Psychosocial Diabetes Care

A Manual for Group-Based Intervention

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Authored by:

Brigitte Sabourin, B.A., MBA   • Shannon Pursley, PhD   • Nicolle Vincent, MSc
Clinical Psychology Candidate   *Clinical Psychologist*   *Clinical Psychology Student*

and T. Michael Vallis, PhD
Clinical Psychologist

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INTRODUCTION

The nature of illnesses and their effects on morbidity and mortality have changed significantly within the past century. Over the past 50 years, the incidence of chronic disease has increased substantially (Booth, Gordon, Carlson, & Hamilton, 2000). The cause of this increase is multi-faceted and includes increased life expectancy, changes in agricultural production and food processing, and increases in urbanization that have created living environments that rely less on physical labour while promoting sedentary behaviour (Lake & Townshend, 2006; Siedell, 2000). One of the most prevalent and significant chronic diseases of our time is diabetes. Diabetes is a worldwide epidemic with prevalence rates of type 2 diabetes increasing at an exponential rate (Steyn et al., 2004). The increased prevalence of diabetes is attributable in large part to increases in obesity rates and sedentary lifestyles as well as to an aging population (Canadian Diabetes Association, 2013). There are an estimated **285 million people** worldwide that are affected by diabetes, and this number is expected to increase to 438 million by 2030 (Canadian Diabetes Association, 2013). In Canada, there are currently 9 million people living with diabetes and prediabetes (Canadian Diabetes Association, 2013). The prevalence, personal and economical costs and burden, and the increased risk of morbidity and mortality make diabetes one of the largest health care problems in Canada (Canadian Diabetes Association, 2013; Lipscomb & Hux, 2007).

Diabetes Management is Largely Behavioural

Although a physiological disease, the *management* of diabetes is largely behavioural (Glasgow et al., 1999). In fact, diabetes has been referred to as the most behaviourally demanding of the chronic illnesses (McGrady, 2007). Health care providers (HCPs) have a role to play in providing education and recommendations for diabetes management but the onus of management falls on the person living with diabetes. There are many aspects to managing diabetes, including glycemic monitoring, regular physical activity, healthy eating, weight management, and, in many cases, medication and/or insulin injections for glycemic control (Canadian Diabetes Association, 2008).

Self-management is much more complicated than HCPs providing their best advice and patients following through. Each person living with diabetes is unique and many factors can influence the relationship between recommendations and behaviour. Ultimately, self-management consists of countless daily choices made by the person living with diabetes (Lorig et al., 2012). One can choose to actively manage, to avoid, or do very little about management (Lorig et al., 2012). For each person, choices vary overtime and across different behaviours. The role of HCPs is not to judge these choices, but to seek to understand the reasoning behind them (see Chapter 2 on Motivational Interviewing Principles). To draw out the reasons and meaning behind an individual patient's choices, it is important that HCPs ask the right questions. It is not simply about asking "Do you want to take care of your diabetes?", as the majority of people want to be healthy (Meichenbaum & Turk, 1987). It is more about asking "*Why* do you want to take care of your diabetes?", "How hard are you willing to work (for those reasons)?" and "What gets in the way of you being able to manage

your diabetes?". Exploring individuals' motivation, their readiness and commitment for the challenges of self-management, and their barriers for change helps HCPs better support patients in their choices about self-management. Strategies to explore these choices are described in more detail throughout the manual.

Exploring a patient's motivation, health beliefs, and other factors that influence one's choices about self-management is particularly important for diabetes (or any other chronic disease) management. Self-management is life-long and it is important to foster health behaviours that are sustainable for the long-haul. The challenge is that humans tend to be creatures of habit, and it takes a long time to develop new habits. This means that making a behavior change can be easy in the short-term but change is typically very hard to maintain in the long-term as individuals tend to fall back into old habits quite easily (Orleans, 2000). Adherence rates to diabetes self-management behaviours are low (Deakin, McShane, Cade, et al., 2005; Nelson, Reiber, & Boyko, 2002). Imparting knowledge to patients is important but often not enough for adherence. Many patients experience diabetes self-management as a burden and struggle to balance and adhere to the many aspects of self-management over time.

The Biopsychosocial Approach to Diabetes Management

This manual adopts a biopsychosocial approach to diabetes management. This approach is derived from the biopsychosocial model, which is a conceptual framework that emphasizes the contribution of psychological, social, and cultural factors in combination with biological influences on disease determinants, symptoms, and treatments (Suls, Davidson & Kaplan, 2010). The biopsychosocial approach provides a framework for understanding the influence of psychosocial factors on diabetes management.

Psychosocial issues present a major impediment to diabetes care (Funnell, 2006). In the DAWN (Diabetes Attitudes, Wishes, and Needs) study, a cross-sectional international survey of 5104 patients with diabetes and 3827 physicians and nurses, numerous psychosocial issues and barriers to diabetes care were identified. A large number of patients (i.e., 41%) reported poor psychological well-being. Diabetes-related worries were common among patients and many patients reported experiencing emotional stress related to their diabetes (Funnell, 2006). It makes sense that most persons living with diabetes experience emotional distress related to their disease. Diabetes management is demanding and requires diligent monitoring of health status as well as strict adherence to behavioural regimens around diet, exercise, self-monitoring of blood glucose, taking medication, and administering insulin. These are challenging tasks for anyone, particularly in the context of making lifestyle changes in response to a disease as opposed to making a lifestyle change based on one's own volition. Even for persons inclined towards making healthy choices, adherence to a healthy lifestyle is challenging in our current environment. Our industrialized societies encourage increasingly sedentary behaviour, and changes to food production and accessibility have rendered processed, caloric-dense, and nutritionally sparse foods normative and more readily available (Lake & Townshend, 2006; Siedell, 2000). Although our environments have changed markedly in the past century, humans have not evolved at the same rate. Our brains remain programmed for survival in conditions of scarce food accessibility. As such, we are driven to conserve energy (i.e., take the path of least resistance) and to prefer immediate benefits over long-term gains (i.e., what is most desirable in this moment regardless of the long-term

consequences). For safety and survival, we are motivated to prefer pleasure and avoid pain. These principles become very relevant for understanding the challenge of health behaviour choices: foods that are high in salt, sugar, and fat activate the reward centres in our brain and bring us pleasure. In contrast, physical activity represents a drain on our energy and the potential for increased fatigue and pain in the short-term (despite being beneficial in the long-term; Vallis, 2001).

It is therefore essential to recognize and address the influence of psychosocial factors in diabetes management. Psychosocial issues include the influence of the above-described psychological principles (e.g., pleasure principle; Vallis, 2001), symptoms of psychological distress (e.g., emotional stress, anxiety, depression, etc.), social and family considerations, relationship issues, and cultural influences on both the micro and macro level.

Psychological Distress and Diabetes

Individuals living with diabetes are more likely to experience depression and anxiety than individuals in the general population (Anderson, Freedland, Clouse, & Lustman, 2001; Egede, Zhen, & Simpson, 2002; Gribsgy et al., 2002). These emotional difficulties compromise optimal self-management behaviours (Fisher & Glasgow, 2007; Glasgow et al., 1999; Vallis, 2001). Even for individuals who do not meet diagnosis for clinical depression or an anxiety disorder, emotional distress, and especially distress over diabetes management, can affect the body physiologically (Lehrer, Woolfolk, & Sime, 1992) and impede one's ability to engage in health behaviours (Peyrot et al., 2005; Sultan & Heurtier-Hartemann, 2001; Survit, Schneider, & Feinglos, 1992). Conversely, positive changes in diabetes-specific perceptions are associated with increased commitment to diabetes management (Malemute et al., 2011).

A key finding of the DAWN study was the recognition from both patients and providers of the importance of psychosocial factors on diabetes care. Providers reported that most patients had psychological problems that affected diabetes self-care, yet providers reported often not having adequate resources to manage these problems. Despite the degree of reported psychological difficulties, few patients (i.e., 10%) reported receiving psychological treatment (Funnell, 2006). The DAWN study has contributed to a growing body of literature and recognition of the need for psychological resources as a part of standard diabetes care. This manual devotes two full sessions on strategies to help manage difficult emotions such as stress, anxiety, and sadness. Pilot-testing of the manual has shown a decrease in diabetes-related distress (Sabourin, Vallis, & Currie, 2011) following the six session intervention.

Attention to Psychosocial Influences as part of the Canadian Diabetes Association Clinical Practice Guidelines

The Canadian Diabetes Association (CDA) clinical practice guidelines (2008) emphasize the importance of addressing psychosocial influences such as motivation and coping skills, as these have a significant influence on patient goals and behavioural outcomes in diabetes (Canadian Diabetes Association, 2008). The guidelines emphasize the importance of Self-Management Education (SME) for all persons diagnosed with diabetes, and purport that SME should include individualized education, skills training, and cognitive behavioural strategies such as goal-setting, problem solving and self-monitoring to promote self-care

behaviours (Canadian Diabetes Association, 2008; Funnell & Anderson, 2002). Most available programs in Canada contain these core components and tend to be prescriptive (i.e., covering essential information and providing directives to patients). The challenge for patients becomes adopting these recommendations. As described above, knowledge is not enough to guarantee adherence. The CDA guidelines (2008) recognize this disparity and recommend that SME include appropriate psychological support. While recognition of psychosocial influences is important, there are often a lack of resources to address these issues and many HCPs are unsure of how to address this important aspect of diabetes self-management.

Goals, Contents, and Structure of this Treatment Manual

This treatment manual has a few key goals:

a. To help HCPs working in diabetes care better understand and address why patients might not adhere to their diabetes management regimen. This includes exploring and understanding psychosocial factors that influence diabetes self-management.

b. To utilize theory-driven and evidence-based interventions from the psychological literature to inform the development of a psychosocial program that is accessible for HCPs from a variety of disciplines. The program draws on principles of cognitive behaviour therapy, motivational interviewing (see Miller & Rollnick, 2002, the transtheoretical model of change (see Prochaska, Redding, & Evers, 2008), and relapse prevention (see Marlatt & Donovan, 2005)

c. To create a program that is client-driven and supports the development of self-management skills that promote behaviour change and adherence over the long-run. The client-driven approach is consistent with the philosophy behind motivational interviewing (described further in Chapter 2), which emphasizes a non-judgmental approach and meeting and working with clients where they are.

The manual's six sessions deal with the following topics that can significantly impact diabetes self-management:

a. Readiness and Motivation in Diabetes Self-Management
b. Goal Setting
c. Stress Management
d. Emotional Management
e. Emotional Eating
f. Relapse Prevention

Each chapter contains the following information for facilitators:

a. Goals for the session
b. Content for the session (including sample dialogues and helpful hints)
c. Participant handouts for the session
d. Troubleshooting clinical challenges

Who is the treatment described in this manual for?

This program is designed for persons living with diabetes, particularly those who are struggling with self-management. They may be struggling with low motivation, be having difficulty following through on recommendations and/or their best intentions, or feel overwhelmed by the demands of diabetes management. The program is designed to address a variety of factors that affect self-management. The program is also suitable for caregivers or family members of persons living with diabetes who may wish to attend. The content is specific to diabetes self-management behaviours; however the principles are universal to human behaviour.

This program might not be sufficient or appropriate for individuals who are experiencing serious mental illness and/or emotional difficulties at a level that is significantly impacting their functioning. Such individuals would likely benefit from more intensive treatment from an appropriate mental health professional prior to considering participation the enclosed program.

Who should provide the intervention?

This program is designed to be delivered by any health care practitioner working in diabetes care. It is not necessary for facilitators to have a background or any formal training in mental health.

This manual is not meant to provide formal education about diabetes or associated treatment regimens. Rather, the manual is meant to provide education about psychosocial issues that may affect optimal diabetes self-care. The manual also provides empirically-based tools to support diabetes self-management. These tools are designed to help address common psychosocial issues that may impede optimal self-management. The manual is designed to be hands-on and practical and walks facilitators through the provision of tools and "tricks" to best support persons in their self-management.

Group Intervention

The intervention described in this manual has been developed as a structured, time-limited, closed group. A closed group refers to a group where participants sign up and participate in all six sessions. It is recommended that a participant who does not attend one of the first two sessions wait until the next available group rather than begin the group in the third session.

The manual's intervention is designed to focus on both content and process. Content refers to "what" happens in the group, or the material presented in group, whereas process refers to "how" things happen in group. Examples of group processes include how group members react to each other and to the facilitators, how much discussion occurs, any potential conflict between members, and cohesiveness between members. Group cohesiveness is believed to be one of the most important factors in determining the extent to which members benefit from group interventions (Davis, Budman, & Soldz, 2000). Thus, in addition to delivering content, two important functions of facilitators are to encourage group cohesiveness, and to keep groups on track with discussion.

There are suggestions throughout the manual about various ways to increase group cohesiveness. Briefly, facilitators want to give all interested participants opportunities to actively engage in the group and share their experiences. Thus, if one or a few members are dominating the conversation, facilitators may want to encourage them to let others participate with statements such as "We have enjoyed what you have had to share with other group members thus far. We want to make sure that everyone has a chance to share". If one or a few members do not appear to be participating, facilitators may encourage them to participate with statements such as "We haven't heard from ('Michael' or 'this side of the room') for a while. Is there anything that you would like to add or share about ('X') topic or about your experiences?" In order to keep groups from going off track, facilitators want to be aware of when the group is on tangents and be comfortable re-directing the group to the topics being discussed. Facilitators interested in learning more about group processes are invited to read *The Theory and Practice of Group Psychotherapy, 5th Edition* by Irvin Yalom (2005).

Timing of Groups

Groups can take place weekly, or be staggered to every two weeks. Holding weekly groups can help maintain momentum and can make it easier for participants to remember session content as well as when the group will be held (e.g., every Tuesday at 10:00am). On the other hand, staggering groups to be held every second week might give participants greater opportunities to implement some of the changes discussed in group, and deal with psychosocial issues in real time as the group progresses. There is no clear advantage to holding sessions weekly or every two weeks. Facilitators are encouraged to offer groups at a frequency that best suits their clinic schedule and patient needs.

In addition to the core six group sessions, booster sessions either a few weeks or a few months after the intervention might be a welcome refresher for participants. In order to help increase attendance at booster sessions, facilitators might want to host one booster session open to any participant who has previously attended any of the closed groups offered, regardless of which specific group they have attended. Booster sessions can be more informal, with facilitators refreshing participants on topics that were discussed during the six-session intervention, and leaving ample room for group discussion. Some potential topics that might be of interest include: tips and challenges for maintaining behaviour change once group is finished, further discussion on emotional eating, lapses and relapses, challenges participants have encountered since finishing group, and strategies participants have used that have been helpful. Considerations on timing of groups and the addition of refresher or booster sessions can be determined at facilitators' discretion and depending on resources and logistical realities.

A Few Principles of Motivational Interviewing to Help Facilitators Get Started

It is not the role of the facilitator to motivate participants to make changes. Rather, by using some of the principles and practices of motivational interviewing, facilitators can better understand and augment participants' own reasons for change. The following information was derived from Miller and Rollnick's work on Motivational Interviewing. The principles are briefly mentioned below and incorporated throughout the manual. Facilitators interested

in learning more about Motivational Interviewing are encouraged to read *Motivational Interviewing: Preparing People for Change, 2nd edition* by Miller & Rollnick, (2002).

1. *Express empathy*

   Diabetes self-management, and adapting and maintaining healthy behaviours are difficult tasks. Many individuals struggle with the many behavioural changes associated with diabetes self-management, resulting in feelings of failure and low self-confidence with respect to their ability to maintain these changes. Facilitators can support participants by openly acknowledging and normalizing that optimal diabetes self-care is challenging and, in fact, not the norm. Through reflective listening (e.g., clarifying and restating what the participant says) facilitators seek to understand participants' feelings and perspectives without judging, criticizing, or blaming.

2. *Take a curious, non-judgmental stance*

   Facilitators can show that they are interested in participants' reasons for their behaviour, while suspending judgment. Facilitators want to convey an "I want to understand why you do what you do" tone, rather than a "Why do you behave this way?" or "I don't understand why you do what you do" tone. The latter two statements can be interpreted by participants as judgmental or as in fact saying, in other words, "I don't think you should be doing what you do". Individuals usually have good reasons for their behaviours. That is, there are usually benefits to unhealthy behaviours. By trying to understand these reasons and suspending judgment, facilitators take the first step to a helpful examination of the functions of certain behaviours, so that participants can learn other ways to fulfill these functions.

3. *Learn to sit with ambivalence*

   Ambivalence towards health behaviours refers to having competing interests and values for and against engaging in any particular health behaviour. For example, a person who generally enjoys running outdoors might feel ambivalent about running on a rainy day because of their competing interest to stay warm and dry. Most individuals experience ambivalence about health behaviours (e.g., even Olympic athletes have days when they don't feel like training). Listening to and exploring ambivalence is more likely to be helpful in enhancing participants' motivation than trying to fix or convince participants to engage in the behaviour regardless of their ambivalence.

4. *Ask questions and minimize statements or advice.*

   When facilitators make statements aimed at encouraging adherence to health behaviours, these can paradoxically lead to resistance on the part of participants. Alternatively, asking open-ended questions and engaging in reflective listening conveys an attitude of non-judgment and demonstrates an interest in trying to understand the participant. Open-ended questions such as "What worries you about what you are currently eating?", or "How important is changing your eating to you?"

encourages participants to speak of the disadvantages of staying the same and of some of their intentions of changing. These types of questions can have a much stronger impact than simply telling patients why they need to change their diets.

5. *Avoid argument*

It can be difficult for facilitators to disregard what they want for participants, and instead let participants take responsibility for their own health behaviours. However, when facilitators try to convince participants of the importance of engaging in healthy behaviours, this might elicit what is called "resistance talk". Resistance talk occurs when participants defend their current health behaviours. Resistance talk sometimes appears in more subtle ways with statements such as "yes but", which usually mean "no, because". When facilitators try to convince participants to engage in new behaviours, and participants defend their current unhealthy behaviours, this can lead to a power struggle between the facilitator and participant. Alternatively, by adhering to the first four principles outlined above, participants are more likely to voice arguments for change, which is called "change talk" and is more likely to lead to change.

6. *Roll with resistance*

It typically takes time and a few unsuccessful attempts to implement new health behaviours. Many participants will run into roadblocks. It can be more helpful to teach participants to use these roadblocks and unsuccessful attempts as learning opportunities rather than to try to fix or solve the problem for participants. The ability to learn from difficulties and challenges is an important skill for participants to acquire, so they can navigate the many other roadblocks they will encounter in their efforts to sustain long-term healthy behaviour choices. Additionally, rolling with resistance conveys respect for the participant. Each participant's behaviours are ultimately that person's individual decision.

7. *Support self-efficacy*

One of the most important determinants of continued behaviour change is self-efficacy, which refers to confidence in one's ability to successfully perform a specific behaviour. It is important to emphasize that self-efficacy is behaviour-specific: an individual may have very high self-efficacy with respect to one behaviour (e.g., increasing daily vegetable servings), but not to another behaviour (e.g., walking at least three times per week). There are specific techniques throughout the manual designed to enhance participants' confidence in their capabilities to overcome obstacles and succeed in change (e.g., supporting minor changes and thereby creating the experience of success; teaching problem-solving skills). Additionally, facilitators can positively influence participants' self-efficacy by genuinely expressing belief in the participants' ability to engage in diabetes self-care behaviours.

8. Shame is toxic to behaviour change

If individuals feel bad about themselves, adopting and maintaining healthy behaviours can become even more challenging. Feeling bad about oneself can lead to beliefs that efforts to be healthy are not worth it, or even that the individual is not worthy of efforts aimed at improving their health. Shame frequently leads to increases in unhealthy behaviours. Facilitators can help foster self-forgiveness and compassion in participants when they slip from optimal self-care behaviours, by expressing empathy and normalizing the challenges associated with optimal self-care. Also, rather than engaging in self-blame and reproach, facilitators can help participants look at slips as learning opportunities (see "Roll with Resistance" above).

Format for Every Session

Given that the group intervention was developed as a structured intervention, each session has a similar overall format consisting of three main parts:
1. Check-in and homework review
2. Current week's content
3. Wrap-up and assignment of homework

A Few Words on Homework

If participants engage in activities and work on their goals between sessions, they have the opportunity to be active over the week and gain more exposure and practice with the concepts presented during sessions. Homework completion has been associated with improved therapy outcome (Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010). That is, the more effort that is put in-between sessions, the more people can benefit from the intervention. Homework compliance is also usually higher in groups than in individual interventions. This may be because of social pressure to complete homework. One tool to increase homework completion is to explain to participants the importance of homework. Also, facilitators can assess participants' willingness to do homework and inquire about potential barriers to homework completion. Using the principles of motivational interviewing described above, facilitators can problem-solve with participants some of the barriers that might get in the way of completing homework.

Facilitation

If possible, it is recommended to have two co-facilitators for the intervention. One facilitator assumes the active role of presenting material and the other attends to nonverbal behaviour and helps to manage group processes. Facilitators can keep the same role throughout the intervention, alternate between sessions or between topics within a session.

One last note about facilitation: It can be difficult to be a health care provider and accept our patients' unhealthy behaviours. It can be helpful to remember that diabetes self-care is the patient's/participant's, and not the facilitator's, responsibility. By managing our own anxiety and feelings of responsibility towards participants, accepting where they are at, and putting the responsibility on them, we are more likely to support them for the long term.

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Readiness and Motivation in Diabetes Self-Management

1

OBJECTIVES

✓ Develop the group alliance and cohesion

✓ Facilitators should help participants to feel understood and validated about their difficulties in adopting self-management practices

✓ Participants will learn that behaviour change is a process

✓ Participants will develop an appreciation for the importance of homework in determining long-term outcome of group participation (i.e., you will only get out of it what you put into it)

✓ Participants should leave session one with a better understanding of the difference between short and long term motivators

✓ Participants will learn that it is important to pay attention to reasons for *not* changing

✓ Participants should leave the first session with a sense of "realistic optimism" about behaviour change

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ICON KEY

☝ Hints for Facilitators

! Troubleshooting

📖 Participant Handout

💬 Sample Dialogue

SESSION OUTLINE

(20 minutes)	Introductions & Group Guidelines
(20 minutes)	Discussion of why Diabetes Self-Care Behaviours are Difficult
(10 minutes)	Introduction to Motivation as a Two-Step Process
(10 minutes)	Readiness to Change
(10 minutes)	Introduction to Decisional Balance as a Motivation Enhancement Tool
(25 minutes)	Completing the Decisional Balance
(10 minutes)	Positive and Personally Relevant Reasons for Change
(15 minutes)	Wrap-up and Assignment of Homework

HANDOUTS

📖 Participants' Handout: 1.1) *Are You Ready to Change?*

1.2) *Maintaining Motivation in Behaviour Change*
(facilitators may want to print two copies of this handout to
allow participants to complete the Decisional Balance exercise
for two separate health behaviours)

SESSION ACTIVITIES

General Note: Facilitators should make the sessions as interactive as possible. The goal is that participants feel they can share their experiences, challenges, successes, and frustrations with the group. Personalizing the training will help participants connect these abstract concepts to their real-life experiences. This engagement at the personal level facilitates motivation to start and maintain coping strategies, and helps create positive outcomes. Therefore, facilitators should beware not to let the sessions become overly didactic.

> **HINT**
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> In order to build group cohesiveness, facilitators should openly acknowledge whenever there seems to be nonverbal agreement to what one participant says. Example comment: *"I see a lot of people nodding their head while Mark is speaking, which says to me that a lot of you are feeling that you find it hard to 'be good' about your eating."*

Introduction and Group Guidelines

1) Facilitators introduce themselves, including their professional background, relevant experience, etc.

2) Group guidelines:

   ○ Confidentiality. Whatever is discussed in group stays in group. Participants are encouraged to share with people close to them what they learn in group and how it applies to them, but not about what each member shares. This is a way to help everyone feel more comfortable to share their thoughts and experiences.

   ○ Respect for each other (i.e., everyone gets a chance to speak). We are all here to help each other out. So we listen to others, and let everyone have a chance to speak.

   ○ Attendance and Homework Completion. First, participants are expected to attend every session if possible, and to arrive on time. Also, if participants are unable to attend a session, make sure that they have facilitators' contact information to let them know that they will not be attending. Second, this is a very time-limited group,

with only 6 sessions - therefore participants will be asked to try things at home. It's important to complete this homework, as it will be discussed in group the following week. In addition, research has shown that homework completion is associated with better treatment outcomes. The more people put into the group, the more they will get out of it.

- o <u>Any additional guidelines</u>. Facilitators can add any additional guidelines they feel to be appropriate and/or involve group members by asking for their input about additional guidelines.

3) Group participants introduce themselves to the group. With respect to an ice-breaker activity, this can be at the discretion of the facilitators (make it something that is compatible with facilitators' personalities). A simple *"Tell us who you are and what brings you here today"*, works well, and it often gives the participants a sense that they are all there because of similar reasons, which helps to build cohesiveness.

4) Facilitators give a brief overview of the overarching goal of the group. Because diabetes self-management is a long haul - and diabetes self-management is very involved...It's been called "the most behaviourally demanding of the chronic illnesses". So the goal of group is to assist participants in optimizing self-management by addressing some of the psychosocial issues that might get in the way of self-care.

> Example explanation

"We've heard from the group and it sounds like most of you find that diabetes self-care is not easy. It is a long haul. It's very demanding and involved. So what we'll be doing in group in the next six weeks is talking a lot about some of the psychosocial issues that arise that might prevent us from doing the health behaviours that we know are important. By psychosocial, I mean examining the psychological principles behind health behaviour, and also the influence of our environment, or the social parts of having diabetes. We'll be talking about how to set appropriate goals, how to stay motivated, manage stress and other difficult emotions, about the role of emotional eating, and also about how to stay on track after the group is done. How does this sound to you? Are there any questions?"

Discussion of why diabetes self-care behaviours are difficult

Facilitators initiate a discussion among participants wherein they talk about their own self-care behaviours.

> Example questions: *"What do members of the group find the hardest about having diabetes?" "Why do you think diabetes self-care is so difficult?"*

During the discussion, facilitators should incorporate the following six principles into the discussion to normalize the difficulties in adopting/maintaining healthy behaviours:

1. Behaviour is more emotion-based than logic-based:

> Example question: *"Is there anybody here who has had good intentions to do something (a health behaviour) but did not end up doing it?" "Why didn't you do it?"*

We know logically that we are supposed to behave a certain way, but we often don't follow that because of how we feel. If we are tired, we might **not feel like** exercising at a given time; a bag of chips would **make us feel** so much better. Or, perhaps we don't want to take insulin because we are **scared** of the consequences.

2. It is hard to start a new behaviour and easy to stop it:
And once we have gotten off track, it is hard to get going again. It takes a long time for a behaviour to become "automatic" or "routine".

3. Willpower is a myth:
Many people think that people who are healthy have more "will power" than people who are unhealthy. This is a myth. And it's a dangerous myth because it implies that some people simply are not capable of change. In reality, we all struggle to create and maintain willpower, so we have to work around this. People who are more successful at change are most likely better at organizing their environments to make healthy behaviours as easy as possible.

HINT
Stories can help to better explain concepts and are more likely to be remembered. Try to include a personal example or a patient story from your clinical work.

> Example question: *"What do you think about willpower? Can you think about things that you have more or less willpower for? What is the difference between them?"*

> **NOTE TO FACILITATORS:** If participants are curious about what this means, or want more information, perhaps you can let them know that this is a big part of what you will be doing in group for the next six weeks. There is no need to get a great deal into this topic at this time, other than a brief introduction to these concepts.

4. "The pleasure principle" or short term gain at the expense of long term pain:
It is normal to want to maximize our pleasure right now, regardless of longer term consequences. We want rewards now. This is a strong biological drive that has helped us to survive in the past. Rewarding things like eating high fat foods helped us survive when food was scarce and difficult to obtain. Our brains are hard-wired to want foods that are high in fat and sugar. This is why, for example, eating ice cream is more pleasurable for most of us than eating celery. We prefer ice cream, even though we know that eating celery is a better choice for our health in the long run. This is normal.

5. The path of least resistance:
Of course we want to make our lives as easy as possible. Our brains are programmed to conserve energy. It is easier to take the car to work than to walk to work. It is easier to sit and chat at lunch than to go for a walk.

6. Obesogenic environment:
We live in an environment that promotes overeating and sedentary lifestyles. This comes in many forms. Some obvious examples are television commercials and other forms of advertisements for high fat/high sugar foods. Also, there are so many drive-thru fast food restaurants that are very accessible. Certain restaurants (e.g. Cinnabon, McDonalds) use smells to entice potential customers to eat. Many North American cities are designed to promote driving rather than walking (e.g., box stores, grocery stores located far from residential areas).

> Example question: *"Can you give an example of how your environment encourages unhealthy behaviour?"*

Final point:
In order to develop a healthy lifestyle, we must be prepared to work hard and swim against the tide. And the hard work doesn't get easy for a while. In the long run, many people who have made healthy changes to their lifestyle embrace these changes and find these changes easier to do because they become part of their lifestyle and how they see themselves. But it takes a while and a lot of effort in the short term. Tackling change in small steps helps you pace yourself for the long-haul of change.

Facilitators can give an example of little changes that can be made that become part of lifestyle. A couple of ideas are:

- Trying to change the habit of putting a lot of creamy salad dressing on a salad. Decrease the amount of salad dressing little by little and trying other, less creamy types of dressings until one becomes used to the taste of salad with only a small amount of vinaigrette.

- Trying to increase physical activity by walking at lunchtime at work with a co-worker (even if only for 5-10 minutes). At first, it is hard to adapt, but little by little, people find that when they don't walk at lunchtime, they miss it.

A few words about ambivalence.
Discussing the above principles is meant to normalize ambivalence about healthy behaviours. When it comes to health behaviours, ambivalence refers to having competing interests and values in favour and against engaging in health behaviours. For example, *"I really want to exercise, but I also really like sitting on the couch and relaxing"*. It is normal to be ambivalent, and by

HINT
It is more helpful to spend time listening to and exploring ambivalence than to try to help by fixing or convincing. It's okay to acknowledge the downsides of healthy behaviours.

acknowledging our ambivalence, we can work towards addressing the issues that create the ambivalence. *"We are all motivated, but…"*. It is these "buts" that we should be paying attention to. Ambivalence is actually a good thing. In individuals who might not be ready or willing to change or who are resistant to change, developing ambivalence can actually be a step towards change.

Introduction to Motivation as a Two-Step Process

MESSAGE: Motivation is a 2-step process involving 1) short-term and 2) long-term processes.

> To introduce the topic, facilitators could start with the following introductory discussion activity:
>
> **TO THE GROUP**
> Facilitator asks*: How easy is it to stick to a New Year's Resolution the first two weeks of January?*
>
> Facilitator asks*: How easy is it to stick to the same Resolution by April?*
>
> Facilitator asks*: Why?*
>
> Have participants discuss and come up with their own explanations.
> The take home message from this discussion is: The motivation for sticking to a New Year's Resolution for the first two weeks was feeling bad (i.e., feelings of guilt, shame, and worry after holiday eating/weight gain). But by April you have long forgotten your "bad behaviour" over the holidays, so you no longer are feeling bad. The motivation is no longer there.

1) SHORT-TERM: Negative feelings are powerful, short term motivators.

> Example question: "*Has anyone started a positive health behaviour (e.g., exercise, eating better) because of feeling bad or something bad happening? Anyone want to share what those negative feelings or events were?*

Common negative feelings or events that can act as short-term motivators include: nagging partners, scare tactics by medical doctors, personal or health crises, fear, or guilt.

Negative events or feelings can be helpful to "kick-start" behavior change. BUT….

2) LONG-TERM: Long-term behaviour change requires positive sources of motivation.

> Example questions: *"What do you think are some of the positive motivators that have either helped you or that you think would help you maintain your motivation to act in a healthy way in the longer term?"*

Possible positive motivators for the long-term include: you start to feel good about your new behaviour, you get positive reinforcement from achieving your goal, you start to identify with the new you, and you have more energy.

In your group discussion, emphasize that these positive motivators are not easy to arrive at, but in order for healthy behaviour to be maintained in the long run, we have to start to identify with the new healthier behaviours. Remember: "Anything worth having is worth working for".

> Example explanation of POSITIVE MOTIVATION:

"It can take time to develop positive motivators. However, in order for lasting motivation and for health behaviours to start becoming "easier", they have to become part of our self-identity. So focus your energy on learning to like the new (healthier) you! Self-esteem, which is feeling good about yourself, is a great positive motivator that can make new health behaviours that much easier to maintain. If we don't start to identify with our new healthier behaviours, they will always be hard work."

Possible example: *"As an example of making a health change part of your identity, some ex-smokers begin to identify as a non-smoker. For them, the thought of smoking becomes very unappealing which makes it easier to make the choice every day to not smoke. For other ex-smokers, they see themselves as a smoker who has quit. So naturally, the desire to smoke is that much stronger. And even if they don't smoke, it's always hard work for them to resist."*

Note: short and long-term motivation are mentioned in Handout 1.2

Readiness to Change

Facilitators introduce the concept of "readiness to change".

> Example explanation of READINESS TO CHANGE:

"We all have ideas and good intentions about making changes in our lives. Before starting into a change, it is important to take time to reflect on how ready you feel to change at this time. This can help you to better understand you own motivation for change and how realistic a given change is for you at the present time. The Traffic Light Assessment is a tool you can use to help you to determine how ready you are to change a specific behaviour."

Refer to Handout 1.1. Ask participants to write down a specific health behaviour they would like to change, or one that they have been told they should change. It should be a behaviour they are not currently doing. On their Handout 1.1, have them answer each of the following four questions:

      1. Do you consider X (their chosen behaviour) to be a problem?
      2. Does X cause you concern or distress?
      3. Are you interested in changing X?
      4. Are you ready to change X now?

Have a few participants volunteer to share their answers with the group.

Facilitators should listen for "Yes" and "Not Yes" in each answer. A "Yes" is clear agreement; everything else is a "Not Yes" (these can include "Yes, but…", "No", or reference to someone other than the participant being bothered by the behaviour). Listen for "Yes" and "Not Yes" in each answer.

Red: All or nearly all *Not Yes*

Yellow: Some *Yes*, some *Not Yes*

Green: All *Yes*

It is important for facilitators to provide participants with feedback by summarizing their responses and based on those, indicating what light colour they sound like. Facilitators also want to check with participants to see if they agree with the assessment.

Example dialogue of TRAFFIC LIGHT ASSESSMENT:

Facilitator: *So what I'm hearing you say, Christine, is that you consider smoking to be a problem for you and you worry a lot about the impact on your health. You would like to quit smoking but you are concerned about starting this process now because it is a really busy time and you do not want to add any more stress into your life. Based on the traffic light assessment, you sound like a yellow light: you are worried about smoking and you want to quit but you are not sure that now is the right time. Is that an accurate assessment?*

Facilitators can then give the group general feedback on what to do with their traffic light colour:

Green Light: You are ready to move ahead with planning your behaviour change. Making behaviour plans will be addressed in Session 2. It may still be helpful to do a decisional balance exercise as well to help with long-term motivation (see below).

Yellow light: Before moving ahead with a goal and a plan for change, spend some time thinking about the parts of you that want to change and the parts of you that are not ready. The exercises we will talk about for the rest of the session (decisional balance, positive and personally relevant reasons for change) will be particularly important to try.

Red Light: This is not a behaviour you are ready to change right now. Take it off the table for now, but think about what might help you to be ready to revisit it again in the future. For example, you may want to get more information from a health care professional, or talk it

over with a friend or family member. It is a good idea to go through this assessment with yourself again in a few months to see if your readiness has changed.

Note: Remember, the light colour applies to specific behaviours, not a person as a whole. At any given time, we can be all three light colours for different behaviours (e.g., red light for increasing physical activity, yellow light for quitting smoking, green light for testing blood sugar). The traffic light assessment can be used again and again for the same behaviours and for new ones.

Introduction to Decisional Balance as a Motivational Enhancement Tool 📖

One helpful tool to enhance motivation is to complete a decisional balance exercise with a behaviour that we are thinking of trying/changing. Decisional balance involves thinking about all of the reasons to change and also the reasons to stay the same.

People do unhealthy things for good reasons. These reasons are personal. The key is to understand those reasons. It is normal that sometimes people don't think about or want to talk about what the positive aspects might be of engaging in unhealthy behaviours. But this is not helpful for promoting change. For example, some people might say, "there is nothing good about smoking", but if we explore a little bit deeper, people might realize that there are in fact some positives about smoking for them (e.g. allows one to a take breaks at work, connects someone to a particular group of people, relieves stress, etc.). Understanding why we do something is an important first step in problem solving and changing our behaviour.

Completing the Decisional Balance 📖

Have participants complete a decisional balance exercise for a health behaviour they would like to change (see Handout 1.2: *Motivation in Behaviour Change).*

STAYING THE SAME
PRO   CON

CHANGING
CON   PRO

Impedes Change   Facilitates Change
Total: _____   Total:_____

HINT
Pay particular attention to reasons NOT to change (staying the same) as this can be informative for understanding difficulty with accomplishing a goal.
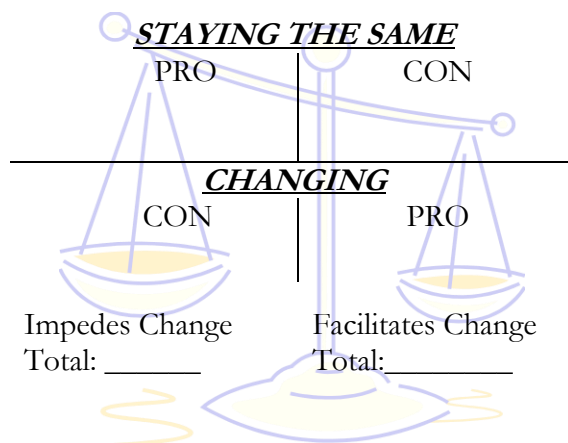
Handout 1.2. STEP 1: Participants are to think of all of the pros or advantages of *Staying the Same* - which means NOT doing the new health behaviour. Then they are to think of all of the cons or disadvantages of *Staying the Same.* Next, they are to think of all of the cons of *Changing* and finally all of the pros of *Changing.* It is normal for items on the same side to be similar. For example, the cons of *Staying the Same* may be similar to the pros of *Changing.*

Participants then rank the importance of each item (in each of the four boxes) from 1 to 4 (4 being greatest importance) and add these scores in the columns on either side of the scale. This will generate a separate score for *facilitating change* and *impeding change*.

How does the scale tip – facilitate or impede change? Do reasons for changing outweigh reasons for staying the same? People stay the same because reasons for staying the same are stronger. Pose the rhetorical question to participants: *What will make the scale tip for you?*

Positive and Personally Relevant Reasons for Change

Handout 2.2. STEP 2: Ask participants to list POSITIVE AND PERSONALLY RELEVANT REASONS to change that are longer-term considerations (i.e., things that will apply for a long time).

Possible examples:
- I want to be healthy enough to walk my daughter down the aisle when one day she gets married.

- I want to be able to go on a holiday with my spouse next year, so I want to be healthy for the trip.

- I want to be able to play with my grandchildren.

Wrap-Up and Homework Assignment

1) Participants will complete a decisional balance exercise for an additional behaviour they are hoping to change.
2) Participants will attempt to engage in the behaviour changes identified in the decisional balance exercises, as applicable.

! TROUBLE SHOOTING

Scenario: Participant does not know which behaviour to choose for the readiness assessment or the decisional balance exercise.

Suggestion: Let the participant know that for now the important thing is to learn the skill of examining the pros and cons of changing and staying the same, and the particular behaviour chosen is secondary. Ask them if there is anything related to how/what they eat, exercise, or blood glucose testing that a health care professional or family member have recommended they change (e.g., eating more vegetables, eating breakfast).

SESSION 2

Goal Setting

OBJECTIVES

- ✓ Continue developing group alliance and cohesion

- ✓ Participants will learn what SMART goals are and how to plan for behaviour change

- ✓ Participants will identify barriers to health behaviours and ways to overcome these barriers

- ✓ Participants will begin to learn to use setbacks as learning opportunities. They will learn that it is normal to "fall off the wagon"; the key is getting back on quickly

ICON KEY

☞ Hints for Facilitators

❗ Troubleshooting

✎ Facilitator Handout

📖 Participant Handout

💬 Sample Dialogue

SESSION OUTLINE

(10 minutes)   Check-in and Review of Homework

(20 minutes)   Discussion of Strategies for Good Self-Care Behaviours

(10 minutes)   Introduction to SMART Goals as a Way to Promote Healthy Behaviours

(35 minutes)   In-session Exercise: Handout 2. *Behaviour Change: Setting and Managing Goals*

Participants identify one problem behaviour from a diabetes self-care standpoint, elaborate on why this is a problem, set a SMART goal, and develop concrete steps to accomplish the goal. They also plan rewards for themselves

(10 minutes)   Behaviour Cycling – AKA: Everyone Strays from their Goal

(20 minutes)   Identifying Barriers to Change and Overcoming Them

(15 minutes)   Wrap-up and Assignment of Homework

HANDOUTS

📖 Participants' Handout: 2) Behaviour Change: Setting and Managing Goals

SESSION ACTIVITIES

General Note: It is always better to ask questions rather than offer advice. Remember, as the facilitator, you are trying to encourage participants to develop awareness of their behaviour choices and to problem-solve their own challenges.

Check-in and Review Homework

Facilitators will review with participants the decisional balance exercise for two behaviours (one should have been completed or almost completed last session and the second one for homework). If some participants did not complete the decisional balance exercise, facilitators can ask what they think got in their way (it is important to ask these questions in a non-judgmental way that conveys an attitude of "how can we overcome these barriers in the future?"). Facilitators can then ask the participant what they think might be a helpful way to increase the chances that they complete the homework going forward.

> ☞ **H I N T** From last session, participants may have identified behaviours that were challenging for them. Try to reference these examples when providing didactic content.

Facilitators will also ask participants how successful they were with implementing the behaviours identified in the decisional balance worksheets. It is expected that it will be difficult for participants to specify success. Facilitators can explain that this is most likely because their goals may have been vague and difficult to assess. Part of this session will focus on establishing SMART goals – that is, goals that are specific, measurable, action-oriented, realistic, and timely.

Discussion of Ways to Adapt and Maintain Good Self-Care Behaviours

During this part of the session, change will be the focus. Facilitators can open the discussion by asking about participants' intentions and prior attempts at changing. This part of the discussion might also help solidify the principles mentioned during the last session.

> Example Questions: *"Is there anything you want to change?" "Have you changed before?" "Did this change last?" "Do you know why the change didn't last?"*

(Note: some of the principles described below can be incorporated with the discussion on setting SMART goals, further below. As long as the topics are discussed at some point during the session, there can be flexibility about how to best incorporate these points in a fluid and interactive way).

Example introduction of the topic: *"So now we will start discussing some of the ways that we can set ourselves up for success. We can use some of the principles we discussed last session to our advantage."*

Example questions: *"Have you noticed anything that helps you in terms of managing your diabetes or engaging in what we would call good self-care behaviours (e.g., SMBG, eating healthy, exercising, taking insulin)? Why do you think these strategies work?"*

Example feedback to a participant's response: *"That's a great point, Sally. In fact, making sure that our expectations are realistic and giving ourselves a break for not being perfect has been shown to help keep us on track in the long run. Does anyone else have an example of how it felt to meet their expectations about a healthy behaviour and if that encouraged them to keep going?*

- **Having reasonable expectations.** If we expect too much from ourselves, we are more likely to fall short and have a sense of "I can't do this", rather than a sense of accomplishment and success. This can negatively affect our motivation. It's better to have small successes than big failures.

    Example question: *"Does anyone have an example of when being asked to do too much too soon, you have felt overwhelmed, and done nothing at all?"*

- **Setting up our environment.** Because relying on "willpower" is not an effective strategy, the objective here is to make behaving healthy easy, and behaving unhealthy difficult. For example, we can put the extra portions of vegetables on the table, and keep the extra portions of meat on the stove (or packed away in the fridge). We can make sure that we don't keep unhealthy foods in the house, or if we do keep them, that they are harder to get to. We can prepare our exercise clothing or other equipment ahead of time so that it is easier to get started exercising when the time comes.

- **Measuring success based on behaviours rather than outcomes.** For example, keeping track of how we are eating and not how much weight we are losing. Behaviours are things like checking our blood sugar or exercising. Outcomes are things like weight or HbA1c. We can control our behaviours, but we can't necessarily control the outcomes. By focusing our attention on things that we can control, we are more likely to feel motivated to continue.

- **Building in rewards for healthy behaviours.** It is important and helpful to pat ourselves on the back. If we have accomplished something, we should be proud of it and reward ourselves. This will be discussed a bit later this session.

- **Developing confidence in our ability to do the healthy behavior.** Confidence comes about with small successes. This is tied to the expectations (i.e., setting smaller, more

realistic goals makes it more likely you will accomplish your goals, which helps you to feel more confident).

- **Reasons for changing outweigh reasons for staying the same.** As was demonstrated in Session 1, we acknowledge that there are reasons for staying the same, but we have found more reasons for change.

- **Having a plan for dealing with barriers and temptations.** There will always be situations when it is more difficult to stay on track...how do we deal with this? This will be discussed later during the session.

- **Identifying with and liking the new changed you.** If we start to identify with the new healthy behaviours that we have adopted (e.g., I am a walker or a runner, I am someone who eats breakfast), the behaviours will become easier to do. If not, then they will continue to be a challenge.

Introduction of SMART goals as a way to promote healthy behaviours

Note: It might be helpful to emphasize the principles above when explaining SMART goals. For example, talking about expectations in the context of setting realistic goals, or measuring success based on behaviours (rather than outcomes) might be highlighted when discussing setting action-oriented goals.

Facilitators can ask for examples of types of goals that would fulfill the following guidelines:

SPECIFIC:	How much? What does it look like? The more specific the goal, the better equipped we are to reach it.
MEASURABLE:	We can see if we have reached our goal. We can measure success.
ACTION-ORIENTED:	Something that we do. Our behaviour is all that is in our direct control. We can hope for outcomes, but we cannot control an outcome.
REALISTIC:	Set ourselves up for success.
TIMELY:	We can start the behaviour now.

> *Remember:*
>
> Incorporate flexibility in the goals as well.

Some examples of **non-SMART** goals:

1. Exercise more.
2. Lose 20 pounds.
3. I want to be better at checking my blood sugars.

Discuss with the group why these three goals are not SMART. (1. Not specific, not measurable. 2. Not action-oriented and may not be realistic or timely. 3. Not specific, not measurable). Facilitators can help the group to translate one example into a SMART goal.

*Some examples of **SMART** goals:*

1. Walk before supper for 20 minutes 3 times per week.
2. Eat at least two servings of vegetables at least 4 times per week.
3. Eat no more than one small bag (40g) of potato chips once per month.

It is encouraged to change no more than 3 behaviours at any one time. Once we are comfortable with a behaviour and it is no longer an effort, we can "pick up" a new behaviour that we'd like to change. Humans are more like turtles, not hares, so we must give ourselves time to make and adapt to healthy changes to help them last for the long run.

In-session exercise 📖

At this time, facilitators review Handout 2 with participants. Participants begin filling out the material for Handout 2.

> Participants identify one problem behaviour from a diabetes self-care standpoint, elaborate on why this is a problem, set a SMART goal and develop concrete steps to accomplish their goal, and ways to reward themselves.

Once participants have identified what they think is a SMART goal, facilitators can ask each participant if they are comfortable sharing their SMART goal. Facilitators can encourage participation with other members by involving them in feedback for specific group members (e.g., "Does anyone have any suggestions for Sally?"). Other participants can benefit from these exchanges.

Example dialogue

Facilitator: "*Sally, what did you put down for your smart goal?*"

Sally: "*I put down that I want to exercise more.*"

> When trying to assess if participants' goals are realistic, it might be a good idea to ask about what they are currently doing.
>
> **HINT**

Facilitator:: *Okay - that's great that you want to exercise more. How can you make this goal more specific? How much do you want to exercise? What type of exercise do you want to increase?"*

Sally: "*Well, I guess that walking is probably the most realistic for me at the moment. I would like to walk more.*"

Facilitator: *"Great. It's good to pick something that's realistic for you. How much do you want to walk? Remember that we want this to be specific and measurable -- and you want to keep your expectations reasonable."*

Sally: *"I think that I should be walking every day."*

Facilitator*: "How much are you walking now?"*

Sally: *"Well, I probably walk about twice per month right now".*

Facilitator: *"Okay - so if we want a goal to be realistic, do you think that going from twice per month to every day is do-able? You want to set a goal that you can meet, so that you have some success, even if the goal doesn't seem overly ambitious. The aim is to have success in achieving our goal. So how many times per week do you think that it is realistic for you to start walking starting now?"*

Sally: *"Maybe I can walk 2 times per week? Once during the week and once on the weekend?"*

Facilitator: *"That sounds great. How long do you want to walk for? We want the goal to be as specific as possible."*

Sally: *"I think that I heard that walking for one hour is good. Maybe I should try for one hour?"*

Facilitator: *"From what you had talked about in terms of how much you are currently walking, one hour is a long time to have as a goal. Again, we want to be sure that you are realistic in setting your goals. How long do you think would be realistic? You can start small and then build up with time."*

Sally: *"Maybe I can walk for 25 minutes?"*

Facilitator: *"Okay - so your goal is to walk for 25 minutes, 2 times per week. How does that sound to everyone else in the room? Does that fulfill all of the SMART goal requirements?"*

At this point review the five SMART principles and confirm with participants that the goal is one they feel comfortable with for the following week.

HINT

Usually participants are more motivated and feel more responsibility toward meeting their goal if they feel that they have set up the goal themselves. It is okay to help fine-tune the goal to make sure that it fulfills all of the SMART requirements. However, as facilitators it is important to refrain from setting goals that "we" think would be good for participants.

Participants will then continue to fill out the worksheet - facilitators can look to see that participants have a plan to fulfill the goal. The more specific the plan, the easier it is to follow. It can also be helpful to build in flexibility in the plan and to foresee and problem-solve anything that can get in the way of the plan.

Participants identify personal rewards.

Finding the motivation to make changes can be very challenging. When we first start with the process of making change, we need to reward ourselves for each small step. Smaller, more frequent rewards earned for smaller steps are more effective than larger rewards for bigger long-term steps. Rewards are intended to recognize our achievements and to create a more motivating, positive environment. Rewards should be timely (happen close to the completion time of the goal), desirable, and easily achievable.

☞

HINT
If participants suggest a reward that appears like it might sabotage a goal, or is food-based, facilitators can explore with participants why this might not be a good idea. It is always better to explore with participants by asking questions and opening a dialogue, rather than by being directive and/or prescriptive.

> Example Goal: Walk 30 minutes, 3 times per week
> Reward: Watching a movie after the third walk is complete

Other reward examples: buying a CD/DVD or clothing, putting away money towards a larger purchase, coffee with a friend, guilt-free relaxation time, etc.

Rewards should be chosen so that they do not sabotage goals. For example, if the goal is to reduce the intake of desserts at suppertime 4 days per week, it would be unwise to have high-caloric food as a reward. In fact, it is generally unwise to use food as a source of reward as this generates a habit of emotional eating (discussed further in Session 5).

Behaviour Cycling - A.K.A.: "Everyone Strays from their Goal"

The group has just finished establishing a SMART goal and making a plan to meet this goal. This part of the session deals with the fact that no one is perfect with implementing their new health behaviours.

Everyone strays from their goals or "falls off the wagon" – this is normal! It is important to pay attention to how far you stray and for how long. We can all learn from behaviour cycling!

> Example question: *"Does anyone in the group have an example of when they fell off the wagon and/or strayed on something? It could be an example related to work, or family commitments, or a health behaviour. What happened? How did you deal with it?"*

One example that facilitators can use if participants cannot think of examples: "*Suppose you are at work and you have a project to work on. You begin procrastinating by reading an on-line newspaper. If you spend 5-10 minutes doing this, and then get back to the project, is there much harm done? Probably not. However, if you let yourself get side-tracked for a lot longer, then you might start to feel bad about not working. And then you might find that you can't focus on work because you are thinking about how you should not have been reading the paper. Then, 1 ½ hours go by. At this point, you tell yourself that it's not even worth working on the project anymore and you end up spending the rest of the afternoon being unproductive*".

Another potential example: "*Suppose you really like ice cream, and someone in your household has bought ice cream that has sugar in it. You know that you are not supposed to have any. You break down one day and have a tiny little bowl. At this point, you have not done that much harm. You have strayed, but it's just a little bowl. But then suppose that you start thinking "oh darn, you had that little bowl, now you've really done it, and so you might as well just keep eating the ice cream". And while you are at it, you indulge in these really good cookies that go really well with the ice cream. The next day, you think to yourself, "well, I was bad anyway and had some ice cream AND cookies, so I might as well just have more ice cream now, because really, what's the difference?!" So you have more. Then the next day you say to yourself, "well, if I just finish the tub, then there will be no more ice cream left to tempt me, so I may as well just finish off the whole container".*

Avoiding Guilt Traps and Learning from Setbacks:

When we stray from our health behaviours, we tend to feel angry at ourselves and quickly become discouraged. Instead of getting caught up in this cycle, we can view straying as an opportunity to learn by asking ourselves:" What led to the stray? What can I do next time to try to prevent it?" We can also try to minimize the possible damage (e.g., one bowl of ice cream instead of the whole tub). We can try to focus our energy on getting back on track as soon as we can.

Feeling bad about the fact that we strayed is not helpful. Negative feelings are toxic to long-term behaviour change and tend to make it take longer for us to "get back on the wagon". It is more helpful if we acknowledge that we strayed, learn from it, and move on.

It is more helpful to think about straying in more "grey" rather than "black and white" terms. For example, changing reactions such as "I totally blew it, I'm such a failure!" to "I didn't stick to my goal 100% but that's okay, I'm only human. I'll figure out what got in the way and I'll try again tomorrow".

It can also be helpful to look more at the "big picture" when we have "bad days" or when we feel that we have been "behaving badly". In general, how are we doing compared to how we were doing a few months ago? We can look at the whole week, rather than just one particular day, or one particular meal.

Identifying Barriers and Temptations and Overcoming These

Barriers and temptations can get in the way of accomplishing a health behaviour. Barriers can exist in different domains. Facilitators can ask participants to identify a few examples from their own lives for each of these domains:

1) *Negative Thoughts or Beliefs:*
   E.g., We think that a change won't make a difference, or we don't believe that we can do it.

2) *Emotions:* As discussed in Session 1 - we act more on our emotions than logic:
   E.g., We feel down so it's easier to reach for the remote than the running shoes

3) *Social Network*: Lack of social support
   E.g., Our spouse buys a lot of tempting foods, or we have nobody to walk with

4) *Resources*:
   E.g., No money, no time

5) *Physical Environment:*
   E.g., No grocery stores nearby, no exercise facilities.

Handout 2. Item 6: Have participants begin to complete the part of the handout that identifies barriers and temptations. Encourage participants to be as specific as possible. What are some specific situations, times, people, etc. that will tempt them away from the healthy goal behaviour or toward the unhealthy behaviour?

Wrap-up and Assignment of Homework

For homework, participants will complete the handout if they have not already done so. They will commit to their goal behaviour for the next week. They are encouraged to keep track of whether they meet their goal. Facilitators will explain that the next week, they will discuss how they were doing with respect to the goal.

> **HINT** It might be a good idea to reassure participants that even though they may not have completely achieved their goal, that they need not feel embarrassed about coming to the group, or think that they shouldn't attend the group. The goal is to find a way, during the six week program, to improve health behaviours. If we are not able meet our goals initially, we can use these setbacks as learning opportunities. Maybe the goal was unrealistic, maybe there are problem-solving strategies that we can put in place to make the behaviour more likely later on. The important thing is to come back to group to work together.

! TROUBLE SHOOTING

Scenario: Participant's goal appears to be overly ambitious.

Suggestion: Congratulate participant on having a good long-term goal. Explore with participant how to break down the goal into smaller pieces that they can begin to work on within the next week, with the objective to perhaps build up toward the more ambitious goal.

Scenario: Participant can't decide on a behaviour. They want to change so many different behaviours.

Suggestion: It doesn't really matter where someone starts - as long as it is in the direction of improving health behaviours, or something that is important to the person. They are welcome to change this goal along the way, if they feel later on that something else might be more relevant for them. They can always expand on the goal later on. But just to have something to work towards is the main point.

Scenario: Participant does not want to change anything. They feel overwhelmed and discouraged.

Suggestion: Validate their feelings and acknowledge how hard it is to make changes and remind them these challenges will continue to be explored in group. Explore with them what brought them to the group and what they are hoping to gain from participating in the group. From this discussion, try to help them identify a very small starting goal. Or have them set a SMART goal focused on identifying ideas for change (e.g., write down 2 behaviours that are a problem for my health).

SESSION **3**

Stress Management

OBJECTIVES

✓ Continue developing group alliance and cohesion

	ICON KEY
☞	Hints for Facilitators
!	Troubleshooting
✐	Facilitator Handout
▥	Participant Handout
☐	Sample Dialogue

✓ Participants should leave session three with an understanding of the difference between stressors and the stress response

✓ Participants will learn that individuals can cope with stress using either self-focused coping or problem-focused coping

✓ Participants will be introduced to the three steps involved in problem-solving

✓ Participants will learn about assertive communication skills

✓ Participants will identify a stressful interpersonal situation in their own lives and practice assertive communication skills for that situation

✓ Participants will practice a new relaxation strategy in session and as homework

SESSION OUTLINE

(20 minutes)   Check-in and Review Homework

(15 minutes)   Introduction to Stress Management

(10 minutes)   The Stress Response

(5 minutes)   Coping with Stress 1: Problem-focused Coping

(5 minutes)   Introduction to Problem Solving

(25 minutes)   Assertive Communication

(5 minutes)   Coping with Stress 2: Self-focused coping

(15 minutes)   Relaxation Exercise – Deep Breathing (or other)

(10 minutes)   Wrap-up and Homework Assignment

HANDOUTS

📖 Participants' Handouts: 3.1) *Stress Management*
                            3.2) *A guide to deep breathing*

SESSION ACTIVITIES

General Note: It is always better to ask questions rather than offer advice. Remember, you're trying to encourage participants to develop awareness of their behaviour choices and problem-solve their own challenges.

Review Homework

Facilitators check-in with each participant regarding the formal homework and chosen health behaviour from Session 2. Facilitators congratulate and reinforce participants if they have achieved their behaviour goal for the week. If they have not, then this is the time to encourage the participant to use that as a learning opportunity. Ask participants what they believe got in the way of achieving their goal?

Example questions: *Were there scheduling issues? Was the weather an issue? Did something unexpected come up? Was the goal too ambitious?*

Explore whether the person wants to maintain the same goal for next week, or if they feel that they would have a better chance of meeting their goal if it were adjusted. For those participants who struggled with their goal, encourage them to consider any possible changes or adjustments that might make it easier to meet their goal for next week. It can be more motivating to achieve a more modest goal, which can be revised later if desired.

> **HINT** 👆
>
> It is helpful to include other group members in the homework review when appropriate. Example questions: *"Who else in the group has experienced this kind of barrier?", "What have others done when they have been in Mary's situation?"*

NOTE TO FACILITATORS*:* Reflective listening means that you acknowledge and restate what participants have said before you move on. This helps participants to feel like they have been heard and encourages them to share more.

Example dialogue of goal review:

Facilitator: *"John, can you remind the group what your goal was and share with us how you did in meeting the goal?"*

John: *"Yes, I was going to eat at least three different vegetables per day at least four days this past week. I ate three different vegetables on three days, but then the weekend came, and we had eggs for brunch and then went out for supper and I only had two different vegetables. The next day we were invited to our friends' house for supper and she made lasagna so I didn't get to eat my three vegetables again. So I didn't meet my goal".*

Facilitator: *"Sounds like you were very diligent on three days this past week. Compared to how you described where you were last week that sounds like a good improvement, so that is great. It also sounds like the weekend was a real problem for you. When you look back now, do you think that the goal is achievable in the future?"*
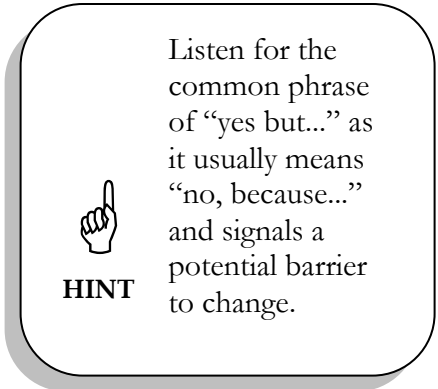
John: *"I think so. I was really close to meeting it, so I just have to tack on one more day and that's it."*

Facilitator: *"Great, so you are pretty confident that you can achieve your goal. In thinking about what happened this past week, is there anything that you think you could have done differently to overcome the barrier of not eating at home during the weekend and meet your goal?"*

John: *"Well I guess I could have said that I couldn't go over to our friends' house for supper but I really like their company."*

Facilitator: *"Okay, so I get the impression that not accepting the invitation for an evening at your friends' house might not be your first choice. What else could you do?"*

John: *"I guess if I would have eaten my three different vegetables during the three days this week, then I wouldn't have had to worry about trying to eat them on the weekend".*

> ☞ **HINT** Listen for the common phrase of "yes but..." as it usually means "no, because..." and signals a potential barrier to change.

Facilitator: *"That sounds like a pretty good plan. You're saying, if you plan to eat your vegetable servings during the week days, you don't have to sacrifice your social outings, but you can still meet your goal. How do you feel about your ability to meet your goal next week?"*

John: *"I feel okay about it I guess, but I find that I run out of ideas about what to eat for vegetables and I'm getting tired of the same vegetables".*

Facilitator: *"You are describing a very common obstacle. What does the rest of the group think? Do any of you find it hard to plan and fit in vegetables in your diet? I know that for me it's also sometimes a challenge. What have others done to try to overcome this?"*

In the above dialogue, the facilitator did not try to problem-solve for John. Instead, she asked him about his thoughts and then called upon the rest of the group to become involved as well. Also, the facilitator congratulated John's positive changes and acknowledged that challenges are normal. The facilitator also used reflective listening by acknowledging what John was saying before asking a question. In the above dialogue, John mentioned a possible solution accompanied by a "but", so the facilitator followed up on this additional barrier and tried to see if there was another way to overcome John's obstacle.

NOTE TO FACILITATORS: A considerable amount of time is spent in reviewing homework, including the behaviour change goal, to encourage participants to incorporate the "skill building" portion of homework (e.g. decisional balance, temptations and barriers) into their own behaviour change goals.

Even if participants do not meet their goal 100%, congratulate them on meeting a part of their goal. Avoid responding to participants' health behaviour using an "all-or-nothing" approach (i.e., the only options are success or failure). Instead, help to encourage graduated approximations towards change. For example: *"You met your goal of walking 3 days this past week, which is great! But it sounds like it was hard for you to walk for the full 30 minutes that you had planned. You were okay on the first day but for the other two walks you were only able to go for 15 minutes. This is actually a great opportunity for us to talk more about what made it challenging to walk for 30 minutes on those days so that we can better understand how to tweak your goal for next time."*

Introduction to Stress Management

Example questions for discussion with group to introduce stress:
- o *What are your stressful situations?*
- o *Why are they stressful?*
- o *How do you respond to these situations?*
- o *Have you ever noticed a link between stress and blood sugar?*

As group members are discussing the above questions, see if there are common themes that emerge. As well, the points below should be incorporated into the group discussion on stress. As participants discuss their own situations, facilitators should try to use the participants' experiences to highlight the following points:

- o Stress is *not* the situation we are in. The situation is the *stressor*. It is our response to the stressor that we call stress. For example, 2 people can experience the exact same situation and one person may respond with stress while the other will not.

- o Stressful situations are often beyond our control.

- o Stressful situations can come from health concerns or social and/or physical environments.

o   Dealing with stressful situations can make it more difficult to engage in self-care behaviours. We may forget to take our insulin, or skip a meal, or eat fast food, or decrease exercise levels.

o   Stress affects our sleep.

o   Stress directly affects blood sugar levels. This is because part of the stress response includes release of glucose from the liver, muscles, and fat stores.

o   Stressful situations can range from everyday annoyances (e.g., traffic) to big life events (e.g., loss of a job).

o   Daily hassles and annoyances can be just as detrimental to our health as big stressors (e.g., divorce). This is because our bodies do not get a break from continuous stress. Often times we are not aware of the presence or impact of smaller ongoing stressors. Even handling multiple tasks that are not, in and of themselves, frustrating or stressful, can have a cumulative stressful effect.

The Stress Response

Factors that influence how we respond to stressors:

Among others, the following two common factors can affect how stressful we perceive a particular situation to be:

1) Appraisal of the Situation

This is the perception of the likelihood and magnitude of a potential threat and of our perceived ability to cope with that threat.

Example situation and appraisal:

Situation: *"You are in a long grocery store line-up, and you have guests coming over for dinner. You know that this long line-up means that you will not have everything ready by the time the guests arrive."*

Appraisal 1: *"One way to think of this situation is to say to yourself: 'Oh my goodness, I'll be late for preparing for the dinner party, my guests will think that I am so disorganized, it will be really embarrassing, and the evening will be ruined'."*

➔   Example Questions: *"If this is how you interpret the situation, how do you feel? What does your body do? How do you react?"*

Appraisal 2: *"Another way to think of this situation is to say to yourself: 'Well, this line-up will cause me to not be completely ready for the dinner this evening, but my guests are my friends. They will understand and won't judge me. The whole point is for all of us to get together and enjoy each other's company, so it doesn't really matter if things are ready when they get to the house. I can just continue preparing once they are there'."*

➔ Example Questions: *"If that is how you interpret the situation, how do you feel? What does your body do? How do you react?"*

The point of the above discussion is to demonstrate to participants that *how we perceive a situation* has a big influence on how stressful it is for us.

2) Availability of Coping Strategies

Depending on how we feel we can cope or deal with a given stressful situation, we will feel more or less stress. Coping strategies will be the focus of the second part of today's discussion.

How the stress response manifests itself:

Next, facilitators use either participants' own examples or the hypothetical example above to convey that the stress response occurs at four levels:

1) Our Emotions (feelings): Worry, anxiety, irritability, sadness, etc.

2) Our Thoughts: Worrying thoughts such as thinking the worst of what is happening and what might or will happen (i.e., focusing on the worst-case scenario).

3) Our actions: Avoidance, attempts to increase control, or problem-solving.

4) Our Bodies: The perception of a threat triggers our stress response, which causes physiological changes including: increased heart rate, sweating, increase in blood pressure, muscle tightness, stomach cramps/nausea, fatigue, and changes in sleep and appetite.

> It can be helpful to use participants' own experience to engage them in the dialogue about stress responses. Be sure to ask participants' permission. Example: *"Janine, the situation you described earlier might be very good to explore our stress response further. Is it okay if we use it for this next section?"* (after consent) *"In the situation you described Janine, what were some of the physical sensations that you felt? What about the rest of the group, what would be some of the physical sensations you would feel if you were experiencing something similar?"*
>
> **HINT**

The Vicious Cycles of Stress

Stress directly affects our bodies in very complex ways. For example, cortisol production is part of the stress response. Increases in cortisol levels affect our mood and our appetite. Stress can also affect our ability to sleep. Sleep deprivation decreases our ability to effectively deal with stress and with negative emotions. Sleep deprivation also increases cortisol levels.

Stress and sleep deprivation can be said to reinforce each other: the more stress, the less sleep, the less sleep the more stress. The same can be said with our mood: the more stress, the worse our mood, the worse our mood, the less we can deal effectively with stressors.

These are called vicious cycles.

STRESS

EFFECTS ON BEHAVIOUR AND BODY
(examples: sleep, mood)
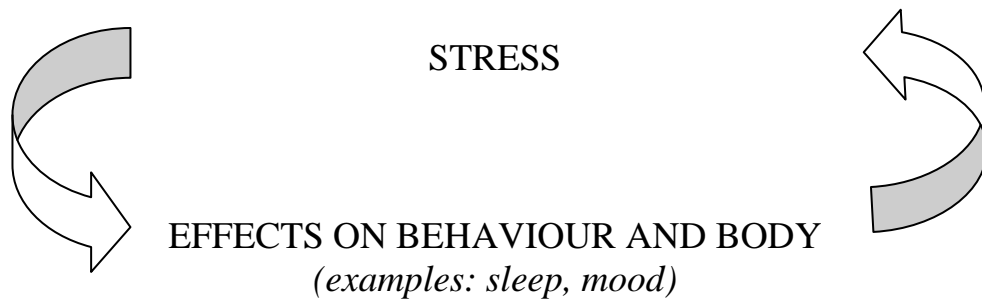
In a way, stress management means developing strategies to break these vicious cycles. Facilitators can use Handout 3.1 to help guide the discussion on stress management.

Coping with Stress

There are two different types of ways that we can cope or deal with stress: problem-focused coping and self-focused coping. Each can be helpful, depending on the way it is used. In any stressful situation, it is important to ask ourselves "What can I control about this situation?" For those aspects of the situation that we can control, we can engage in problem-focused coping (A). For those aspects of the situation that we cannot control or change, we can engage in self-focused coping (B).

A. Problem-focused coping

For some situations, stressors are controllable or modifiable in some way. In these types of situations, steps may be taken to decrease the chances or the magnitude of harm (e.g., it is possible to begin looking for work if we know we are going to be fired or laid off). Taking a problem-focused approach also helps us to focus our energy on what we can control. Sometimes, even when we think at first that we cannot change a situation (e.g., an annoying co-worker), by engaging in problem solving, we discover that perhaps there are some things that we can change (e.g., moving desks, speaking to the co-worker in cases when perhaps the co-worker doesn't realize that what they are doing is affecting us).

1. PROBLEM SOLVING:
This is a systematic method of assessing the situation and determining which circumstances may be modified and how.

Facilitators can briefly go through the steps as outlined in the participant Handout 3.1. Facilitators can stress the importance of listing all possible solutions before making a decision. Sometimes when we list a very impossible solution, it can lead us to a much better solution. Flexibility and openness at STEP 2 is very important to give us the best chance at coming up with a workable solution.

STEP 1: Identifying stressful situations.

STEP 2: How can you cope with the situation?
- Will you use self-focused coping, problem-focused coping, or both?
- List ALL possible solutions, no matter how unlikely or impossible.

STEP 3: Evaluate each solution and list those that are most feasible. This may involve combining bits and pieces of several solutions into one. Circle or highlight the BEST solution.

STEP 4: List the steps involved in implementing this solution and dates when these steps will be implemented.

When thinking of possible types of solutions, some helpful questions to ask:

> *1) Is there a way I can change my physical environment?*
> *(e.g., having exercise clothing in the car or by the door, changing how food is placed in the kitchen)*

> *2) Is there a way I can change my social environment?*
> *(e.g., asking friends or family for specific help; recruiting a partner or friend to share in exercise or healthy eating behaviours)*

> *3) Is there a way that I can use my time more effectively? Time management is a common element of problem solving that can be helpful in managing many of life's daily hassles.*

2. ASSERTIVE COMMUNICATION :

DESC Model of Assertive Communication

Facilitators can continue to go through Handout 3.1 and describe the DESC model of assertive communication. Below are a few key points to emphasize with participants:

1) It is important to remain specific when describing a situation. Statements like "You are so messy", "You never listen to me", or "You're inconsiderate" can hurt the communication

process by leading to resistance from the other person. Help participants consider the difference between the above statements and statements like, "When you leave the dirty dishes on the counter instead of in the dishwasher", "When you look at your smart phone while I'm talking to you", or "When you leave your shoes in the front entrance".

2) It is important to use "I" statements when communicating feelings. It is easier to dispute a statement like "You make me feel…" – the partner may respond with "No I don't…". However when one says "I feel..", it is much more difficult to respond with "No you don't…".

Facilitators can then ask participants to think of a recent difficult interpersonal situation where they can practice applying the DESC model. If participants feel comfortable, have one or two volunteer their example (encourage recent examples for more vivid details). Using these volunteered examples, have the group work through a communication strategy, using the DESC principles.

Facilitators will want to verify that the following recommendations are followed when reviewing the exercise (also outlined in Handout 3.1):

- ✓ Is the participant able to pinpoint the behaviour that is affecting them? (rather than a personality characteristic, etc.)

- ✓ Does the participant use "I" statements when describing their reaction to the behaviour?

- ✓ Does the participant give a reasonable alternative? Perhaps one that has some flexibility or gives the other person some choices?

Other Assertive Communication Strategies

Facilitators can briefly point out a few other helpful strategies for assertive communication:

1. **Broken Record**

The broken record method can be helpful when we want to make a point, but we are not sure if the other person wants to hear us. Imagine a neighbor asks you to look after their dog for a weekend, and you say "I'm sorry, but I don't think that will be possible for me to do this weekend". The neighbor may say something like, "Oh, but our dog is very low maintenance. She doesn't shed and is very quiet, and it's just for the two days". We may be tempted to explain ourselves: "Yes, but I have a pretty busy weekend and won't be home much". This leaves the door open for a counter-response from the neighbor ("Oh, but you won't have to be home much at all because you only have to feed her and make sure she leaves the house a few times per day"). We then need to come up with another explanation, which will be met by another counter-response. If the other person doesn't want to hear us, we will usually run out of explanations before they run out of pressuring comments.

To avoid this, we can use the broken record method. We first identify what it is we want to say, keeping it brief, simple and polite. Then, like a broken record, we repeat the exact same

phrase over and over again (without explanations or justification), using the same words and tone. Eventually the other person will get the message and stop pressuring us.

This might require a bit of practice at first, so you may want to role-play with someone a few times before actually using the method. But it can relieve a lot of stress that comes with being talked into things we really do not want to do.

2. **Fogging**

Fogging refers to agreeing without actually agreeing, and can be used quite effectively with the broken record method. Fogging means that we agree in principle or to a part of what the person is saying, without agreeing with the behaviour they are asking us to do. Some examples of fogging include: "I understand that this is important to you, but (insert broken record here)", "I can see why you would say that, but (insert broken record here)", "You might be right, but (insert broken record here)", "I can see your point, but (insert broken record here)." "I'm sorry, but (insert broken record here)". Participants may want to come up with a few stock phrases of their own that they can use.

Using the example from above, combining the broken record method and fogging would look something like this:

Neighbour: "*Can you look after our dog this weekend?*"

You: "*Sorry but I'm not able to look after your dog this weekend.*"

Neighbour: "*Oh but our dog is really low maintenance and well-behaved. It will be very easy.*"

You: "*Your dog is great but I'm not able to look after him this weekend.*"

Neighbour: "*I'm really stuck here and I need your help. If you can just do me this one favour…*"

You: "*I'm sorry to hear that but I'm not able to look after your dog.*"

A NOTE ON SOCIAL SUPPORT

Social support can be particularly important in helping individuals prevent some of the symptoms of depression or anxiety that can accompany stress. It is important to explore the type of social network that participants have, and encourage them to seek out healthy and fulfilling relationships with others.

B. Self-focused coping

When we cannot change a situation, we can still change our response to the situation, by focusing on our physical reactions, behaviours, and thoughts.

a) PHYSICAL RELAXATION EXERCISES: Exercises such as deep breathing and progressive muscle relaxation can help the body rid itself of some of the physical tension that often

accompanies stress. Physical relaxation can be useful in **all** stressful situations, even when additional problem-focused coping strategies are used as well. It is helpful for facilitators to guide the group through a relaxation exercise together at the end of session. This can be a deep breathing exercise (see below) or another relaxation exercise of the facilitators' choice.

b) EXERCISE: Exercise serves the same purpose as relaxation with many additional health benefits. Individuals with health problems may be restricted in type and intensity of exercise that they can and/or should attempt. This does not mean that they should not do some kind of physical activity. Just getting up and walking around the house or doing stretches while seated can be very helpful. In order to be beneficial, exercise need not be vigorous or strenuous, but it should be enjoyable, sustainable, and performed on the regular basis.

c) BEHAVIOURAL CHANGES: This involves focusing on enjoyable actions instead of on stressors. Examples include being and/or talking with loved ones, seeking and receiving social support, and distraction from stressors (e.g., mental and physical time outs).

d) ALTERING OUR UNHELPFUL THOUGHTS (i.e., cognitive restructuring): Our beliefs and thoughts are very influential on our feelings and behaviour. In Session 4, we will focus more on changing thoughts that increase our stress response.

Relaxation Exercise

The group engages in a relaxation exercise together. Below are some sample instructions for a deep breathing exercise.

Facilitators begin by explaining the role of breathing in stress.

Example explanation:

> *"When our bodies are stressed or tense, our breathing tends to become more rapid and 'shallow' – that is, from higher up in the chest. Conversely, when our bodies are relaxed, we tend to breathe more slowly and deeply. The reverse relationship also stands. When we breathe rapidly and in a shallow fashion, our bodies can become more tense. This explains the importance of changing our breathing pattern in decreasing our physical tension. Slowing down our breathing and breathing more deeply can help us to achieve a state of relaxation. When we breathe deeply, we make better use of our lung capacity. We get more air in each breath. Because there is more air in our lungs, our heart rate slows down and our blood pressure lowers.*

Facilitators explain the difference between "shallow" or "deep" breathing. Deep breathing can also be called diaphragmatic breathing or belly breathing.

Example explanation:

> *"To understand the difference between shallow and deep breathing, let's put one hand on our chests and one on our stomachs, so that our pinky is pretty much touching our belly button. Now breathe like you would normally breathe."* (Facilitators allow some time for participants to take a few breaths) *"Which hand is moving more? It is quite common for the 'chest' hand to move more than the stomach hand. However, this is a sign of shallow breathing. Now, let's try exaggerating our chest breathing by making our upper hand move quickly with our breaths. How does that feel? Now we'll try to deep breathing. Let's inhale slowly and deeply, sending the air down as low as we can into our lungs. We push our stomachs out as we breathe in. We pull our stomachs in as we breathe out. The hand on our abdomen should rise while the hand on our chest stays still. Also, when we are practicing our deep breathing exercise, we want to breathe in for about 4-5 seconds, hold our breath for 1-2 seconds, and then breathe out for 5-6 seconds. If this is difficult at first, you can start with shorter breaths and practice extending these as you become more accustomed to the sensation of slow, deep breathing".*

Once the group has practiced this, facilitators will then lead the group in the deep breathing exercise. This will consist of first encouraging them to get in a comfortable, but upright position, perhaps taking off glasses, and loosening any tight clothing or shoes. They can close their eyes if they are comfortable doing so. Then, they will take 10 deep breaths. As they breathe in, they can count up from one to five and then back down from five to one. On each out-breath they can just say the word "relax" to themselves, or another equally calming word. For example, on the first breath they would say "1" on the in-breath, and "relax" on the out-breath. On the second breath, they would say "2" on the in-breath and "relax" on the out-breath, and so on. Facilitators can speak the count and "relax" out loud as a guide to participants during the exercise.

Deep breathing is a skill, and like any other skill, it is important to practice before it really can be used effectively. For some people, when they first start to practice deep breathing, they feel worse, not better. This is because they are disrupting their current normal breathing pattern. With practice, deep breathing feels better and more relaxing than shallow breathing and it becomes the

> ☞ *HINT*
>
> It might be helpful that participants establish a specific time and place for their deep breathing exercises before leaving the session.

new normal. This is why it is better to first practice deep breathing when not feeling stressed. After a few weeks after practicing when not stressed, individuals can start using deep breathing as a calming technique when they are stressed or nervous. They will also be able to "check-in" with themselves and take a few deep breaths throughout the day, either when they are driving in traffic, at their desk, in the supermarket line-up, etc. But first, it is important to develop the skill in a systematic way at times when they are not feeling stressed.

Homework Assignment

1) Participants are to try and practice assertive communication once during the week. If they do not encounter a new situation, then they can write down a past situation and apply assertive communication to this past situation.

2) Participants should practice the deep breathing exercise at least once per day.

3) Participants are to continue with their health behaviour goal for the week. This will be reviewed again next week.

! TROUBLE SHOOTING

Scenario: Participants are having trouble coming up with a stressful situation.

Suggestion: Facilitators can suggest some common life areas that many people find stressful as a cue, including: work deadlines, difficulties with family members (children, aging parents), too many demands on a person with too little time to meet all of these, conflict with friends or loved ones, feeling rushed, feeling disorganized, etc.

Scenario: Participants express discomfort with the deep breathing exercise.

Suggestion: Participants can take a break for a few moments from the exercise. They can then try to adjust their breathing so that it is not quite as pronouncedly deep, and slowly progress to belly breathing. Facilitators can also encourage participants to adjust the count and/or experiment with different calming words and images to find a combination that works for them. The key is practice! It may take time before it feels comfortable.

Emotion Management

OBJECTIVES

✓ Continue developing group alliance and cohesion.

✓ Participants will learn about the role of emotions in health and health behaviours.

✓ Participants will learn about the relationship between thoughts, behaviours, physical sensations, and feelings.

✓ Participants will begin to use strategies to identify and challenge unhelpful thoughts.

✓ Participants will learn about the benefits of engaging in physical exercise and rewarding activities in managing difficult emotions.

ICON KEY
☞ Hints for Facilitators
! Troubleshooting
✎ Facilitator Handout
📖 Participant Handout
🗩 Sample Dialogue

SESSION OUTLINE   ✎ *see facilitators' handout*

(15 minutes)	Check-in and Review Homework
(10 minutes)	Introduction to the Role of Emotions in Health Behaviours
(15 minutes)	Identifying some Common Unhelpful Coping Strategies
(5 minutes)	Cognitive Behavioural Model of Emotions
(30 minutes)	Identifying Unhelpful Thoughts and Challenging these Thoughts
(20 minutes)	Completing a Thought Record
(5 minutes)	Fear of Hypoglycemia
(5 minutes)	Role of Exercise and other Behaviours in Managing Emotions
(10 minutes)	Wrap-up and Homework Assignment

HANDOUTS

✎ Facilitators' handout: *Session 4 Outline*

📖 Participants' Handout: 4) *Managing Difficult Emotions*

SESSION ACTIVITIES

G *eneral Note:* It is always better to ask questions rather than offer advice. Remember, you're trying to encourage participants to develop awareness of their behaviour choices and problem-solve their own challenges.

Check-in and Review Homework

Facilitators check-in with each participant regarding their participation during the past week in, 1) their target health behaviour, 2) the breathing exercises and, 3) any practice using assertive communication. As with previous sessions, if a participant was unable to meet their behaviour goal, facilitators might want to ask the participant what they think is getting in the way of completing the health behaviour. Support from other group members might be enlisted to help change the participant's goal and/or expectations, or problem-solve around the identified barriers.

> Example questions: "Mary, w*hat do you think has been getting in the way of completing [the behaviour]? Has any member of the group experienced this type of challenge in the past? Does anyone have ideas of how Mary can overcome this barrier?"*

Introduction to the Role of Emotions in Health Behaviours 📖

Emotions matter in diabetes management. Engage the group in an interactive discussion to introduce this concept. Possible questions to start the discussion include:

- o *"How much work is it to manage diabetes when you are feeling good?"*
- o *"How many people here ever get stressed, anxious, sad, or angry?" (*facilitators should raise their own hands here as well)
- o *"How easy is it to manage diabetes when you are feeling stressed, anxious, sad, or angry?"*
- o *"What happens to your motivation in these cases?"*

During the interactive discussion about emotions, facilitators are encouraged to cover the points below. .

1) Diabetes management is never an easy task. It involves:

   - ➤ Strict medication regimens
   - ➤ Strict dietary restrictions
   - ➤ Regular physical activity

2) Feeling sad, anxious, angry, stressed is a normal part of life.

3) Feeling overwhelmed by these emotions can decrease our motivation to exercise, eat right, and generally take care of ourselves.

☞

HINT
As much as possible, use specific examples from group members to make the link between emotions and diabetes

4) We are naturally drawn even more towards the "quick feel good strategy"

A summarizing statement at the end of the discussion can highlight the above listed points

Example summarizing statement:

"As we heard from group members, we all have times that we feel sad, anxious, angry, or stressed. This is normal – and these kinds of feelings just naturally come and go. When we occasionally feel these types of feelings, it doesn't have a big impact on us. But if we find that we are feeling these types of feelings either for long periods of time, quite frequently, or very intensely – then they can have a negative impact on our health.

As Norm was mentioning, when he feels sad, he just doesn't feel like he has the energy to go for his walk. He just wants to sit on the couch and watch some reality TV. In general, for many people, feelings of sadness affect motivation to exercise.

Like we heard here in the group from several people, when a lot of us feel anxious, we don't feel like eating a well-balanced meal. We just want to jump right to our comfort food – whether that's chips or ice cream. Again, our feelings can have a direct impact on how we eat. In fact, we'll spend all of next week talking about emotional eating."

### *Identifying Some Common Unhelpful Coping Strategies*

Facilitators can have a brief discussion about some common coping strategies many individuals use that might be helpful in the short term, but unhelpful (or perhaps even harmful) in the long term. Facilitators can ask participants to supply some examples of things they do when they are feeling stressed, sad, anxious, or angry. The point should be made that once in a while, it's okay to stay home and curl up in bed when one is feeling sad, but that this should only be for a brief period, and that it is more helpful to leave the house when one is feeling down. The same holds for escaping situations that make one anxious: if they stay in the situation, they can learn that they can handle it – but if they escape, they will never learn that they can handle it. Similarly, lashing out or hitting something can result in feelings of guilt and can negatively impact one's relationships. Finally, drugs and alcohol are never a good way to cope with difficult emotions.

Common unhelpful responses to emotions

Sadness	Stress/Anxiety	Anger
Stay at home	Avoid the situation	Lash out
Curl up in bed	Escape the situation	Hit something
Retreat from the world	Try to control the situation	Drugs or alcohol
Drugs or alcohol	Drugs or alcohol	

Cognitive Behavioural Model of Emotions

Emotions have four components: thoughts, behaviours, physical sensations, and feelings.
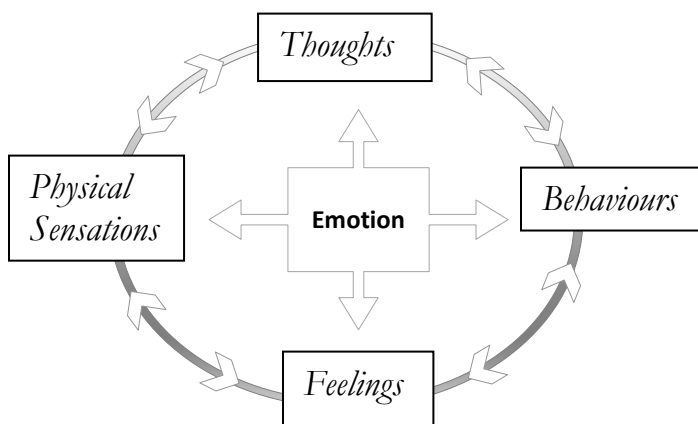
All of these components of emotions affect one another. (*note*: figure included in Handout 4).

One way to illustrate this is to ask a participant to describe a recent situation when they felt anxious. Facilitators then ask that participant what the situation was, if they remember any physical sensations they felt, if they remember what they were thinking, and if they remember what they did. And then how they felt after that behaviour.

Example dialogue:

Facilitator: *"Does anyone have an example of a time recently when they were feeling anxious or nervous?"*

John*: "Well, the other day my boss asked me if I would present our new project at the departmental meeting. I really hate speaking in front of groups and was feeling really anxious about it. Plus, I wasn't sure exactly what my boss wanted me to present."*

Facilitator: *"That's a great example John. Now if you go back to right after your boss made the request – can you think of that moment? Can you remember at all what your body was feeling like? Did you feel any physical tension anywhere, and if so, where was it?"*

John: *"I can't really remember specifically that time, but I know that when I do feel anxious, my stomach gets pretty upset. I know that I clench my jaw a lot too. So I was probably clenching my jaw and my stomach was probably all in knots."*

HINT
Sometimes participants can benefit from gentle probing when they begin with broad statements like "I hated that" or "I felt terrible". The goal is to identify more specific and underlying thoughts and emotions Maybe asking them what they pictured happening, or what else they were thinking or feeling at the time.

Facilitator: *"Yes, those are two really common physical signs of anxiety – does anyone else here in the room feel their anxiety in their stomach or find themselves clenching their teeth or jaw?* (wait for nods). *Okay John, do you remember what you were thinking, or what you were telling yourself at that time?"*

John: *"I remember thinking that I hate presenting in public. I couldn't believe that my boss wanted me to present the new project. I mean, she knows what the project is, so why doesn't she just present it?"*

Facilitator: *"This is very helpful John, thank you for sharing. Now continue to think back to that time – do you remember thinking about how that meeting would go, or what would happen at the meeting?"*

John: *"Yes. I remember picturing myself at the meeting and that I would stutter. I was thinking that I would probably get some of the information wrong, and then my boss would correct me in front of the whole department. Then I would look really dumb, like I didn't know what I was talking about – that would be really embarrassing."*

Facilitator: *"Okay, that's really good information. So you thought to yourself 'I'm not going to do a good job, I'll get some of the information wrong, my boss will correct me in front of everybody and then people will think that I'm not competent.' So those were your thoughts, do you remember how you felt?"*

John: *"Well, I was just really anxious and was dreading going there."*

Facilitator: *"What did you end up doing?"*

John: *"Well, I woke up that morning, and I wasn't feeling great, so I thought I should stay home. I knew that my boss was going to be there anyway, and was more than capable of presenting the new project. I called in sick and just rested up to make sure that I wouldn't get too ill."*

Facilitator: *"Okay – so you stayed home to prevent from getting sick and you ended up avoiding the presentation. How did you feel about that?"*

John: *"I was relieved to not have to present, but I also felt a little guilty. I guess I was kind of upset at myself in a way. But it was good that I avoided looking dumb in front of everyone."*

Facilitator: *"Thanks for sharing that example John. That is a really great example, and I think that most of us can relate to a time when we were really anxious about doing something and ended up avoiding the situation entirely. In*

> **HINT**
> When facilitators are explaining the connection between thoughts, physical sensations, behaviours, and feelings, they may want to refer to and point to the four components diagram on participants' handout.

John's case, can the group see how his feelings of anxiety were felt in his body? They were also influenced by some of his thoughts. He was thinking that he wasn't going to do a good job and that he would be criticized or judged by others. Then his behaviours were affected by his thoughts and feelings of anxiety. Finally, his behaviours affected the way he felt as well. As we can see from this example, these four components of anxiety are all related. In many cases, though, we are not consciously aware of these different reactions happening and influencing each other. And usually we don't even know we are having what we call unhelpful thoughts, because they become so automatic. We just know that we are having the feelings of anxiety, but we can't identify why. A lot of the time, however, it's because of something that we are thinking, or some kind of messages we are telling ourselves, even if we are not aware of these messages. So part of the challenge is to try and identify these thoughts and messages to break the cycle."

Identifying Unhelpful Thoughts and Challenging These Thoughts 📖

Facilitators can begin the discussion on altering unhelpful thoughts by emphasizing that it can be difficult to change some of the difficult emotions we experience. How many times have we heard advice like "Oh, don't worry", or "Cheer up" – how helpful is this for actually *changing* our feelings? Of the four components of emotions, the feeling is the most difficult to change. But our feelings are influenced and can be changed by other components. This is why the rest of today's session is focused on thoughts and behaviours, starting first with 'thoughts'.

Thoughts: At this time, facilitators can remind participants that, as with the grocery store example the previous week, situations can be stressful or not depending on how we interpret or react to them. The same holds true for any emotional reaction. One thing that we can change is how we interpret different situations (past, present, or future). That is, we can alter our thoughts when our thoughts are not helpful.

It is important for facilitators to make the point that it can sometimes be difficult to identify one's own thoughts. Thoughts become very automatic, or can be hidden behind other types of thoughts. John's example above shows how, at first, John came up with a thought that was not directly linked to anxiety (i.e. why doesn't the boss just present), but when probed more directly, he was able to come up with anxiety-provoking thoughts (i.e. I will be judged, make a mistake and be embarrassed). Identifying those particular thoughts that are associated with a feeling is a skill that has to be developed. At first, it can take some time and effort to uncover. With practice, it becomes easier.

At this point of the session, facilitators go over common types of unhelpful automatic thoughts with participants (found in the 'Label for Automatic Thought' column in the box below). Facilitators can ask for participants to give an example of when they had any of these types of thoughts. Or, they can come up with a hypothetical situation, and then ask participants to provide a thought that would fit into each category. Then, by using the column of "Alternate ways of thinking", they can help to counter those thoughts by coming up with a specific statement related to the situation.

Example question:

"Mind reading is when we think that we know what others are thinking – these tend to be negative. Can anyone come up with a situation when they have done some mind reading in the past? (If no one answers). Okay, what about if you go see your doctor, and she doesn't spend as much time with you as she usually had in the past. If you were mind reading, what might you think? (Wait for answer). *Now, what would be a more helpful, and perhaps more realistic way of thinking about this?"* (Wait for answer).

☞

HINT

The situations and thoughts below are only examples that can be used if participants are having trouble coming up with their own examples. Facilitators should encourage participants to come up with their own situations, specific thoughts, and alternate ways of thinking. This personalization will lead to better learning. Facilitators can also use examples that have been brought up by participants either earlier in this session, or in previous sessions.

Example Situations For Common Automatic Thoughts

Situation	Specific Thoughts	Automatic Thought	Alternate Ways of Thinking
The doctor didn't spend as much time with you today as she used to	"She must have given up on me. She must think I'm a lost cause"	Mind reading	"I don't know what people are thinking"
You forget to test your blood sugars (or) Your spouse is upset at you for forgetting something.	"Ugh! I'm NEVER going to get this diabetes thing right!" (or) "Why can't I ever remember anything?"	Overgeneralization: Always, never	"This is just one example" "There are examples of times when I wasn't or didn't do this type of thing."
You've been encouraged to improve your diet	"I won't be able to do this. I'll fail"	Predicting the future	"I don't know that things will go badly"
You are about to give a speech in public	"I'm gonna really mess up this speech"	Overestimating the probability	"What are the chances? How many times has this happened before?"
You are about to give a speech in public	"I'will mess up this speech. It will be so embarrassing"	Thinking the worst *(catastrophizing)*	"So what if that happens? Is it really as bad as I think? Will I survive?"
You have one cookie	"I've blown it now. I might as well forget this whole diabetes-friendly diet."	All or nothing thinking	"I've been following a diabetes-friendly diet for most of the week. This was just one time"
You did not have time to prepare a lunch and had to buy lunch instead.	"I should be organized enough to make my lunches!"	Should thinking	"It would be nice, but it's not necessary. If it doesn't happen, it's still okay"

Completing a Thought Record 📖

Facilitators direct participants' attention to the second page of Handout 4. Participants are asked to think of a recent situation when they felt stressed, anxious, sad, or angry and to fill out the form accordingly. Facilitators will want to check-in with participants at this time to see if anyone either does not understand a part of the exercise, or has trouble thinking of a recent situation (facilitators can refer to the troubleshooting section below).

Once participants have completed the thought exercise, they can either review it with a partner, or facilitators can ask one or two volunteers to share with the group.

Fear of Hypoglycemia

Facilitators can begin this discussion by asking participants if they ever feared a hypoglycemic episode (blood sugars becoming too low) from not eating enough. Inform participants that research indicates fear of hypoglycemia drives some individuals to overeat and end up with blood sugar levels above recommended levels.

The group can have a brief discussion to highlight the difference between motivation to avoid potential short-term consequences of a hypoglycemic episode and the negative long-term consequences of maintaining blood sugars above recommended levels. Facilitators can help participants determine the pros and cons of overeating in attempts to avoid hypoglycemic episodes. Participants can also be encouraged to consider whether their thoughts about some of the possible negative consequences of a hypoglycemic event are realistic or exaggerated. As has been mentioned before, it is always more helpful to ask questions of participants in a curious and respectful manner, so that participants arrive at their own answers, rather than provide answers for them or give them advice. For example, some individuals might fear becoming irritable, or feeling humiliated; however, balancing these potential short-term consequences with the long term consequences of overeating can be helpful. Additionally, individuals who have elevated anxiety levels might misinterpret the physiological signs of anxiety (e.g., sweating, dizziness) as an impending sign of a hypoglycemic episode, leading to unnecessary overeating. If this is a concern for some participants, they can be encouraged to learn to better distinguish between perceived and actual impending hypoglycemic episodes by assessing their glucose levels at these ambiguous times. Facilitators can assess the needs of the group to determine the length of time to spend on fear of hypoglycemia.

Role of Exercise and other Behaviours in Managing Emotions

We have discussed the role of our thoughts. Now, the other component we can look at for managing difficult emotions, is our behaviour. As was explained, avoiding situations that make us anxious or escaping from the world when we are feeling down may seem appealing and temporarily rewarding, but in the end, these types of strategies are just not helpful.

ANXIETY AND AVOIDANCE

The group can have a discussion about the importance of *not avoiding* situations that make us anxious. There are several points that should be covered during this discussion First, avoiding a situation has the effect of teaching us that we cannot handle that situation. Second, our thoughts about feared situations are often far worse than the reality of that situation, so facing the situation teaches us that "it's not as bad as we had thought it would be". Third, sometimes when we avoid situations that make us anxious, we miss out on important parts of our lives, career development, or personal growth.

SADNESS AND RETREAT

When we feel down, we sometimes don't feel like doing anything, but not doing anything can perpetuate our feelings of sadness. This can become a cycle.

FEELING DOWN

NOT DOING THINGS THAT GIVE
US PLEASURE OR THAT ARE REWARDING
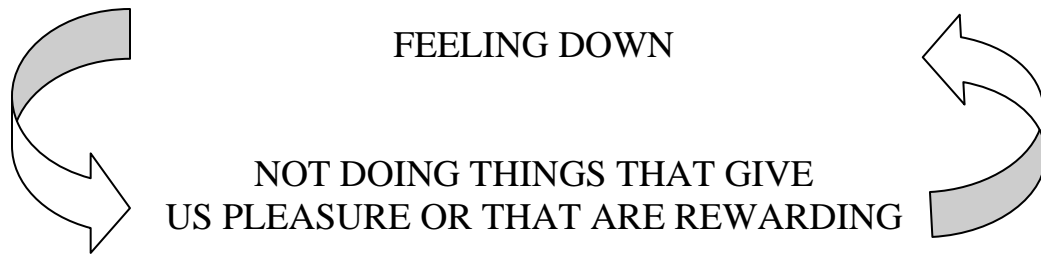
It is important to note that one of the best ways to break the cycle is to do *something* to get us started – even when we don't feel like doing it. This can mean going out to meet with friends, exercising, or any other behaviour that gets us doing **something.** One saying to remember is:

DO IT NOW - FEEL LIKE DOING IT LATER!

Doing something is better than nothing, but it is also important that we do not limit ourselves to just doing things to check them off a "to-do list". It is much more helpful when we engage in activities that are fulfilling and meaningful to us, or that give us pleasure. Doing things that are meaningful and give us pleasure are both satisfying and reinforcing, which helps our motivation and our mood. Non-meaningful or non-pleasurable activities may not be as useful in lifting our moods.

Facilitators should include a brief discussion on the emotional health benefits of physical activity or exercise. Research has shown that exercise can be as effective, and sometimes even more effective, in treating mild to moderate depression than antidepressants. Exercise can also be considered a preventative measure against depression. Exercise has also been shown to decrease anxiety levels, and to increase subjective emotional well-being. Facilitators can ask participants to recall an instance when they felt good after engaging in some form of physical activity. Recalling positive feelings and reactions that emerge right after engaging in physical activity (e.g., sense of accomplishment, pride, endorphins leading to mood boost) can also increase our motivation to exercise when we might not particularly feel like it. Facilitators can remind participants that the expression "Do it now, feel like doing it later" can also be interpreted to mean that once we've done it, we are really glad that we did.

Again, it is important to find something that we enjoy doing when we think about engaging in exercise. This is the best way to ensure that we will keep at it for the long-term. Facilitators can encourage participants to create their own list of physical activity ideas.

Wrap-Up and Homework Assignment

1) Participants will choose two situations during the next week when they feel a difficult emotion – perhaps a situation where they feel stressed, anxious, sad, or angry. They are asked to complete a thought record for these two situations.

2) Participants will continue to work on their goal behaviour.

! TROUBLE SHOOTING

Scenario 1: Participants have trouble coming up with a scenario for the thought record.

Suggestion: If they can't think of a specific example from the recent past, they can maybe come up with a scenario that they know would make them feel anxious. Perhaps an upcoming evaluation at work or a time when they would have to speak in public.

*Scenario 2:* Participants have trouble identifying thoughts associated with a specific feeling and situation.

Suggestion: It can be challenging to become aware of thoughts. The facilitator can help by probing with questions like, "how did it make you feel", "what was going through your mind at the time". Alternatively, the facilitator can leave the sentence incomplete for the participant to fill in, "you were nervous to present at the meeting because…", and, if needed, continue following up the participant's answers with comments like "and what does that mean to you?" in order to find the trouble thought (e.g. participant: "I was nervous to present because I might say something wrong in front of all my superiors", facilitator: "and what does that mean to you", participant: "that I might get fired", facilitator: "and what does getting fired mean to you", participant: "that I'm a failure". The belief that "I'm a failure" is likely the source of anxiety in this scenario and worth evaluating.)

SESSION 5

Overcoming Emotional Eating

OBJECTIVES

✓ Continue developing group alliance and cohesion

✓ Participants should leave session five with a better understanding of some of the common factors associated with emotional eating

✓ Participants will begin to differentiate between times they eat to satisfy physiological hunger and times they eat because of boredom, sadness, etc.

✓ Participants will identify ways they can begin to substitute emotional eating with other healthier options

✓ Participants will continue to establish healthy eating patterns

ICON KEY

☞ Hints for Facilitators
! Troubleshooting
✎ Facilitator Handout
📖 Participant Handout
💬 Sample Dialogue

SESSION OUTLINE   ✎ *see facilitators' handout*

(15 minutes)   Review Homework

(10 minutes)   The Difference Between Hunger and Appetite

(15 minutes)   Introduction to Emotional Eating

(20 minutes)   Recognizing Signs of Emotional Eating

(10 minutes)   Risks and Consequences of Emotional Eating

(10 minutes)   Understanding Triggers to Emotional Eating: *Using a Food Log*

(30 minutes)   Decreasing Emotional Eating

(10 minutes)   Wrap-up and Homework Assignment

HANDOUTS

📖 Participants' Handout: 5) *Emotional Eating: Food Log*

SESSION ACTIVITIES

General Note: It is always better to ask questions rather than offer advice. Remember, you're trying to encourage participants to develop awareness of their behaviour choices and problem-solve their own challenges.

Review Homework

Facilitators review with participants their involvement in the behavioural goals they have been working on since the beginning of the group. Facilitators also review last week's homework, which consisted of completing two thought record entries. Facilitators ask participants if they were able to recognize and challenge any unhelpful thoughts, and if this impacted their mood. It is also helpful to let participants know that this is a new skill they are developing, and it will take some time, and a lot of practice, before participants become adept at this exercise. The goal of the exercise is to eventually be able to challenge our unhelpful thinking "in the moment" to help with difficult emotions.

The Difference Between Hunger and Appetite

Facilitators can begin the discussion by asking participants if they know the difference between appetite and hunger. Alternatively, they can ask if participants have ever eaten when they were not feeling particularly hungry.

Below is the general information that should be conveyed during this discussion.

We can eat because of internal cues or physical hunger. HUNGER is a complex process, and is influenced by certain hormones. For example, the hormone leptin *decreases* our physiological drive or motivation to eat, whereas the hormone ghrelin *increases* our drive to eat. The amount of leptin and ghrelin released is a complicated process that is influenced by factors such as the amount of time since we last ate, whether we are "dieting", whether we have recently lost weight, etc.

On the other hand, APPETITE is our desire to eat. It is not influenced by the physiological need for food. A number of external cues influence our appetite. Facilitators can ask the group if they can think of factors that might affect appetite levels and eating. The following points should be covered during the discussion.

- **Availability of food** – Availability of food has the most direct influence on what and how much a person eats (e.g., if we know the chips are in the cupboard, we will more likely want to eat them; if the candies are visible from our office desk, we will more likely eat them)

- **Smell and look of food** – It is said that we not only eat with our mouths, but also with our eyes and noses. Seeing and smelling appealing foods will make it harder to resist eating (e.g., seeing television commercials with delicious-looking food, smelling food in a shopping mall or on the street)

- **Social cues** – Social activities are often paired up with eating (e.g., our mother-in-law offering us seconds, meeting friends at an establishment where food is served)

- **Environmental cues** – We learn to associate certain environmental cues with food (e.g., being at the movie theatre, driving by our favourite fast food restaurant, being in front of the television)

- **Emotions** – Most of us eat in response to our emotions at some point in time or other (e.g., feeling down and reaching for the chocolate)

Introduction to Emotional Eating

1. Emotions that can trigger emotional eating

Facilitators can engage the group in an interactive discussion about emotional eating.

> Example Question: *"Who can think of a time when they engaged in emotional eating? What led you to eat during those times?"*

As group members speak of different situations and emotions associated with eating, facilitators can highlight the emotion and the situation. If group members do not mention eating in response to the following emotions during the interactive discussion, facilitators can specifically ask for examples of eating in response to the following emotions:

Negative Emotions	Positive Emotions
Boredom	Excitement
Stress	Happiness
Sadness	
Anxiety	
Loneliness	
Anger	
Fatigue	
Guilt	

> **H I N T** Facilitators might want to highlight that even positive emotions can trigger emotional eating. This might be overlooked by some as a cause of emotional eating

2. The Emotional Eating Cycle

Facilitators can explain that when we engage in emotional eating, we sometimes get trapped in a cycle. We eat to feel better, but then we feel worse, and then we end up eating more. Or, as was discussed during the second session, we fall off the wagon and feel discouraged and then give up our resolve to be and eat healthier.

The purpose of this discussion is to establish and normalize that most, if not all, individuals engage in emotional eating to some degree. The difference is in the extent to which they engage in emotional eating, and whether they *over*-eat in response to emotions. The purpose of the session today is to identify the personal triggers of emotional eating for participants,

and to decrease the frequency and amount eaten in response to emotions. The goal is to learn to avoid getting caught in the cycle.

3. Some reasons why emotional eating occurs

Facilitators can ask the group why they think emotional eating is so common. Ensure that the following points are addressed/highlighted during the discussion.

Evolutionary benefits to eating -- We have a strong motivation to eat – this is because of evolution – those who did not eat enough did not survive to pass on their genes. Although there have been severe negative consequences for not eating enough (dying and not passing along our genes), there have been no negative consequences for eating too much from an evolutionary standpoint. Also, high fat and high caloric foods were an advantage in terms of helping with our survival because these foods provided sustained energy in an environment where food was scarcely available. So, some believe that we have evolved to prefer high fat / high calorie foods. Unfortunately, our bodies have not adapted to our current environments where there is an abundance of food and our lifestyle is much more sedentary.

Rewarding properties of food -- If we think of our evolutionary history – because of the physical efforts of gathering food, eating had to be rewarding to encourage continued efforts to obtain more food and ensure survival. Some of the same chemicals, like dopamine, that are released when we engage in other rewarding activities like sex or drug-taking, are released when we eat.

Eating as distraction -- Eating can act as a distraction to negative emotional experiences. Our attention is focused on getting food and eating. That means that we are not thinking about the fact that we are bored, lonely, stressed, anxious, etc.

Recognizing Signs of Emotional Eating

How do we become aware that we are emotionally eating?

Facilitators can ask participants to reflect on and discuss the following questions by recalling a time when they either ate or thought of eating, outside of a meal or regular planned snack time.

- **Did they notice the desire coming on fast, or did it grow gradually?** Physical hunger is gradual, first a little gurgle, then a grumble, then hunger pangs.

- **Did they feel an almost desperate need to eat something right away?** Physical hunger can hold off; emotional hunger needs food immediately.

- **Would any nutritious food have sufficed, or did they need a certain type of food or treat to satisfy themselves?** Cravings are the difference here. Physical hunger allows for a conscious choice while emotional hunger pulls us towards comfort foods (sweet, salt, fat).

- **Did they eat when they were emotionally upset or experiencing feelings of "emptiness"?** Emotional eating is triggered by an emotion, physical hunger is due to a physiological need.

- **Did they use food as a reward?** Thoughts like, "I deserve this piece of chocolate because….." can be a trigger for emotional eating.

- **Did they eat secretly or hide the evidence of what they ate?** With emotional eating, we are sometimes ashamed that we are eating or else don't want anyone to know (e.g., we throw the empty fast food bag out at the gas station on our way home).

- **Did they pay attention to what went in their mouth, or did they just stuff it in?** Mindfulness is the difference here…physical hunger allows us to make a choice about food. Emotional hunger does not and sometimes leads to eating when we are not even aware of the fact that we are eating.

- **Did they feel that they couldn't control the amount that they were eating and continued to eat even when they were obviously full?** Sometimes with emotional eating, we feel that we can't stop eating even when we are physically full. When eating because of physical hunger, it is usually easier to stop once we have satisfied the physical hunger.

- **Did they feel guilty after they ate?** Emotional hunger often results in guilt, satiating physical hunger typically does not.

Risks and Consequences of Emotional Eating   📖

Facilitators can engage the group in a discussion about risks and consequences of emotional eating. They should ensure that the following points are covered during the discussion.

1. Usually with emotional eating, we head for high fat, sugary, or salty foods - or more generally, calorie-dense food. These are usually not a good choice for anyone, but they are potentially dangerous for individuals with diabetes. There has been some research suggesting a biological basis for this preference. For example, rats in controlled environments, who are exposed to chronic stressors (like tail pinching), will be more likely to eat during this stress, but only if they have the option of choosing the high-calorie, sweet food. If they are presented with only their regular non-sweet food, they are not more likely to eat during stress.

2. With emotional eating, usually we tend to overeat.

3. We might feel better temporarily, often when we start eating. We feel badly afterward.

4. Emotional eating might affect our blood sugars, leading to hyperglycemia.

5. We become at risk for weight gain, with its associated health consequences

Understanding Triggers to Emotional Eating: Food Log   📖

Participants are instructed to read the food log portion of Handout 5. The goal of this exercise is to learn how to identify the personal triggers of emotional eating. Participants are to complete the form during the following week. They are instructed to NOT CHANGE any of their eating habits during the week. The goal is to become aware of what they normally do, not to make some short-term changes. Every time participants eat outside of a meal or a "planned snack" time, they are to document what they ate, and fill out the rest of the columns on the food log.

Once they have completed the log, they look for patterns. Are there certain times of day that are particularly bad? Are there certain situations that come up often? Are there certain emotions that seem particularly difficult? By understanding how and why we engage in a behaviour like emotional eating, we are better equipped to change the behaviour. With the triggers identified, we can plan for other behaviours to replace the function that eating has (the topic of "*Replacing the Function*" is discussed further in this session).

Decreasing Emotional Eating   📖

GENERAL COMPLIMENTARY STRATEGIES

At this point during the session, facilitators can begin an interactive discussion about some of the general strategies people have used or can use for general healthy eating. These are an important first step to decreasing emotional eating.

1. Limiting access to less healthy foods. Increasing access to more healthy foods.
- Get the problematic foods (e.g., if the trigger is chips) out of the home. If they are not easily accessible, we are less likely to eat them. If that is not an option, then we can make unhealthy foods more difficult to reach - out of sight in the back of the highest shelf in the pantry. We need support from other members of our household for this, perhaps by having a conversation about our goals to eat healthier. This might be good for the whole household. If other members of the household insist on keeping unhealthy treats in the house, can we agree on something that isn't a trigger for us? Perhaps there is a food that they like, but that we don't necessarily care for. Another idea is to have a separate place where household members keep unhealthy treats that is out of our sight/not accessible.

- To limit the second helpings, we can leave the extra meat and starches in the kitchen, and keep the extra salad and vegetables on the table.

- We can avoid driving by a place that we know will tempt us and pull us in. If we can't resist the temptation, we can change our route.

- Use smaller plates to encourage modest proportion sizes.

- We can avoid cooking too much of the wrong types of food in the first place. Or we can portion out the food and freeze the rest before sitting down. Alternatively, we can throw

it out. Remember that it's okay to leave food uneaten. We don't save money by eating all the food on our plate. We won't use those extra calories we are consuming.

2. **Shopping when we are not hungry**. This is important, because when we are very hungry, we may not make the best decisions about food, and we may bring unhealthy, trigger foods into the house.

3. **Setting a meal plan.** It doesn't have to be the whole week at a time, but when we leave in the morning, we can try to have planned what we are having for supper. What we are attempting to avoid is the "What am I going to have/make for this meal" issue, which tends to lead to emotionally-based decisions. Similarly, we want to avoid the question "What do I feel like, what do I have a taste for?" as this is also emotionally-driven.

4. **Eating at least three meals per day.** Any time our body goes more than 12 hours without a meal (including hours spent asleep) it slips into chronic stress mode, reducing metabolism by as much as 40%. This means our body holds onto calories. The hormones associated with hunger (e.g., ghrelin) also start to increase in our body. If we consistently skip breakfast (and therefore have a prolonged period without eating), we will most likely not lose weight because our body's natural chronic stress response will kick in, slow down our metabolism and increase our appetite.

5. **Reflecting before eating**
    ◦ Stop
    ◦ Breathe
    ◦ Reflect
    ◦ "Why do I want to eat right now?"
    ◦ "Why this food?"
    ◦ "Is this what I really need nutritionally?"
    ◦ Choose

6. **Being mindful of eating**

- Eating mindfully means: Looking at, smelling, feeling, and tasting our food. Letting it settle, savouring each bite and pausing in-between bites.

- We want to aim to eat when "gently hungry" rather than "over hungry". We are more likely to overeat and not enjoy food when over hungry.

- We want to aim to eat consciously, and without distraction (i.e. TV).

- Pausing in the middle of a meal can help us control the amount we eat.

- We don't need to feel obligated to eat all the food on our plate. We can pack the rest away mid-meal if we need to.

SPECIFIC EMOTIONAL EATING STRATEGIES

If we have learned to cope with emotions by using food, and we take away food, what happens the next time we have an emotional experience?

We have to find and plan for adaptive coping strategies that are not food. If we don't, the moment we have an emotional experience or we encounter a significant trigger, we are likely to turn to food because that has been the way we have coped in the past (i.e., it has become a well-formed habit).

Facilitators can encourage participants to ask themselves these three questions when they feel like eating outside of a planned time, or when they want to take a second helping at a meal…

1. **Am I physically hungry or emotionally hungry?** Learn to recognize the signs and feelings of true physical hunger, and eat only when experiencing them.

2. **Am I actually thirsty rather than hungry?** We often confuse the two. Try drinking a glass of water or a cup of tea and then reassess.

3. **Have I given my body enough time after eating to register that it's full?** Wait 15 minutes before taking that second helping.

If these questions lead to real physical hunger, then we know to eat. However, if it is not physical hunger driving us, this is when we need to consider a different approach to eating. It is important to recognize that when it comes to emotional eating, food serves a function – it helps us to manage emotions. To change emotional eating habits, we need to "replace the function".

Facilitators can remind participants that the group has been talking about coping with stress and other difficult emotions for the past two weeks. The group can discuss some of these coping strategies and how they can be used instead of food.

Replacing the function of food:

> If I eat to calm myself….what else helps me feel calm?
> If I eat as a reward….what else can I use as reward?
> If I eat to feel better…what else makes me feel good?

Facilitators should ask participants, as a group, to generate a list of coping alternatives to eating. Below are some examples:

- Read a good book or magazine or listen to music.
- Go for a walk.
- Take a bubble bath.
- Do deep breathing exercises.
- Play cards or a board game.
- Talk to a friend.
- Do housework, laundry, or yard work.
- Wash the car.
- Write a letter.
- Do any other pleasurable or necessary activity until the urge to eat passes.

Wrap-Up and Homework Assignment

1) Participants will fill out the food log for the next week.

2) Participants will continue to work on their goal behaviour.

! TROUBLE SHOOTING

Scenario: Participants have difficulty managing emotional eating in social situations (e.g., feeling stressed at a work function with food, or feeling happy and celebratory at a family party).

Suggestion: Facilitators can normalize the fact that social situations can be difficult to navigate when it comes to healthy eating. Eating is very closely tied with our social culture. Availability is also a challenge – there tends to be a lot of variety and foods we enjoy at social events. Facilitators can seek input from the group about suggestions for maintaining healthy and/or hunger-based eating in social situations. A few strategies to try include:

- Eating a small meal and drinking water beforehand so that you're not "over hungry" when we arrive

- Survey the food available before choosing what we want to eat the most

- Using a small plate and selecting only 2 or 3 items at a time

- Filling our plate with vegetables and salad! If we feel pressure to eat multiple helpings, choose seconds of these items

- Before getting more food, drink a glass of water

- Being mindful of what we're eating - put down our utensil or plate between bites
- If we are being pressured to eat by others, practicing the broken record method to refuse food

SESSION

6

Preparing for the Future

OBJECTIVES

✓ Participants will identify ways to remain accountable after the group is finished

✓ Participants will learn the difference between lapses and relapses

✓ Participants will learn to identify trigger situations and strategies to remain on track when faced with these situations

✓ Participants should leave session 6 with increased confidence that they can sustain the changes they have made thus far in the long term

ICON KEY
☞ Hints for Facilitators
! Troubleshooting
✐ Facilitator Handout
📖 Participant Handout
💬 Sample Dialogue

SESSION OUTLINE   ✐ *see facilitators' handout*

(20 minutes)   Homework Review

(10 minutes)   Reviewing Past Materials

(20 minutes)   Staying Accountable after Group has Ended

(5 minutes)   Introduction to "Lapses" and "Relapses"

(20 minutes)   Dealing with Triggering Situations

(10 minutes)   Getting Back on Track after a Lapse

(10 minutes)   Wrap-up

HANDOUTS

📖 Participants' Handout: 6) *Preparing for the Future*

Homework Review

Part of today's session will focus on tips for staying on track with the chosen health behaviours after the group has ended. First, facilitators check-in with participants about, 1) their target health behaviour, and 2) their food log. Regarding the food log, facilitators can ask participants if they have noticed any patterns with respect to snacking. Was there a time of day that was particularly troublesome? Mid-evening, a few hours after supper, is a time of day when many individuals find themselves engaging in unhealthy snacking? Were there any specific emotions that triggered eating? The group can discuss ways of limiting unhealthy snacking based on results of participants' food logs. They can, for example, discuss ways to replace eating with another activity during these troublesome times and when experiencing triggering emotions.

> *HINT*
> It is often more helpful when recommendations and suggestions come from other group members rather than from facilitators.

Reviewing Past Materials

At this point, facilitators can invite participants to share with the group what they have learned from participating in the group, and what they remember from the previous five sessions. Handout 6 contains a few salient points from the past five sessions.

Staying Accountable After Group Has Ended

Participants often report that while they are in the group, they are able to engage in their target health behaviour; but, that sometime after the group ends, their healthy behaviour goals dwindle and revert back to old bad habits. This is partly due to the fact that every session participants check-in with the group about their health behaviours, thereby increasing accountability. Participants are encouraged to discuss ways to remain accountable and on track after the group ends.

Facilitators can ask for input from group members of general ways they can remain accountable. Below are a few ideas of some possible ways to remain accountable after the group ends. Facilitators might also want to prepare a few ideas prior to the group based on the knowledge they have gained about group members over the past six weeks.

Examples to maintain accountability:

- o Keep a journal or calendar to keep track of your involvement with the target health behaviour.

- o Write down reasons to engage in these health behaviours and keep this list close by and visible. Perhaps revise the list on a regular basis to incorporate any new information.

o   Have a friend or family member help you stay on track. Regularly check-in with the person to "report in" on your health behaviours.

o   Even better, have a partner to participate in the health behaviour with. This way, even when one doesn't feel like going out and exercising, for example, you know the other person is relying on you. This will help you stay accountable.

o   Plan for rewards when engaging in the health behaviour for a certain period of time.

o   If you find yourself getting bored or tired of a certain activity, or that you are continuously dreading the activity and no longer find it rewarding, take some time to think of alternatives. For example, with walking, maybe you can find a new walking route. Alternatively, you can try to find someone new to walk with. Walking with a new person can be an excellent way of getting to know new people. You might have a lot to talk about if you are getting to know each other and the time walking will pass by quickly.

Participants can record their strategies on Handout 6.

Introduction to "Lapses" and "Relapses"

The concept of lapse and relapse originated in the field of addictions. When speaking with people with a drug or alcohol use disorder, a lapse is described as a brief break in recovery behaviours. An example of a lapse can be having one drink when one is trying to abstain from alcohol. A relapse is described as a more serious and pervasive absence from maintaining recovery behaviours. Using the same example, a relapse would be going back to old drinking patterns. These concepts are not limited to the addiction world, but can be adapted to any behaviour goal. In terms of eating, for example, a lapse might be having a second piece of cake, whereas a relapse might be falling into our old pattern of a nightly piece of cake for an extended period of time. Sometimes it can help to recognize lapses early, and make a conscious effort to help prevent the lapse from becoming a relapse. Encouraging messages such as, "*Okay, I didn't eat particularly healthy today, but there was really not much damage done in one day. Tomorrow I can get back on track*", can be much more helpful compared to discouraging messages as, "*I've really blown it now with what I've eaten today. I should have known that I couldn't stay on track. I always sabotage myself. I may as well give up on these goals because I'll never be able to follow-through anyway*".

A lapse is very similar to the concept of "falling off the wagon" that was discussed during Session 2. In a way, lapses can be considered as FALLING OFF the wagon, and relapses can be considered as STAYING OFF the wagon. We all experience lapses in our behaviours. The important part is not to let that lapse become a relapse. That is, not to fall back into old habits even when we've strayed temporarily from our goals.

For any health behaviour, there are triggering events and times of the year when it can be difficult to maintain one's behaviour goal. Facilitators can engage the group in an interactive discussion where participants come up with situations that can trigger unhealthy behaviours. Participants then brainstorm ways that they can stay on track even during those times (these can be recorded on Handout 6).

Examples of common triggering situations:

- Going on vacation/ being away from home

- Visiting certain friends or family members whom we know will "push" to engage in unhealthy behaviours.

- A busy time at work (e.g., before year end, before major reports are due)

- The holiday season

- Change in weather/season

Example strategies to deal with these triggers:

☞

HINT
These examples are meant to stimulate discussion in the case where participants are not volunteering their own situations or strategies. They should only be used as a last, or at least later, resort.

- Prepare ahead of time what to say to others in difficult situations (remembering the broken record from session 5).

- Plan for busy times by having healthier snacks and meals ready ahead of time

- Use healthy eating strategies from session 5 to help with situations outside of a regular routine (e.g., parties, vacation)

- Identify alternative physical activities in the event of a change to schedule or of season.

- Even if we have to decrease the amount of time we have to exercise, try to fit in 5-10 minutes here and there (it is hard argue that we don't have a spare 5-10 minutes in our schedule)

Next, facilitators can encourage participants to discuss ways to get back on track during times that they find themselves falling off the wagon or lapsing (record these on Handout 6).

Examples of common strategies to get back on track:

- Remember not to be too hard on ourselves. Most people, at some point, get off track.

- When we identify that a lapse has happened, we can write down a plan to get back on track.

- We can talk to a friend or family member about being off track. Sometimes getting something off of our chest, instead of keeping it inside, can be helpful.

- We can look back at the materials from the group and think about the things we learned during this group.

Wrap Up

Facilitators can ask participants if they have any parting comments before the group ends. Facilitators can also inform participants of other resources and/or services that are available to them on their quest to move forward. Facilitators can also prepare an evaluation form in order to obtain feedback from participants for ideas on ways the manual can be adapted to best meet the needs of specific populations (e.g., rural populations, visible minorities).

Content for this final session was estimated at 1 hour 45 minutes. This gives a chance for participants to chat for 10-15 minutes after the group has ended. Group members frequently develop a connection during these interactive groups and it can be helpful to allow for a little bit of time to say goodbye informally and perhaps even exchange contact information to stay in touch after the group has ended.

HANDOUTS

Are You Ready to Change?

Your Health Behaviour

Complete the following:

A behaviour I would like to or feel I should change: _____

_____

Are You Ready to Change?

Note: X= *the behaviour you identified above* (a behaviour I would like to or feel I should change….)

1.	Do you consider X a problem?	YES	NO
2.	Are you bothered by X?	YES	NO
3.	Are you interested in change?	YES	NO
4.	Are you ready to change now?	YES	NO

RESULTS

GREEN LIGHT: You are ready to move ahead with planning your behaviour change. It's helpful to do a decisional balance exercise as well to help with long-term motivation (see next Handout).

YELLOW LIGHT: Before moving ahead with a goal for change, spend some time thinking about the parts of you that want to change and the parts of you that are not ready. The decisional balance exercise will be particularly important to try.

RED LIGHT: This is not a behaviour you are ready to change right now. Take it off the table for now, but think about what might help you to be ready to revisit it again in the future. For example, you may want to get more information from a health care professional, or talk it over with a friend or family member. It is a good idea to go through this assessment with yourself again in a few months to see if your readiness has changed.

Green: All Yes
Yellow: Some Yes Some NO
Red: All or nearly all NO

NOTE: The light colour applies to specific behaviours, not to a person as a whole. At any given time, we can be all three light colours for different behaviours (e.g., red light for increasing physical activity, yellow light for quitting smoking, green light for testing blood sugar). The traffic light assessment can be used again and again for the same behaviours and for new ones.

Handout 1.2

Motivation in Behaviour Change

STEP 1:   Tipping the balance towards facilitating change.

A. Think of a health behaviour goal. What it is you would like to change:_____

_____

There are reasons NOT to change (staying the same) as well as reasons TO change.
In the table below, list the PROs and CONs for "Staying the Same" and "Changing".

Score (1-4)	PRO	*STAYING THE SAME*	CON	Score (1-4)
	CON	*CHANGING*	PRO	

_____   *Impedes Change* Total: *Facilitates Change* Total: _____

B. In the "Score" column, rate each of your reasons according to how important each is to you.
1 = a little important   *2* = moderately important   *3* = very important   *4* = extremely important

C. Add all of the numbers to the left and then all to the right. Which way does the scale tip?

STEP 2: Focus on the POSITIVE AND PERSONALLY RELEVANT reasons why incorporating healthy behaviours is important.

Place a star (*) next to the reasons you listed above that will get you through the long haul. In considering your longer term reasons for change, you may think of additional points you can list below (An example of a longer-term reason for change*: "I want to be able to play with and help take care of my grandchildren/ great grandchildren").*

_____

_____

_____

_____

TO REMEMBER

- ✓ Starting a new behaviour is hard

- ✓ Stopping a new behaviour is easy

- ✓ Negative emotions are good short-term motivators
  (outside influences can help to get started, e.g. doctor or family member)

- ✓ For the long term – there needs to be positive reasons for change *(e.g., health, control, self-esteem)*

- ✓ In the long term – the change needs to become part of our IDENTITY

Handout 2

Behaviour Change: Setting and Managing Goals

Setting SMART goals

S	pecific
M	easurable
A	ction oriented
R	elevant
T	imely

1. THE BEHAVIOUR: Select ONE behaviour that is a problem for you right now.
      (e.g., lack of daily exercise, inability to maintain a healthy diet, etc.)

> **Describe the problem as specifically as you can.**

2. THE PROBLEM: Why is this behaviour a problem for you? How do you know?

3. THE GOAL: What is your goal for the behaviour change? Make sure it is a SMART goal.
      (e.g., to eat at least 5 servings of fruits and vegetables every day; exercise for at least one hour 4 times per week


4. REDUCE GOAL: Break down the goal into smaller units.
    What can you do NOW as a 1st step to achieving your goal?
      (e.g., eat 3 servings of fruits and vegetable, 3 times per week; walk for 1/2 hour, 2 times per week; do yoga once per week)

WHAT (*is the goal for this week):*

5. A PLAN: Make a specific plan to achieve your first behaviour.

The more specific your plan is, the more likely you are to follow through
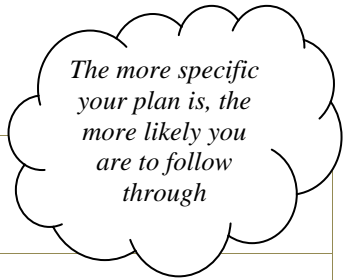
How (will you reach the goal):
When (will you do it):
Who (could help you):
Where (will you do it):

6. IDENTIFY BARRIERS AND TEMPTATIONS that may get in the way of achieving your goal

Barriers/ Temptations (*e.g. I never seem to have time to exercise*)	What I can do to overcome it (*e.g. I can walk for 15 minutes before supper*)

7. REWARDS: List 5 possible rewards that you will earn if you accomplish your goal.
    (e.g., buy CD, relaxing bath, excursion with family/friends, movie, etc.)
    Circle one reward you can use this week

1. _____

2. _____

3. _____

4. _____

5. _____

TO REMEMBER
- ✓ To avoid getting discouraged, **count the behaviours** (e.g. walking), not the outcomes (e.g. weight loss).
- ✓ Be flexible with your plans
- ✓ It's not falling off the wagon that's a problem, it's how long you are off and how far you stray

Handout 3.1

Stress Management

Points to remember:

1. Stress is a response to a stressor (or a stressful situation).

2. A stress response occurs at four levels:
   - i) Our emotions   *(e.g., worry, irritability, anxiety, sadness)*
   - ii) Our thoughts   *(e.g., negative thinking, assuming the worst)*
   - iii) Our behaviours   *(e.g., avoidance, problem-solving)*
   - iv) Our bodies   *(e.g., increased heart rate, sweating, stomach cramps)*

3. We can cope with stress in two different ways:
   - i) Problem-focused coping
     - a) Problem-solving around stressor (*e.g., time-management is important - watch out for time zappers like the internet/social media*)
     - b) Practicing assertive communication
   - ii) Self-focused coping
     - a) Relaxation
     - b) Exercise
     - c) Re-appraising situation (*is there another way to think about this?*)

PROBLEM SOLVING

STEP 1: Identifying the stressful situation.

STEP 2: How can you cope with the situation?
- Will you use self-focused coping, problem-focused coping, or both?
- List ALL possible solutions, no matter how unlikely or impossible.

STEP 3: Evaluate each solution and list those that are most feasible. This may involve combining bits and pieces of several solutions into one. Circle or highlight the BEST solution.

STEP 4: List the steps involved and your projected dates in implementing this solution.

When thinking of possible types of solutions, some helpful questions to ask:

1. Is there a way I can change my physical environment?
   (e.g., having exercise clothing in the car or by the door, changing how food is placed in the kitchen)

2. Is there a way I can change my social environment?
   (e.g., asking friends or family for specific help; recruiting a partner or friend to share in exercise or healthy eating behaviours)

3. Is there a way that I can use my time more effectively?
   Time management is a common element of problem solving that can be helpful in managing many of life's daily hassles.

ASSERTIVE COMMUNICATION

The DESC Model for Assertive Communication

This is a communication formula which can be useful in dealing with conflict and confrontational situations. Use it as a guide and fit it to your own style of communicating.

Describe the situation	Say what is happening that you want to deal with now. Focus on the immediate situation (e.g. "right now you are telling me that _____" or "When you do _____") and be sure to be specific (e.g., "When you don't let me finish my sentence") and NOT general (e.g., "You never listen to me")
Express **your** feelings	By using "I" statements instead of "You" statements, you are less likely to get resistance (e.g. USE, "**I** feel _____"; NOT, "You make me feel_____")
Specify what you want	(e.g. "I prefer that _____" or "I need you to_____" or "No, thank you, but I would like _____")
Consequences	Indicate what the POSITIVE PAYOFF will be for yourself and the other person if you get what you want (e.g. "I think that this will help me feel more comfortable being with you and we can have a better relationship.")

THOUGHT OF THE DAY
Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom." - Victor Frankl

Handout 3.2

Deep Breathing

When our bodies are stressed or tense, our breathing tends to become more rapid and "shallow" - from higher up in the chest. Conversely, when we breathe rapidly and in a shallow fashion, our bodies can become more tense.
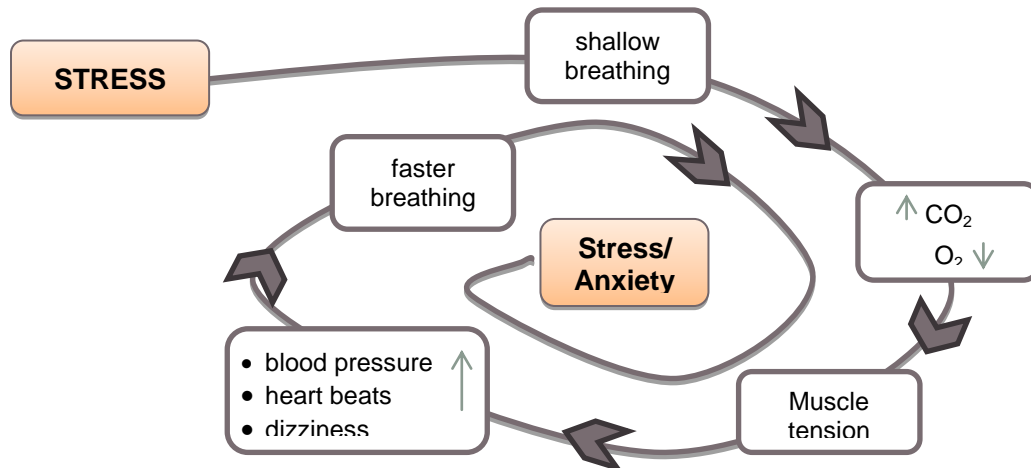
Break this *stress-(shallow) breathing-anxiety* cycle by using deep breathing methods.

DEEP BREATHING INSTRUCTIONS

1. Ensure that you are sitting on a comfortable chair or lying on a bed
2. Take a **deep breath*** in for approximately 3-4 seconds (through your nose if possible)
3. Pause for 1-2 seconds
4. Release the breath, taking approximately 5-6 seconds (through your mouth).
   You can think the word "relax" (or another calming word) as you exhale.

*deep breath: remember to use your "belly" when you inhale, rather than your chest.

TROUBLESHOOTING

- *It feels uncomfortable:* When you first begin, you may need to start with shorter breaths (such as 3-in, 1-hold, 4-out). With practice (e.g. 5 minutes once to twice a day), it will feel more natural for your body and you will be able to lengthen the breaths in and out. You may also start to breathe more efficiently on a regular basis.

- *Having difficulty using my belly to breathe:* While on your back, put a book on your stomach. Purposely try to move the book while you're breathing. Alternatively, with your hands on your stomach, try pushing your hands when you inhale. As well, exhaling completely will encourage deeper breaths.

- *Feel light-headed/ dizzy while deep breathing:* Try holding your breath for a second or two longer during the "hold" section. This should reset your carbon dioxide levels (you may have been temporarily low in CO_2) and allow you to resume to the original deep breathing instructions. Alternatively, take a few moments before continuing with the exercise.

Handout 4

Managing Difficult Emotions

Points to remember:

1. Feeling sad, anxious, angry, stressed is a normal part of life.

2. Difficulties managing our emotions decreases our ability to comply with treatment demands (i.e. decreases our motivation to exercise, eat right etc.)

3. Emotions have 4 components. Each component affects the other two. Modifying our thoughts and behaviours can affect how we feel.
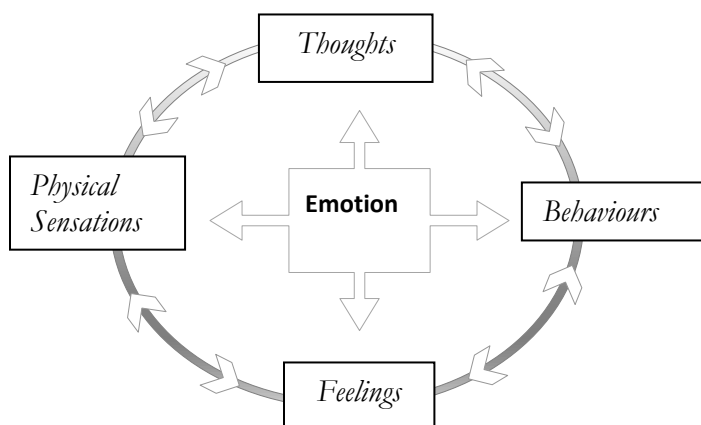
4. Some automatic thoughts and alternative ways of thinking.

Original / Automatic Thought	Alternative Way of Thinking
Mind reading	"I don't know what they are thinking"
Overgeneralization: *Always, Never*	"This is just one example"
Predicting the future	"I don't know that things will go badly"
Overestimating the probability	"What are the chances? How many times has this happened before?"
Thinking the worst (catastrophizing)	"So what if that happens? Is it really as bad as I think? Will I survive?"
All or nothing thinking	"Is there a middle ground?"
"Should" thinking	"It would be nice, but is not necessary...if it doesn't happen - or if it didn't happen, it's still okay"

5. Behaviours ... just do it! You'll be glad you did!

6. Exercise...SO MANY BENEFITS!!! Decreases stress, provides distraction, hormonal and physical benefits, increases self-esteem.

THOUGHT EXERCISE

STEP 1: Identify a situation when you felt sad, anxious, stressed, or angry. Try to be as specific as possible. What, when, where, with whom?   What were you feeling? Rate the intensity of your feelings (0 - 100).

Situation *(what, when, where, with whom):*

Your feeling(s)/emotion(s):_____

Intensity of feeling, 0 (least)- 100 (most): _____

STEP 2: Identify some thoughts that you might have been having. These are sometimes automatic, so they can be challenging to identify. Do they fit into any of the labels listed in the table?

_____

_____

_____

_____

STEP 3: What are other ways of thinking?

_____

_____

_____

_____

STEP 4: How do you think you would have felt if you had challenged some of the unhelpful thoughts? Rate feelings again (0 - 100).

_____

The goal for the thought exercise is to learn to do it "In The Moment". That is, instead of thinking back to the past – learn to challenge and replace unhelpful thoughts during the situation.

THOUGHT OF THE DAY
Do it now. Feel like doing it later

Handout 5

Emotional Eating

Emotional eating is common. Most of us engage in emotional eating at some point. Common emotional reasons for overeating include boredom, stress, anxiety, anger, loneliness, sadness, frustration, and happiness. Food can help deal with negative emotions in two ways: a) Releasing "feel good" chemicals and hormones (e.g. chocolate), b) Acting as a temporary distraction.

Risks and Consequences of Emotional Eating

1. Often, emotional eating leads to eating high-calorie, sweet, salty and fatty foods.

2. Usually we tend to overeat.

3. We might feel better temporarily, usually when we start eating. We feel badly afterward.

4. Emotional eating might increase our risk for hyperglycemia.

5. We become at risk for weight gain, with its associated health consequences.

General helpful tips for healthy eating:

1. Limit access to less healthy foods. Increase access to more healthy foods.
2. Shop when you are not hungry
3. Set a meal plan
4. Don't skip meals.
5. Be mindful of your eating

Before reaching for food ask yourself:

a) *Am I physically hungry or emotionally hungry?* Learn to recognize the signs and feelings of true physical hunger, and eat only when you experience them.

b) *Am I actually thirsty rather than hungry?* We often confuse the two. Try drinking a glass of water or a cup of tea and then reassess.

c) *Have I given my body enough time after eating to register that it's full?* Wait 15 minutes before taking that second helping.

Replacing the function of food

If you eat to calm yourself….what else helps you feel calm?

If you eat as a reward….what else can you use as reward?

If you eat to feel better…what else makes you feel good?

> **What are your alternatives to eating?**
>
> - Read a book/magazine, listen to music.
> - Go for a walk.
> - Take a bubble bath.
> - Relaxation exercises.
> - Play cards/board game.
> - Talk to a friend.
> - Housework, yard work.
> - Wash the car.
> - Write a letter.
> - Do any other pleasurable or necessary activity until the urge to eat passes.

FOOD LOG

Fill in this chart whenever you eat without having planned to: *(To help with monitoring, you might want to post this chart on your fridge)*

Date	Time	Location/who you are with	Thoughts before eating	Emotion/Feeling	Food/approx. amount
Sample	*9:30 pm*	*Watching TV- home/ spouse*	*Worried about meeting with boss*	*Anxiety*	*1 bag of chips, 5 Coke*
1					
2					
3					
4					
5					
6					
7					

Track your eating habits for **at least a week**. Review your journal for patterns: recurring emotions, danger times, and other triggers.
(Common emotions related to eating are: Sadness, depression, fear, anxiety, boredom, loneliness, fatigue & anger)

Handout 6

Preparing for the Future

What We Have Learned:

1. Diabetes management is a long road for all.

2. There are advantages and disadvantages to everything.
    Do not ignore advantages of staying the same - understand these and work with them

3. Count behaviours, not outcomes.

4. Build in rewards for good behaviours.

5. We can always learn from our slips.

6. Ask questions to whomever you can, knowledge is power.

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"Welcome to the Diabetic Hotline! If you need a
new excuse for cheating on your diet, press 1. If you
need a new excuse for skipping your workout, press 2..."

STAYING ACCOUNTABLE   What are some of the strategies you can use to remain personally accountable to yourself in the long run when beginning and/or maintaining healthy behaviours? (e.g. keeping a chart, staying accountable to my spouse, having "accountability buddies")

_____

_____

_____

DEALING WITH TRIGGERING SITUATIONS

High Risk Situations	Strategies to Deal with Them

MANAGING LAPSES   What I will do if I do slip into old behaviour patterns:

_____

_____

_____

_____

To Remember:
When it comes to behaviour change, humans are turtles, not hares...take your time for long term success!

Thank You For Participating In This Group!!!!