maladaptive personality features, may be helpful for patients with co-morbid alcohol dependence and personality disorders. Clients admitted for inpatient treatment for alcohol dependence at Ringgaarden, Denmark (n = 108) were allocated to either standard inpatient treatment with cognitive therapy for alcohol dependence, or PETAD. Both treatments were manualized. Clients were followed up by mail at six months post-treatment and administered the MCMI-I and II and the SCL-90 at intake, post-treatment, and at follow-up. PETAD was associated with better retention, longer time to first relapse, and less time spent drinking post-treatment, although few differences reached statistical significance. Differences in results were mainly found in the subgroup with higher levels of PD. The study suggests that PETAD is a promising approach that warrants further study.</p>



HELPS TOOLKIT FEEDBACK QUESTIONNAIRE

HELPS TOOLKIT FEEDBACK QUESTIONNAIRE

As part of our commitment to improving the HELPS toolkit and service we provide, we give the users of the HELPS toolkit this feedback questionnaire. We would be grateful if you could help us by completing this form and returning it in the enclosed envelop (you do not need a stamp). Please be assured that the survey is completely confidential and unless you complete your details at the end, we will not know who has taken part.

Please fill out the following to help us in continuing to improve the HELPS toolkit.

Many thanks!

The HELPS Network

Name of the facility: _____
Intervention from: _____ to _____
Diagnosis/patients: _____
Profession(s)/staff(s): _____
Number of participants: _____

Please ...	Excited	Interested	Neutral	Not interested	Awful
give us a sense of interest in the HELPS toolkit					
rate the quality of the toolkit					
rate the usefulness of the information in the toolkit to you					
rate the manageability of the information in the toolkit to you					
rate the practicability of the information in the toolkit to you					

ACCEPTABILITY			
	YES	UNDECIDED	NO
I am satisfied with the HELPS toolkit			
I have the intention to continue use			
The toolkit fits within the organizational culture of the facility			

CONTENT			
	YES	UNDECIDED	NO
The content of the HELPS toolkit was interesting			
There was too much in this toolkit I couldn't use			
It is highly relevant for our facility to undertake this toolkit			
The toolkit directly addresses the needs of our patients			
The toolkit directly addresses the aims of the staff			
The toolkit directly addresses the aims of our facility			

DELIVERY / PRACTICALITY			
	YES	UNDECIDED	NO
I found the toolkit easy to follow			
The delivery of this programme was well organised			
There were enough means and resources to carry out the toolkit			
The toolkit is suitable for patients with severe mental illness			

SOURCE MATERIAL			
	YES	UNDECIDED	NO
I found the instruction useful			
The information was clearly presented			
The paper version is useable			
The electronic version is useable			

EFFECTIVENESS			
	YES	UNDECIDED	NO
The intervention had positive effect on patients' physical health			
The intervention had positive effect on patients' well-being			
The intervention had positive effect on patients' health behaviour			
The intervention had negative effect on patients' physical health			
The intervention had negative effect on patients' well-being			
The intervention had negative effect on patients' health behaviour			

Which intervention measure(s) did you use?

How satisfied were you with overall level of the HELPS toolkit? If dissatisfied, please tell us why this is.

Which elements of the toolkit could be improved to make them more appropriate to your needs? Please suggest improvements where possible.

What factors facilitate or hinder the implementation of the HELPS toolkit? (e.g., perceived fit with workflow, perceived sustainability, costs to organization bodies)

Please describe short the effects the “HELPS toolkit” had (a) in general on the patients, (b) on patients’ physical health, (c) on patients’ subjective well-being, and (d) on patients’ lifestyle.

Do you think the toolkit empowers patients to change behaviour for improving their physical and psychological health?

Many thanks for your support!

The HELPS Network



THE HELPS NETWORK

The HELPS Network

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