Manual for Orientation & Training Workshop

For
COMMUNITY LEADERS & COACHES

Of the
CMATCH Nicotine Addiction Recovery Program

FrameWork Health, Inc.
Staunton, Virginia

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Overview of CMATCH Coaching System

FrameWork Health, Inc. is organized to provide programs and services of health promotion and disease and injury prevention of a regional and national scale. Wellness "packages" aimed at reduction of heart disease, cancer, and diabetes are offered to industry, communities, and healthcare organizations with particular interest in tobacco education and cessation, weight loss and management, and alcohol abuse reduction. Programs and services of FrameWork Health are telephonic, consultative, and educational.

It is our intention to Restore the Image of God in the Portrait of Man by:

1. Expressing love and concern for fellow humans struggling with addiction to tobacco and alcohol and with control of optimum weight.
2. Individualizing by assessment and intervention the needs of individuals seeking our assistance in behavior change.
3. Offering a spiritual dimension to decision-making and life change practice that we believe is capable of effecting optimum health and quality of life.
4. Implementing an outcome-based wholistic health promotion intervention utilizing audio/visual, telecommunication, and internet technology.
5. To operate a reliable and valid model of intervention worthy of replicability anywhere in the world*.*

The name *FrameWork Health* alludes to the FRAMES Model of Motivational Interviewing developed by Samet, Rollnick, & Barnes

F=Feedback,
R=Reframe,
A=Advise,
M=Menu of options,
E=Empathy,
S=Self-efficacy

We have modified FRAME to the rubric of:

F = Freedom from addictive/deleterious behavior
R = Restoration of health through quality living
A = Appreciation for personal strengths, creative power of God,
Divine intervention through human sources
M = Meaningful life purpose
E = Experience of helping relationships

Philosophy

FrameWork Health, Inc. believes that God's desire for His created children is to reflect His image through lifestyle and express His love through service. The power lies in God's interest in His human family and His ability to strengthen their resolve in efforts of change, in their attitude and thinking, and in their alteration of behavior. For that reason, FrameWork Health, Inc. proposes to facilitate the restoration of health in individuals through the production and presentation of education programming and the conduct of motivation services that employ wholistic life-changing principles for assisting individuals to reach their maximum potential and experience quality of life. Emphasis is placed on learning how to make critical judgments about one's

lifestyle behavior and how to realize positive change through a system of caring social support. God's desire for His created children is to reflect His image through lifestyle and express His love through service. The power lies in God's interest in His human family and His ability to strengthen their resolve in efforts of change, in their attitude and thinking, and in their alteration of behavior.

Maintaining health requires knowledge about health-preserving strategies that include components of the physical, emotional, cognitive, and spiritual realms. All individuals are subject to biopsychosocial and environmental stress and may display various symptoms which they will evaluate or ignore. Certain lifestyle practices are employed in response to human stress experience that are either life-promoting or deleterious. These practices may be overeating, overworking, indolence, and substance abuse (alcohol, drugs, tobacco), etc. Individuals make irrational decisions or become subject to indecision and require assistance toward health according to their interest, motivation, and determinism.

For that reason, FrameWork Health, Inc. is formed to facilitate the restoration of health in individuals through the production and presentation of education programming and the conduct of motivation services that employ wholistic life-changing principles for assisting individuals to reach their maximum potential and experience quality of life. Emphasis is placed on learning how to make critical judgments about one's lifestyle behavior and how to realize positive change through a system of caring social support.

Vision

Individuals seeking information and assistance in lifestyle improvement will achieve skills and employ tools of strategy that will effectively improve their health. As a result of successfully changed lives through the model of FrameWork Health, other groups and communities will seek to replicate it, thus widening the influence and efficacy of this approach to health promotion.

Aim

It is the intention of FrameWork Health to facilitate restoration and maintenance of health by:

1. Expressing love and concern for fellow humans struggling with addiction to tobacco, achievement and control of optimum weight, reduction of stress, and general healthy lifestyle challenges.
2. Individualizing by assessment and intervention the needs of individuals seeking our assistance in behavior change.
3. Offering an optional spiritual dimension to decision-making and life change practice that we believe is capable of effecting optimum health and quality of life.
4. Implementing an outcome-based whole person health promotion intervention utilizing audio/visual, telecommunication, and internet technology.
5. Operating a reliable and valid model of intervention worthy of replicability anywhere in the world.

The Business of FrameWork Health, Inc.

The corporation is registered in Tennessee with tax-exempt status. It is intended to acquire a Board of at least 5 individuals to oversee the consistency of the operations with the mission and philosophy. Fiscal support possibilities are:

- grants and donations from the private sector

- public health and foundation grants
- with client companies to service their employees,
- partnerships with primary providers in caring for their patients

Recipients of Programs and Services
Target Population of programs and services are:
- adults at-risk for/with chronic disease
- adults who are residents of the “Tobacco Nation” states: Alabama, Arkansas, Indiana, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Oklahoma, Tennessee, and West Virginia
- Smoking mothers (pre-natal and post-natal) and smoking fathers
- Diverse ethnic groups
- General public in response to outreach of sponsoring groups
- Employees and patients of healthcare organizations
- Patient referrals from primary providers

Components (with future growth in perspective)
There are multiple components to the corporation through which to promote health:
1. A CMATCH Call Center from which motivational interviewing will facilitate the activities of the sponsoring churches and groups conducting the nicotine addiction recovery intervention,
2. a training program for SDA churches to equip them to support their community-based participants in their transformation,
3. the internal mentoring of university health sciences students where there is educational institution partnership
4. a wellness website—www.LivingSmart.Live
5. computer and internet technology behind the scenes that supports operations and interfaces with clients and the public through assessment tools and education.

FrameWork Health Roles and Functions

Executive Director: Possesses the vision with the Board to develop policy and procedure for the ministry, collaborates with local Team Leaders on readiness of training programs for coaches and managers, aids in negotiations with community health entities, oversees functions of a Central Call Center staff and management, collects and manages data, writes and manages grant proposals, manages "contracts" of student coaches, promotes, writes reports, responds to media, promotes collaboration to regional churches.

Internet Technology Specialist: Because accountability of the participant’s behavior toward successful nicotine addiction recovery in CMATCH is essential to build evidence of efficacy, the IT Specialist programs a file on each participant, using their first and last name, TCAT special 7-charactercode as ID, identity of the intervention location, pre- and post-TCAT data, phone coaching attendance and survey scores from those sessions. HIPAA regulations concerning PHI will be carefully followed so that these records will be stored in a secure computer device under PW. Private identities will not be shared publicly.

Local CMATCH Roles and Functions

Health Ministries Team Leader: Gathers data on the local needs of the community, possesses the vision and develops the programming and services in accordance with the FrameWork Health philosophy, aim, goals and objectives. The HP Team Leader will market the corporation programs and services to the designated target community populations and seek new avenues; will network for collaborative relationships; will oversee the phone coaching operations; and will conduct training of workshop volunteers.

Manager: Recruits, supervises, trains, and evaluates performance of mentors and coaches; manages schedules and coordination of registering participants, manages Phone Coaching services, and assists in workshop leading.

Administrative Assistant: Interfaces with the public, manages the use of necessary items for the workshops, retrieves necessary data, corresponds by e-mail and surface mail, assists with reports and promotional activities.

Workshop Volunteers: Plan hospitality activities and events around the “Let’s Begin to Quit” workshops.

Telephone Coaches: Provide pro-active, scheduled calls using standard scripts and expertise in motivational interviewing, applying knowledge of the field of tobacco cessation and prevention education; record call proceedings.

Why This Workshop?

<u>The Purpose of This Workshop is to:</u>

1. Orient new staff and clinical students to purpose, function and expectations of FrameWork Health, Inc. and its entities, particularly CMATCH
2. Prepare selected leadership from the local sponsoring group to promote, plan, conduct, and evaluate the CMATCH intervention in their community
3. Prepare highly effective coaches, including managers, in motivational interviewing principles and techniques during scripted phone calls
4. Train coaches in use of the telephone coaching system and computerized record-keeping for case management and research purposes
5. Educate in principles and practice of addiction recovery and successful lifestyle behavior change
6. Educate in approaches to response in a spiritual dimension
7. Foster team strength in a case management system approach to intervention

Learning Objectives

1. A thorough understanding of the philosophy, vision, and purpose of the company and the CMATCH intervention is obtained

2. Through various modalities of learning the attendees will develop confidence in motivational interviewing for the purposes of lifestyle change facilitation

3. The broad scope of knowledge, skills, and abilities will be referenced and utilized in developing an effective team

Expected Measurable Outcomes

CMATCH is an intensive tobacco cessation intervention that uses guided self-help in 14 daily internet-based coaching sessions combined with periodic mentoring support through means of a community workshop and the telephone over a period of at least one year. Its design has the potential of yielding the following measurable outcomes when used free-standing in the community and in healthcare facilities:

1. The technique of matching the participant with a mentor over a long period of time will yield a higher rate of success than episodic and/or short-term interventions.
2. The Tobacco Cessation Assessment Tool (TCAT) will provide accurate measurement of predictability for single or combination cessation methods chosen in the CMATCH system (self-help, self-help with pharmaceutical aid, and all with telephone support).
3. The multidisciplinary team assessment and implementation approach (health care provider(s), CMATCH Coordinator, and participant) will yield satisfaction in the client (recorded through satisfaction questionnaire).
4. Follow-up by telephone mentors and collaboration with chaplains, other clergy, and community facilitators in accordance with Marlatt & Gordon's Relapse Sensitive timing will reduce recidivism.
5. Contact hours by phone with participant using a carefully designed script and continuity of relationship will demonstrate less expense of man-hours than in the total cost of support classes and/or individual counseling of other methods to effect success.

Health care costs of chronically-ill clients will be reduced, saving $ for the client, the institution, and the community in the care of indigent tobacco users and high-tech care of Medicare clients where all institutional costs are not recovered; costs of neonatal inpatient and follow-up care of children born to smoking mothers will be reduced; episodic emergency care of asthmatic children and smokers (now ex-smokers) with chronic respiratory disease will be reduced. Vaping practices will be reduced and eliminated.

Workshop Schedule

This Workshop is planned for 7 hours of orientation and training to prepare workshop leaders and coaches to conduct effective motivational interviewing by means of a mix of activities and instruction. It is intended for credentialed/licensed health professionals—nurses, mental health workers, social workers, substance abuse counselors and aspiring students of the related health sciences and community volunteers.

The attendee is expected to complete an assessment of skills and learning preferences prior to attendance and is expected to become familiar with all printed materials contained in and supplemental to this Workshop Guide. This workshop will be held at regular intervals to benefit staff and newcomers to staff. It will also serve as adjunct education to nursing and allied health university students.

8:00 – 8:15 am	Welcome and Introductions (During Continental breakfast)
8:15 – 8:45	Overview of FrameWork Health, CMATCH, and telephone coaching
8:45 – 9:30	General knowledge of the field of tobacco control and cessation--proven modalities General knowledge of addiction to nicotine and tobacco use Current standards of tobacco education and intervention
9:30 – 10:00	General Discussion of needs and understandings of tobacco addiction
10:00 – 10:15	Break
10:15 – 10:45	Review of education and psycho-social (behavioral) principles as they relate to lifestyle change facilitation and implementation Defining effective communication
10:45 – 11:00	Defining Motivational Interviewing; Examining the Call Scripts
11:00 – 11:30	Conducting an interview: role plays
11:30 – 11:45	Relating Family Theory to lifestyle change guidance via technology
11:45 – 12:15	Defining the Spiritual Dimension as intervention
12:15 – 12:45	Lunch
12:45 – 1:15pm	Implementing the Spiritual Dimension: tools, methods
1:15 – 1:30	Orientation to support call system: tools, methods
1:30 – 3:00	Practice with the support call system: putting it all together

Phone Coaching: Description and Expectations

It is intended that the local church/group will organize a Phone Coaching service for CMATCH participants, using these training resources. Because of the effectiveness of the telephone and the internet, when service from the sponsoring group is unavailable to clients, FH will provide coaching as designed. Ultimately, supervision of Call Center phone coaching activities of CMATCH sponsors takes place within FrameWork Health management, which is located in Shenandoah Valley, Virginia. The following expectations outline phone support over the year + of service to graduates of CMATCH, whether in the location of the sponsoring group or from the FH office.

The Coaching Staff
Health professionals and health professional students who already use therapeutic communication, have a "customer relations" attitude, and who possess basic computer and internet skills are highly prized for this role; however, individuals otherwise who benefit from this workshop are important to the success of nicotine addiction recovery. The training provided in the workshop and the on-going mentoring in the Call Center will sharpen the coach's ability to interview in a motivational manner while using the computer as a documentation and resource tool.

The Management
Linda Royer, the Executive Director of FrameWork Health, and individuals she selects will be available (on arrangement) to assist coaches.

Support
To keep operations running smoothly, technicians will maintain computer and internet operations and an administrative assistant will complement the staff.

The Role of Phone Coaching and a Call Center
The role of the Call Center is to provide a community-based program of long-term telephone support with individualized intervention.

CMATCH System Strategies for Tobacco Cessation:
1) Assessment and prescriptive plan for cessation
2) Self-Help intervention - Taking Control and 3 Guides: Workbook, Partner Guide, Meal-planning
3) "Let's Begin to Quit" supporting Workshop sponsored by the church or community group
4) Inclusion of household/family through Taking Control messages and "Family and Friends: Their Role in the Quit Smoking Effort"
5) Pro-active, scheduled and scripted coaching telephone interviews from either the sponsoring church or group or from the Call Center over 18 months
6) Distance social support through Chat Room on website
7) Optional collaboration with primary healthcare provider for pharmaceutical aids
8) Staged group education for contemplators in the community - "Let's Begin to Quit" [training given local communities, churches)
9) Group support sessions and celebration banquets provided by local communities, churches for participants

Rationale
Current research reveals that 70% of adults now smoking desire to quit and have probably tried many unsuccessful times. Most interventions, though effective in some respects, allow too brief encounters with tobacco users so that maintenance of cessation lasts about 6 months. The majority of previous smokers lapse by the 3rd month and relapse by one year.

Tobacco product users are getting much information on how to quit and think they know what will work for them. However, they are not so knowledgeable about the insidious mechanisms of nicotine addiction. What they really want to know is how to successfully stay free!

Some managed-care companies are experiencing positive results in telephone counseling-based services over extended times as an adjunct to the point of service contacts by providers (PacifiCare in Oregon, GroupHealth Cooperative in Washington, and Utah's Teen Quit Line). Positive encouragement and reinforcement of personal goals and the accountability of keeping an appointment by phone on a periodic, regular basis over a year is expected to yield much higher maintained quit rates than current practices. Adding a spiritual dimension to the social support for those amenable to it is worthy of implementation and study.

Other Technology Interventions for Smokers

State-produced (early)
- California
- Massachusetts
- Arizona
- Minnesota

All U.S. residents have access to national quit lines

Early funding sources:
- Public Health funds
- Federal grants
- Cigarette taxes

Current funding sources:

Governor's State Tobacco Settlement Funds (TSA's) – yearly payout. Earmarked for prevention of tobacco use among children and youth.

Tobacco Free States funding is designated for conversion of tobacco crops to other non-deleterious ones, some health promotion expectation is there.

Telephone Resources [An internet tour]
Telephone interventions are usually in the form of a Helpline where individuals see or hear about it from the media and call in to register for assistance and participate in a short assessment. They may then receive helpful strategy information from a counselor and continue to receive guidance from a counselor by periodic phone calls out to them or in by their initiative for a

period of a few weeks, with the majority being 5 calls and follow-up in up to 6 months. They also receive printed educational materials. Some will be directed to the related website for continuing information.

A program begun in Philadelphia in the year 2000 called HealthLift is a web-based program sponsored by SmokeStoppers. It is holistic and gives intense guidance for 6 days and is then supplemented with 15 days of follow-up calls. It is run by an expert system that manipulates each individual's data according to programmed protocols for needs expressed by the individual. You can examine this method at www.smokestoppers.com

Some other websites to explore for current quit line practice are: County Health Rankings; MDQuit.org; Minnesota Quitline; NLM article on PubMed

There are several internet-based interventions by public and private organizations and individuals. A search using the keyword(s) "smoking" or "tobacco cessation" or "quit smoking" will yield many URLs.

Certified Resource: Individuals with/without a health professional license may be certified as a CTTS (Certified Tobacco Treatment Specialist -- https://breathingassociation.org/professional-healthcare-training/)

What Makes Our Service Different?

Computer-Based

While the original database concept was developed in California, copied by Arizona, and purchased by Minnesota, many other states have adopted this model. As time progressed, administrators of emerging state-funded programs developed their own to accommodate new research related to methods. The American Cancer Society has a computer-driven helpline out of Texas that serves the nation. It is limited to education and referral.

With documentation of our services and the experiences of sponsors and participants we expect to conduct research on the efficacy of the CMATCH method so that the following phenomena can be evaluated under ethical conditions:

1. Validation of change state of action for commencement of coaching
2. The effectiveness of the assessment tools
3. Changes in mood, confidence, motivation, and stress-coping of participants over time
4. Effectiveness/influence of spiritual dimension on cessation
5. Usefulness of progress pathway and efficacy of intentional phone coaching long-term
6. Effect of biomedical assessment and engagement of Personal Healthcare Provider
7. The role of "Taking Control" and self-help guides
8. Degree of lapses or relapses
9. Changes in health status at 12 &18 months post intervention
10. Changes to health care costs with success in program

Coaching Method

Our coaching service utilizes ethical standards defined by the Patient Advocate Certification Board (PACB) on the topics of:

- The role of an advocate
- Transparency and honesty disclosure
- Protection of confidentiality and privacy (informed consent)
- Fostering autonomy
- Provision of competent services
- Avoidance of impropriety and conflict of interest
- Avoidance of discriminatory practices
- Continuing education and professional development

Other characteristics that may differ are a call script that supports several assessment and tracking tools (mini-questionnaires) to measure change in mood, confidence, and stress-coping. A Spiritual Dimension offers guidance to voluntarily access power from Heaven by using communication skills sensitive to need. The motivation interview method, based on a FRAMES rubric and a Commitment tutorial, philosophically mirrors the corporate vision.

- A case management approach, characterized by:
  - time,
  - multidisciplinary intervention team,
  - referral to community support structure, and
  - periodic and consistent communication with ongoing education
- Programmatic package composed of:
  - comprehensive assessment,
  - self-help cessation program,
  - access to services on website,
  - biometric measuring—*cotinine* testing
  - communication to primary care provider (PCP) when agreed upon
  - community support through churches, along with
  - telephone coaching
- Pro-active calls matched to a schedule based on current research
- Long-term guidance for at least 12 months with as many as 19 calls
- A strategy for recycling in the event of lapse or relapse
- Emphasis on household/family/friend support

WATCH: Tobacco and Nicotine Addiction: Interventions (PPT)

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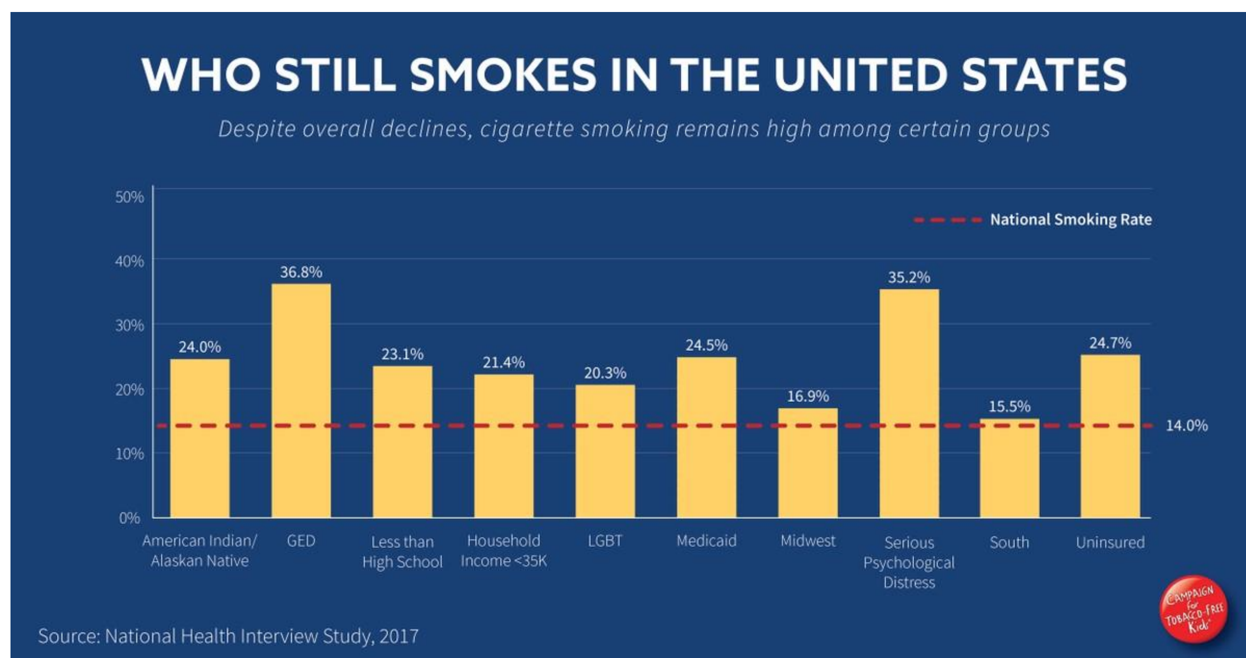


The Next Unit Discusses Behavior Change Theories and Frameworks Integrated into CMATCH

CONSIDERATIONS About Your Audience:

Participants will bring to this intervention various intents and motivations:
--They may come with an attitude of well-considered decision and eagerness to engage in the process.
--Some will come because their primary care provider has told them some bad news about their health, so they are either desperate, or fatalistic.
--Some will come after trying many other methods and have limited self-efficacy.
--Some will come as a result of concern, nagging, begging, shame from family, friends, or co-workers and may demonstrate resistance to learning and committing to quitting.
--Some will come because their employer or insurance carrier has mandated it.
--Some will come because their employer has included them in a benefit package and they are not totally convinced they want to quit but know they should.
--Some will come because their spouse is quitting and either they want to save their marriage or they wish to do something good for their relationship with the spouse.
And there are many more scenarios . . .

Lawrence Kohlberg's MORAL STAGES OF DEVELOPMENT

I. Preconventional level
Responsive to cultural rules and levels of good and bad behavior, right or wrong, but interprets these labels either in terms of the physical or the hedonistic consequences of action (punishment, reward, exchange of favors) or in terms of the physical power of those who enunciate the rules and labels. There are two stages:

Stage 1: *The punishment-and-obedience orientation.* The physical consequences of action determine its goodness or badness, regardless of the human meaning or value of these consequences. Avoidance of punishment and unquestioning deference to power are valued in their own right, not in terms of respect for an underlying moral order.

Stage 2: *The instrumental-relativist orientation.* Right action consists of that which instrumentally satisfies one's own needs and occasionally the needs of others. Human relations are viewed in terms like those of the marketplace. Elements of fairness, of reciprocity, and of equal sharing are present, but they are always interpreted in a physical, pragmatic way. Reciprocity is a matter of "You scratch my back and I'll scratch yours," not of loyalty, gratitude, or justice.

II. Conventional level
Maintaining the expectations of the individual's family, group, or nation is perceived as valuable in its own right, regardless of immediate and obvious consequences. The attitude is not only one of conformity to personal expectations and social order, but of loyalty to it, of actively *maintaining,* supporting, an justifying the order, and of identifying with the persons or group involved in it. There are two stages:

Stage 3: *The interpersonal concordance or "good boy-nice girl" orientation.* Good behavior is that which pleases or helps others and is approved by them. There is much conformity to stereotypical images of what is majority or "natural" behavior. Behavior is frequently judged by intention—"he means well" becomes important for the first time. One earns approval by being "nice."

Stage 4: *The 'law and order' orientation.* Orientation toward authority, fixed rules, and the maintenance of the social order. Right behavior consists of doing one's duty, showing respect for authority, and maintaining the given social order for its own sake.

III. Postconventional level
At this level, there is a clear effort to define moral values and principles that have validity and application apart from the authority of the groups or persons holding these principles and apart from the individual's own identification with these groups. There are two stages:

Stage 5: *The social-contact, legalistic orientation.* Generally, with utilitarian overtones. Right action tends to be defined in terms of general individual rights and standards, which have been critically examined and agreed upon by the whole society. There is a clear awareness of the relativism of personal values and opinions and a corresponding emphasis upon procedural rules for reaching consensus. Aside from what is constitutionally and democratically agreed upon, the right is a matter of personal "values" and "opinion." The result is an emphasis upon the "legal point of view," but with an emphasis upon the possibility of changing law in terms of rational considerations of social utility (rather than freezing it in terms of Stage 4 "law and order"). The "official" morality of the American government and Constitution.

Stage 6: *The universal-ethical-principle orientation.* Right is defined by the decision of conscience in accord with self-chosen *ethical principles* appealing to logical

comprehensiveness, universality, and consistency. These principles are abstract and ethical (the Golden Rule), not concrete like the 10 Commandments). At heart they are universal principles of *justice,* of the *reciprocity* and *equality* of human *rights,* and of respect for the dignity of human beings as *individual persons.*

Maturity of moral judgment is not highly correlated with IQ or verbal intelligence.
Piaget's reasoning stages correlate logic with the maturation inferences of this theory.
The stages are *structures* or moral judgment.

Carol Gilligan Speaks for Women

Ms. Gilligan asserts that Kohlberg's model is based on the male perspective; that human relationships in the context of moral reasoning are experienced differently by women.

Women face conflicting responsibilities rather than competing rights. The resolutions require a mode of thinking in context and narrative, not formal and abstract. Caring centers around the understanding of responsibility and relationships. <u>In Kohlberg's model, the individual who reaches the highest stage obtains independence in making moral decisions. Women reach moral decisions through the concept of connection or interdependence because of their nurturing nature.</u>

ASK: "So, what do you think about that?"

Fundamentals of Behavior

Definition
"Those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements: personality characteristics, including affective emotional states and traits; and over behavioral patterns, actions, and habits that relate to health restoration, and to health improvement." (D.S. Gochman)

Two Operatives
A. Behavior is viewed as being affected by, and affecting, multiple levels of influence:
1. intrapersonal or individual factors
2. interpersonal factors
3. institutional or organizational factors
4. community factors
5. public policy factors

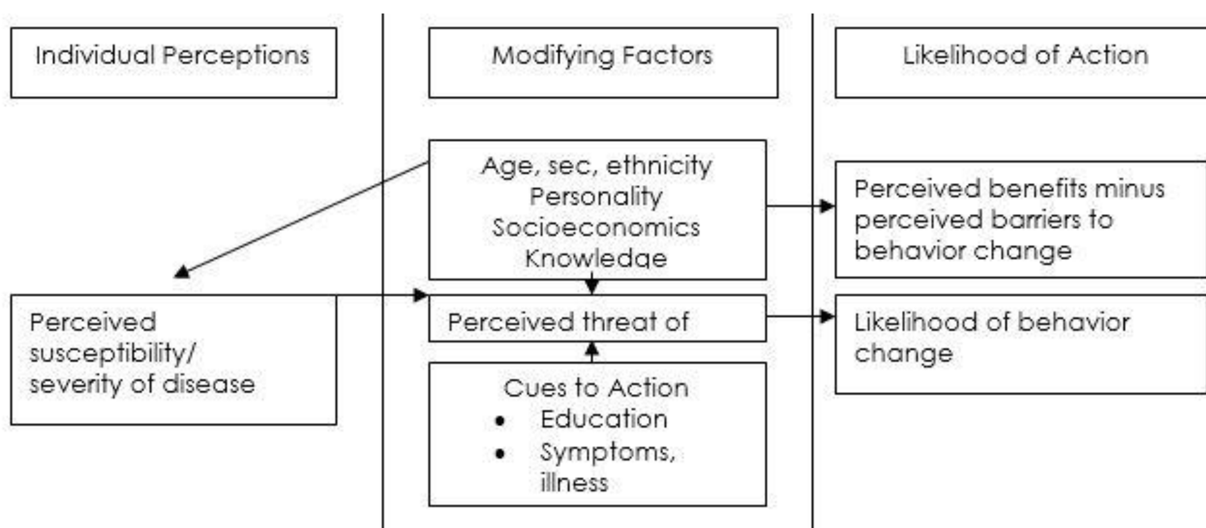
B. There is a reciprocal causation between individuals and their environment (influence and influenced by)
Of the two categories of health behavior (preventive and illness), we will focus on **preventive health behavior.**

Theories of Behavior
One of the earliest theories of behavior is Lewin's Field Theory (1935). Most modern theories have been developed under its influence, because it turned attention on the interaction of

humans with their environment rather than reactionary to another's behavior toward you. Then followed another theory basic to our understanding of behavior -- the Health Belief Model.

Health Belief Model (HBM)

Gradually developed from the 1950s by 2 U.S. Public Health researchers investigating the low participation rate of individuals in the TB screening programs. Science has built upon that through 2 channels of understanding: stimulus-response and operant conditioning. We will discuss operant conditioning later. The HBM is accepted by many disciplines of the health professions. While some elements of the model are still not completely understood and call for further research, it is widely accepted in the attempt to explain why individuals fail to believe what appears plain about health and deleterious behaviors and their consequences and why others believe but may not act on their beliefs.



On the next page is a Glossary of HBM Concepts . . .

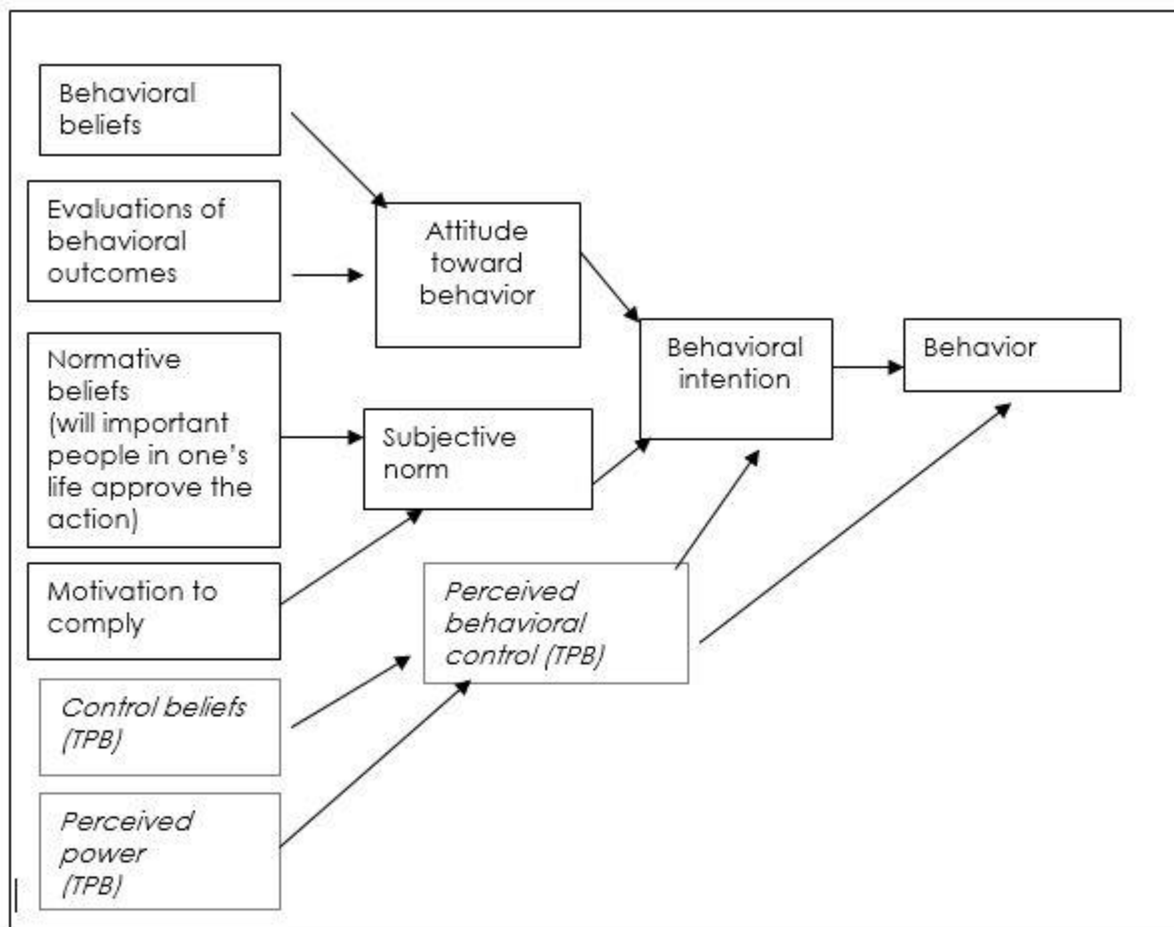
But, before we proceed, we should consider the phenomenon of **Commitment** and how one advances to that, even if belief has been reached. We have prepared a brief guidebook the workshop leader can use with individuals or the group to explore how one gets there. It is entitled, *Commitment to a Lifestyle Change,* and is located on the Leader's Resource page of wwwLivingSmart.Live.

Concept	Definition	Application
Perceived susceptibility	One's opinion of chances of getting a condition	Define population(s) at risk, risk levels. Personalize risk based on a person's characteristics or behavior Make perceived susceptibility more consistent with individual's actual risk.
Perceived severity	One's opinion of how serious a condition and its sequelae are.	Specify consequences of the risk and the condition.
Perceived benefits	One's opinion of the efficacy of the advised action to reduce risk or seriousness of impact.	Define action to take: how, where, when; clarify the positive effects to be expected.
Perceived barriers	One's opinion of the tangible and psychological costs of the advised action.	Identify and reduce perceived barriers through reassurance, correction of misinformation, incentives, assistance.
Cues to action	Strategies to activate one's "readiness."	Provide how-to information, promote awareness, employ reminder systems.
Self-efficacy	One's own confidence in one's Ability to take action.	Provide training, guidance in performing action. Use progressive goal setting. Give verbal reinforcement. Demonstrate desired behaviors.

Outgrowths of the HBM are the Theory of Reasoned Action and the later Theory of Planned Behavior. Both are obviously operative in addictive behavior. Read on . . .

Theory of Reasoned Action

- First introduced in 1967 by Azjen & Fishbein.
- Concerned with the relations between external factors such as demographics, knowledge, self-efficacy; subjective beliefs such as attitude toward one's behavior; and normative beliefs, which are what others think about one's behavior; and finally control beliefs, or one's perceived control. All lead to one's behavioral intention.
- Behavioral intention: What are the motivational factors that determine the likelihood of one performing a specific behavior?



The driving force of motivation is the locus of control: intrinsic attitude built on perceived internal strengths vs. external locus built on the opinion of others (normative). It is assumed that the individual has control over his life.

Favored Rituals of the Tobacco User

It is important to see other avenues for quitting tobacco use that account for the body's connection to tobacco products. While behavioral approaches can be effective, these techniques may not support the sensory and motor connections that have become a way of life for the smoker. Think about the ingrained ritual (lighting a cigarette first thing in the morning or as soon as you get in the car) that is likely a subconscious behavior in

a daily smoker; to treat this way of being with strictly behavior techniques (taking medication and resisting urges and cravings to smoke) ignores the body's habit or way of being. A smoker learns to use a cigarette to relieve stress, relax, socialize, and occupy their time. Incorporating these motor and sensory techniques may help people who are not able or ready to quit adapt to the behavior techniques.

New methods of quitting should consider the strength of the habits of the body. In studying the body's experiences with smoking and the smoker's perceptions of smoking, relationships can be observed between smoking and the body's senses, actions, and emotions. The significance of the role of the body in smoking is a concept that may provide an in-depth understanding of the physical experiences of a smoker. The experience of smoking and the awareness around that experience, such as feeling relaxed and less stressed after smoking, influences smoking behaviors and contributes to the continuation of smoking

Theory of Planned Behavior

Developed in 1991 by Ajzen to account for factors outside the individual's control by the category *perceived behavioral control*. He argues that a person will expend more effort to perform a behavior when his perception of behavioral control is high. Additions to the TRA are pictured in italics in the figure above.

The Transtheoretical Model (TTM)

A widely-accepted health behavior theory that emphasizes differences among people and places their "readiness" to change in categories or "stages." Much work has been done in its development in the field of tobacco cessation. Its authors are Prochaska and DiClemente (1983). Their research has shown that behavior change unfolds through a series of changes: Pre-contemplator, Contemplator, Preparation, Action, and Maintenance. A sixth stage has been added to identify individuals who are certain that they will not revert to previous deleterious behavior-Termination. It is understood that one may pass forward or backward in this stage progression toward termination at various times.

The chart on the following page describes the constructs of the stages, the decisional balance of pros and cons, the parameters of self-efficacy, and the processes of change. Think of the components in the context of tobacco addiction. Intervention based on this theory has allowed health professionals to reach more people engaged in tobacco use because it recognizes that attention must be attracted before health education takes place and that education yields self-assessment and consideration of change.

Constructs	Description
Stages of Change	
Precontemplation	No intention to take action within the next 6 months
Contemplation	Intention to take action within the next 6 months
Preparation	Intention to take action within the next 30 days and has taken some behavioral steps in this direction.
Action	Individual has changed over behavior for less than 6 months
Maintenance	Individual has changed overt behavior for more than 6 months
Decisional Balance	
Pros	The benefits of changing
Cons	The costs of changing
Self-efficacy	
Confidence	Confidence that one can engage in the healthy behavior across different challenging situations
Temptation	Temptation to engage in the unhealthy behavior across different challenging situations
Process of Change	
Consciousness-raising	Finding & learning new facts, ideas, and tips that support healthy behavior
Dramatic relief	Experiencing the negative emotions (fear, worry, anxiety) that go along with unhealthy behavioral risks
Self-evaluation	Realizing that the behavior change is important to one's identity
Environmental evaluation	Realizing the impact of one's negative or positive health behavior on social and physical environment
Self-liberation	Making a firm commitment to change
Helping relationships	Seeking and using social support
Counterconditioning	Substituting healthier alternative behaviors for the unhealthy behaviors
Contingency management	Rewarding positive behavior; demeriting negative behavior

Social Cognitive Theory

Modern psychologists have been working on the phenomenon of how animals and humans learn since the 1940s—consequently named Social Learning Theory. First, they described motivation to learn as a "drive." Then "expectancy" emerged in the context of *operant conditioning* influenced by positive or negative reinforcement in trial and error practice (1950s). From that the terms *internal locus of control* and *external locus of control* took shape to explain motivation for change the researchers understanding moved in the direction of attributing *modeling* to motivation to change (1960s). In the 1970s Bandura explained the principle of self-efficacy in behavior modification. In 1986 he brought these concepts together into a comprehensive framework and published it as Social Cognitive Theory. Major concepts are in the table below:

Concept	Definition	Implications for Intervention
Environment	Factors physically external	Provide opportunities and social support

Situation	Person's perception of the environment	Correct misperceptions and promote healthful norms
Behavioral capability	Knowledge and skill to perform a behavior	Promote master learning through skills training
Expectations	Anticipatory outcomes of a behavior	Model positive outcomes of healthful behavior
Expectancies	The values that the person places on a given outcome, incentives	Present outcomes of change that have functional meaning
Self-control	Personal regulation of goal-directed behavior or performance	Provide opportunities for self-monitoring, goal setting, problem-solving, and self-reward
Observational learning	Behavioral acquisition that occurs by watching the actions and outcomes of others' behavior	Include credible role models of targeted behavior
Reinforcements	Responses to a person's behavior that increase or decrease the likelihood of reoccurrence	Promote self-initiated rewards and incentives
Self-efficacy	The person's confidence in performing a particular behavior	Approach behavioral change in small steps to success: seek specificity about the change sought
Emotional coping responses	Strategies or tactics that are used to deal with emotional stimuli	Provide training in problem solving and stress management; include opportunities to practice skills in emotionally arousing situations
Reciprocal determinism	The dynamic interaction of the person, the behavior, and the environment in which the behavior is performed. Circle of change of influence leading to changes in the social norm.	Consider multiple avenues to behavior change including environmental, skill, and personal change.

Social Support

The concept of social relationship in which a social network serves as a key psychosocial protective, or "buffeting," factor that reduces an individual's vulnerability to the effects of stress on the mental, physical, and social health. Identified social support sources are generally kin or known to the individual or family and may share common experience with them. Seldom do people include health professionals in their list of social support network. They are seen as power figures.

In the work of the CMATCH intervention, coaches and other staff can alter that perception and foster a reciprocal relationship with our participants in the following ways:

- Effective communication
    - Solicitous, reaching
    - Patient, kind, sensitive, caring
    - Knowledgeable

- Facilitating

- Collaborative function
  - Build partnership
  - Advise
  - Seek a level of mutuality
  - Refer as necessary
  - Foster teamwork with participant, primary provider, and FrameWork Health

- Best interest
  - Effectively employing the motivational strategies of the support system

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Tips on Building Therapeutic Interrelationships

Drawing in the individuals who have been important in the lives of the participants will increase the strength of behavior change. Engage at least one of these as a "Partner" in this effort. The Mentor is in the critical position to do so with the communication skills learned in this training session. Once the helping relationship has been established between mentor and participant—hopefully by the end of the first week—plan a meeting of the three (3) and form a team of support using the same or similar language. CMATCH has a Partner Guide that should be reviewed together. From Week 2 on through Graduation and later, some activities should be planned to enjoy together.

EFFECTIVE COMMUNICATION: In Mentoring, In Coaching

Four patterns of communication between individuals have been identified which have an impact on the response obtained and the quality of the relationship between the communicators:

Small talk Chatty conversation, relaxed, friendship-forming

Control talk *Light Control*: Natural in conduct; directing, advising, cautioning, Praising, instructing, giving expectations, stating concerns
Heavy Control: Used when the primary goal is getting one's own way through use of harsh or aggressive conversational tone.

Search talk Exploring or gathering information without accusing. Just getting the facts without being judgmental.

Straight talk Speaking to the behavior, rather than attacking one's self-esteem. Does not use blame or sarcasm. Effective in problem solving, sharing, handling tensions, expressing feelings, discussing anticipated change, asking forgiveness.

Active Listening Skills

Here are five activities that enhance listening:

* Observe for and acknowledge non-verbal signals indicating the learner's desire to respond or to ask a question. (In the case of telephone communication, one can observe for audible, non-verbal sounds, tone of voice, etc.)

* Focus on what the learner says through thoughtful and apt response.

* Maintain non-verbal attentiveness through eye contact and body positioning angled toward the learner.

* Avoid interrupting.

* Evaluate learner questions and responses only after they are complete. Ask for elaboration if unsure.

Through the use of active listening, the stage is set for effective questioning. Seven techniques to support this process are listed below. The nurse-teacher role is to fill in knowledge gaps and facilitate practical problem solving.

Seven Techniques for Effective Questioning

1. Ask open ended questions that foster flexible dialogue, rather than asking questions requiring a "yes" or "no" response.

2. Avoid using either-or scenarios. This implies there are only 2 options to choose from and does not empower the learner to take an active role in learning and problem solving. Discuss and mutually evaluate multiple options instead.

3. Respond to the underlying emotional needs of the learner as applicable to the teaching situation. If a learner is worried about behavior of children or workplace stress, then if may be difficult to focus on the therapeutic interview.

4. In the beginning, ask analysis questions that challenge the learner to break down a situation into its components to understand how they work together to produce the current concern.
5. Ask application questions to help the learner use acquired knowledge to explore and understand the current situation.

6. Ask synthesis questions that call on the learner's creativity to develop solutions based on current knowledge level and individual need.

7. After a plan has been initiated, ask synthesis questions so the learner must evaluate effectiveness and take responsibility for correction where necessary.

MOTIVATIONAL INTERVIEWING

Motivational interviewing is an empathic patient-centered counseling approach for increasing readiness by resolving ambivalence about behavior change.

Motivational interviewing bears many similarities to patient-centered counseling, a model of behavior change that provides support and guidance to participants while respecting their limitations.

The process involves the exploration of the person's ambivalence (i.e., the "pros" and "cons" for smoking) in an atmosphere of acceptance, warmth, and regard. Although the session is directive, direct persuasion and coercion are avoided.

A goal is to enhance the discrepancy between the reasons for changing (e.g., risks to health of self or family) versus staying the same (e.g., not giving up smoking-supportive habits). Important qualities of an effective interviewer are:

- maintaining an optimistic attitude about change
- having a compassionate style
- avoiding arguments or evoking patient defensiveness.

It is used with individuals in the contemplation or determination stages of change where the decision is made. Our clients will be assessed by selected health professionals on staff before they are scheduled with the coaches. A main objective once we begin coaching them is to show any discrepancy between their perception of their progress and their actual progress, as measured by self-report.

While motivational interviewing is integrated into the call scripts and structures the framework of this intervention, the assessment process itself may lead to a reduction in smoking. It is plausible that assessment methods conducted in a reflective, nonjudgmental interviewing style may increase awareness and problem recognition, processes known to promote behavior change.

Ideally, it should be used with patients of high concern in the primary care office; however the Call Center coaches may have to employ the technique intensively in the first week or 10 days of the call schedule to keep the participants focused on their goals and to avoid discouragement. When participants experience a nonjudgmental attitude, respectful interest, and understanding, they feel safe to openly discuss their ambivalence about change. The sooner the participant addresses ambivalence, the sooner he or she can progress toward lasting change. When they verbalize their ambivalence about tobacco cessation, promote exploration of continued abstinence in their lives and ask "What will staying tobacco-free take from you?" or "What will you lose by staying tobacco-free?"

The voice of an empathic style provides an essential ingredient of motivational intervention. This therapeutic skill, called *accurate empathy*, can help successfully treat problem smokers.

Acceptance underlies the principle of empathy: Through reflective, respectful listening, try to understand the person's feelings and viewpoint without placing blame, judgment, or criticism. Acceptance doesn't mean agreeing with the person or approving behavior. Accepting our participants as they are builds a working therapeutic alliance, supports the patient's self-esteem, and allows him or her to change

Clinical studies show that motivational interviewing has been as effective in reducing drinking and related problems as more extensive alcohol treatments such as Cognitive-Behavioral Therapy and 12-Step Facilitation, and consistently yields beneficial and relatively lasting effects (Project MATCH 1997).

CONSIDERATIONS
Participants will bring to this intervention various intents and motivations:
--They may come with an attitude of well-considered decision and eagerness to engage in the process.
--Some will come because their primary care provider has told them some bad news about their health, so they are either desperate, or fatalistic.
--Some will come after trying many other methods and have limited self-efficacy.
--Some will come as a result of concern, nagging, begging, shame from family, friends, or co-workers
--Some will come because their employer or insurance carrier has mandated it.
--Some will come because their employer has included them in a benefit package and they are not totally convinced they want to quit but know they should.
--Some will come because their spouse is quitting and either they want to save their marriage or they wish to do something good for their relationship with the spouse.
And there are many more scenarios . . .

Coaches will learn of these motivations and intents from the Assessment Summary and through the calls. They will need to be sensitive to this background information and maintain control over possible sabotaging of goals and barriers to progress. Health professionals know many expressions of health to use in motivational discussion. The following table of their classification may increase your vocabulary.

Expressions of Health			
Affect			
Serenity	*Harmony*	*Vitality*	*Sensitivity*
Calm	Close to God	Energetic	Aware
Relaxed	Contemplative	Vigorous	Connected
Peaceful	At one with the universe	Zestful	Intimate
Content		Alert	Loving
Comfortable			
Glowing			
Happy, Joyous			
Pleasant			
Satisfied			
Attitudes			
Optimism	*Relevancy*	*Competency*	

Hopeful	Useful	Purposive
Enthusiastic	Contributing	Initiating
Open	Valued	Self-motivating
Reverent	Caring	Self-affirming
Trustful	Committed	Innovative
	Involved	Masterful
		Challenged
Activity		
Positive Life Patterns	*Meaningful Work*	*Invigorating Play*
Eating a healthy diet	Setting realistic goals	Having meaningful hobbies
Exercising regularly	Varying activities	Engaging in satisfying leisure activities
Managing stress	Undertaking challenging tasks	Planning energizing diversions
Obtaining adequate rest	Assuming responsibility for self	
Avoiding harmful substances	Collaborating with coworkers	
Building positive relationships	Receiving intrinsic or extrinsic rewards	
Seeking & using health information		
Monitoring health		
Coping constructively		
Maintaining a health-strengthening environment		

What Does it Take to be a Good Coach?

Here is a list of some qualities that will support you in being a good coach:
• The ability to let go of your needs for being liked, good and lovable.
• Strong convictions that your client can realize their highest potential.
• The ability and willingness to hold that conviction in the face of your client's resistance.
• Being an avatar, a cheerleader, a protagonist.
• Willingness to explore with your clients, without an attachment to the outcome or to how you think it ought to be.
• Being accountable for what is occurring in the session.

<u>Start with Core Skills Using OARS:</u>
O=Open-ended questions using "what", "where", "how" or "tell me"
A=Affirmations offer support and encouragement to increase their self-perception and validate strength, reduce negativity toward self
R=Reflective listening and repeating what client says to clarify and confirm perceptions
S=Summarize with reasons for change, confidence, values, goals, intrinsic motivation

Characteristics of an Effective Coach

Transformational coaching is focused on the person. It communicates, "I am here as a coach to help you grow as a whole person—healthy and happy."

1. *Building relationships.* The quality of the relationship determines the extent to which the coaching will be received. Creating a nonjudgmental, safe space is essential to holding the vulnerability, openness, and courage it takes for transformation to happen.

2. *Cultivating a growth mindset.* Much research has emerged on the importance of a **growth mindset** in learning. Applying the philosophy that we all grow with targeted practice and support is so much more helpful to education than labeling teachers as "good" or "bad." Through a growth mindset lens, observations and student assessments transform from evaluative classifications to growing practices that move teaching and learning from where it is to where it can be.

3. *Listening.* Authentically **listening** to individual experiences can lead to personalized and differentiated support based on needs.

4. *Asking guiding questions.* The heart of coaching lies in dialogue and questions. It isn't about just telling someone how; it's about creating space to pause and reflect on current practices in **partnership**. If posed in the context of observations, questions both before and after a session teaching moment can help create a climate for such reflection.
Sample questions for pre-observation:

- Is there an area you're particularly working on growing in your lifestyle?
- Is there anything you'd like another set of eyes on?
- What is the biggest challenge that you're facing right now?
- What about your lifestyle are you most proud of?

Sample reflection questions for after the teaching moment:

- How do you think it went?
- Is there anything you might do differently?
- What are your next steps?

5. *Being a thought partner.* Coaching isn't hierarchical; it's a collaborative partnership between professionals. Having another set of eyes, or someone to be a mirror for the countless things happening at high speed in a lesson or day can help broaden one's perspective on how to address challenges in the classroom and illuminate next steps.

6. *Enhancing personal reflection practices.* Continuous, reflective dialogue can create a deeper dimension for looking at one's teaching practice. Over time, these reflective strategies and tools will become internalized, and the lens through which he/she is viewed will change.

7. *Keeping an eye on the goal.* Conversations around a vision can help **align learning goals** with guidance practices, assessment of the coachee's work, and what development might be needed to reach shared goals. This can help keep the focus on them and their learning experiences so that both teaching and coaching come from a learner-centered approach.

8. *Continuing the process.* Ideally, coaching is a continuous process that helps coachees grow their practice over time. Though we can certainly learn from a single feedback session, the depth to be gained from an ongoing partnership can accommodate the nuanced, multifaceted, and rigorous practice of learning behavior change.

Positive Supports for Telephonic Coaching

The environment
Headsets are used; hands will be free to take notes, locate resources, work in the computer.
The workstation is ergonomically comfortable.
Noise in the room is kept to a minimum, lights are fused, and a distance of space and a sound-absorbing panel separate the coaches from each other.

The method
Call scripts guide each call; hot buttons and pop-up boxes in the software remind or serve as complimentary resources for the conversation; a clock is evident to gauge timing of the call; the software is programmed to prompt for data necessary for accountability of client, tracking of client success.

Skills & Characteristics Necessary for Telephonic Support

- Cordiality
- Clarity
- Active listening; sensitivity
- Synthesis

Good Source: Motivation Interviewing Network of Trainers (MINT) at https://motivationalinterviewing.org/

The Coach is the *choice architect* in aiding individuals in making positive decisions for Health—organizing the context in which people make decisions. Choices are swayed by the way they are framed to an individual=the structure of the statement or the emphasis on positive or negative perceptions. Structuring choice sometimes means helping people to learn, so they can later make better choices on their own.

If Medications are Considered for Assistance

The following information is necessary for coaches and mentors to know; however, those that are prescriptive must be supervised by the individual's health care provider.

NRT	Additional Information
Nicotine gum -Over the counter (OTC), may be covered by insurance if prescription provided. Dose-2 or 4 mg pieces. Chew hourly as needed not to exceed 24 pieces per day	Chewed until a peppery taste in the mouth occurs and then parked between the gum and the cheek. Once the pepper taste and tingling are gone (about 10 minutes), the user repeats chew. If chewed like a piece of regular gum, it can cause heartburn, hiccups, jaw pain. and park.
Nicotine patch- Over the counter (OTC), may be covered by insurance if prescription provided. Dose-21mg, 14mg, and 7mg	Place the patch on clean, dry skin and change the location daily. It is fully absorbed in about 2 hours and delivers a steady-state of nicotine over 24 hours. Change location of patch every day.
Nicotine Lozenge- Over the counter (OTC), may be covered by insurance if prescription provided. Dose-2mg and 4mg. Not to exceed 24 per day	Comes in regular or mini size and several flavors. Use one hourly as needed. Allow the lozenge to dissolve in the mouth. Do not chew it. The nicotine is absorbed in 20 minutes
Nicotine nasal spray Prescription is required. Dose- One spray each side of the nose, do not sniff.	It is designed for quick delivery of nicotine by spraying into the nose. One spray each side of the nose, do not sniff.
Nicotine inhaler - Prescription required. Dose-Each cartridge can deliver 4 mg of nicotine over 80 small inhalations. Do not exceed 20 cartridges per day.	It is puffed into the oral cavity for mucosal absorption. It should not be inhaled or drawn like a cigarette, or it will cause coughing and throat irritation. The nicotine inhaler is designed to combine pharmacological and behavioral support

Zyban (Bupropion)- *Prescription is required*. If a person has a history of seizures or alcohol dependence/ liver disease you may want to consider different medication. Dosed at 150 mg once a day for 3 days then increased to 150 mg q12hr; should continue treatment for 7-12 weeks; if person successfully quits after 7-12 weeks, consider ongoing maintenance therapy based on individual patient risk/benefit. Zyban/bupropion stimulates the brain to release the feel-good hormone dopamine. It can be prescribed as a sustained release and is not addictive. It reduces cravings and withdrawal symptoms and generally users have less weight gain You can also combine Zyban with NRT for a personalized treatment program.

Varenicline - The four-week starter pack is organized to provide correct dosing to patients. 0.5mg once a day for 3 days. Increase to 1 mg daily for 4 days. Then 1 mg BID for duration of Use Intervention. Doses spaced at least 8 hours apart. The medication should be started one to two weeks before the quit date. The patient can also start it even if there is no interest in quitting as a possible method to reduce or quit tobacco use. Instruct the patient to always take this medication after eating with a full glass of water. The most common adverse effects are nausea and disturbed sleep. Follow patients on this for tolerance to the medication and any new or worsening mental health symptoms. It blocks nicotine from binding to the nicotine receptors in the brain, therefore preventing the release of dopamine.

Spiritual Dimension—Workshop Session

I. Define and Operationalize Spirituality through Discussion

A. Spirituality in the context of Wholism

B. The Source of Spirituality—the True Spirit, the Holy Spirit and His role

C. Relationship and communication in "the Spirit"

D. How the world/nursing/other Christians define Spirituality

II. Define Spiritual Distress/Need

A. How expressed by individuals; by addicted individuals

B. Consequences of spiritual distress

III. Creating Sensitivity to Spiritual Distress/Need

A. Sensitivity exercises

B. Experiential prayer

IV. Cues to Spiritual Need

A. Non-verbal (what is heard through the telephone)

B. Verbal

C. Coach's response

1. Personal prayer life keeps one alert and ready

2. Knowing and being enthusiastic that you have something good to share with them—a gift of love and hope

3. Expressing/Conveying compassion

V. Interventions

A. Based on strength built in personal prayer life, meditation, Bible study, and self-inventory, and counsel of others

B. Practice of methods to introduce the Spiritual Dimension in the call

SPIRITUAL DIMENSION OF THE SUPPORTING CALL

By virtue of the mission and philosophy of FrameWork Health, a wholistic approach to education and facilitation of behavior change is evident. In the interactions with our clients/participants we communicate and demonstrate a caring demeanor and communicate the Spirit-filled lives we lead. And this meets the expectations of employers and primary care providers and others we contract with in order to provide these services. The public expects no more.

However, because we are certain that being deliberate about making a spiritual dimension available increases the ability for success in behavior change, we want to be knowledgeable and skillful in implementing it. Our professional preparation has been our study and practice; some of our spiritual preparation may be found in the following scriptural texts:

Proverbs 10:11; 15:4; 10:19; 25:11; 26:28; 30:5
Matthew 12: 34-37
James 2 and 3

The role of the coach has several characteristics and functions:

- Supporter and Encourager – building trust with the characteristics of
  - “presence”
  - acceptance
- Listener – using active listening techniques, focused
- Empathizer -- using objectivity
- Being vulnerable -- Experiencing the feelings of the other; avoiding judgmental attitude
- Being humble -- God works effectively through our sense of weakness and recognition of our limitations. It increases the level of faith between both client and coach
- Commitment -- Being present through all stages of need

Spiritual Dimension Framework
It can be based on the 12-Step to Recovery method. Resources we have for that are:

- Minerth-Meier-Stoop Clinic & New Life Treatment Centers of Steve Arterburn. “The Twelve-Step Life Recovery Devotional” which gives 30 Bible-based Meditations
- J. Keith Miller’s “A Hunger for Healing” course

Steps to Christ – The Recovery Edition
David Sedlacek and Katia Reinert of the Health Ministries Department of the General Conference of SDAs have adapted Ellen G. White’s little book “Steps to Christ” to a 12 Step spiritual journey of integrating a relationship with Christ into a life change on the path of life. (It is available through Adventist Book Centers.)

RELIGIOUS AND NONRELIGIOUS ATTITUDES

Participants will bring varying orientations to “spirituality”. The following table gives some examples based on a negative event (such as illness, death, accident). We can interpret such an event among smokers as the difficulty or stress they are under and the guilt they experience.

Successful Attitude Conclusions	
Religious Orientation	
Benevolent Religious Reframing	An attempt to redefine the negative in a more favorable religious or spiritual light; an effort to find positive religious value in a negative situation
God's Will	An attempt to find religious purpose in the negative event, although that purpose may be beyond the human ability to understand.
Nonreligious Orientation	
Benevolent Secular Reframing	An attempt to redefine the negative event as a natural part of the cycle of life; an effort to find positive value in a negative situation by connecting the low points of life to life's high points.
Partially Successful Attitude Conclusions	
Religious Orientation	
God's Punishment	Viewing the situation as a just punishment form God for sins
Loving, But Limited God	An attempt to preserve the belief in a loving God by emphasizing that while God is powerless to intervene in the situation, God is still with people in their suffering
Work of the Devil	An attempt to make sense of the situation and preserve the belief in a loving God by attributing the negative event to the devil
Nonreligious Orientation	
Blame Those in Authority	Blaming doctors and others in their extrinsic control circle for the situation
Blame a Loved One	Blaming a loved one for the lifestyle that led to the compromised health condition
Confusion	An inability to understand how or why the situation occurred
Failure	
Religious Orientation	
Apathetic God	Concluding that God is disengaged from or disinterested in the events of this world
Unfair God	Concluding that the situation is an unfair punishment from God
Nonreligious Orientation	
Unjust World	Concluding that life is basically unfair and that the world is fundamentally unjust

Adapted from a study by Mickley, Pargament, Brant, and Hipp on “God and the Search for Meaning Among Hospice Caregivers” in *The Hospice Journal* (13) 4, (1998).

Building Spiritual Awareness and Intervention Skills

Interactive Exercises -- Workshop Leader's Script

These exercises are prepared to take place in a group large enough to elicit rich discussion and with the ability to break up into smaller working groups. Following these activities in the FrameWork Health Coach Training Session, attendees will be introduced to the Spiritual Assessment Record through discussion.

Open with prayer.
"Dear Lord and our God in Heaven, our souls, and those of the people we intend to help, are restless until we all find our rest in You. Only in You may our deepest needs be filled. Our hearts long for peace and confidence that only You can provide. Please give us eyes to see the vacuum in ourselves and in those we care for. Tune up our sensitivities to recognize those moments you arrange for a helping dialogue between us and those who seek our help, we pray in Jesus' name. Amen."

God has created humankind as multifaceted people. We are physical, emotional, mental, social, and spiritual. Perhaps the most difficult of these facets to give expression to is the spiritual dimension. In these activities we will seek to understand spiritual needs more fully, both in ourselves first so that we might give meaning to cues, and in others. We are going to share with each other and hopefully, bring comfort and love to each other. God is here to help us.

Discussion Questions

1. Some say that part of being a Christian is being a spiritual care provider. What are your thoughts on that? If we are care providers in spirituality, is it overt or intentional or is it influence and example?

2. Why do you think it is often difficult for us to talk about spiritual issues and needs?

3. A friend/co-worker responds in a conversation you are a part of: "I don't know what to think about religion/spirituality/God. There is so much evil in the world/our lives—Does God really exist? If He does, does He care?" What would you say or do?

4. You know it takes time to truly deal with another's spiritual concerns. Think about what that means. . . How might you deal with the situation like the following:

You are dashing about in Kroger's, selecting a few items to make for supper tonight.
You see your neighbor from down the street approach you in the produce section.
Greetings are exchanged and the response you get to "How are things going?" is: "Oh, its been a tough week. I'm trying to quit smoking."

You say, "Yes, I understand it is difficult, but hang in there; the cravings will probably go away after your 4th day. I'll be praying for you."
And you dash off . . .

Is this a common pattern among us?

Let's reconstruct the scene . . .

You are again in Kroger's hurriedly gathering items for tonight's supper.
As you neighbor approaches, you change your pace and turn your attention to her. The response to "How are things going?" is the same – difficult week, trying to quit smoking, etc.
You are really looking now and you observe with your other senses:

a. a hint of tobacco odor on her clothes
b. you see her nervousness and tense expression
c. you also remember seeing her husband smoke, so you wonder if the tobacco odor you detect is from *his* smoking.
d. you wonder if she is trying to do this on her own
e. what has prompted her to quit?
f. you also wonder if she knows how to quit.

So you ask her about these things and learn a lot more about her struggles and the level of social support she has in this effort and in her family relationships.

You offer to have prayer with her right there in the produce section of Kroger's.
What would it be like?

I now ask each of you to take 5 minutes to write out the prayer you would pray with your neighbor. . .

[It will later be revised and shared with the group in the Activity "Praying for Another."]

Ministering to Spiritual Needs

Role Play Ministry
Groups of 3 with pencil and paper.

We are going to do some role playing to learn more about ministering to spiritual needs. We each bring a different level of preparation to this subject: some are experienced at spiritual interventions, some are new at it. We don't expect perfect responses. This exercise is designed to make us more acutely aware from the viewpoint of others how sensitive and responsive we should be. It is just as important in the grand scheme of things as a physical or psychological assessment that we may pride ourselves in performing. Employ the principles of the helping relationship and therapeutic communication.

Objectives for these exercises are:

1. Gain practice and comfort in personal devotion

2. Gain confidence in helping others by praying and to pray
3. Learn a variety of approaches in prayer intervention

In each of the three situations, two people will be playing roles, the third will observe. After each interaction, there will be a time for you to discuss what went on. During these discussions, each person should share his or her opinion of the interaction and then all three of you talk together about what was done well and how the helping could have been more effective. Identify yourselves as Person A, B, or C.

In the first situation, A & B role play and C observes.
A, your husband has lost his job and the family income is dwindling fast because your part-time job is inadequate to fund the needs. [Other scenarios: serious illness, dysfunctional family problems, errant child]
B, you care for A. As you do this, encourage A to open up about spiritual issues.
You have 5 minutes. . .

Now discuss in your small groups for 5 minutes . . .

In the next situation, A is the observer and B and C role play.
B, you have been feeling very depressed recently and you are telling C about this.
C, you care for B and also try to explore the spiritual dimensions of this problem by asking open-ended questions.
You have 5 minutes.

Now discuss for 5 more minutes in your small group.

In this final situation, A and C role play and B observes.
C, you are feeling vaguely uneasy about your relationship with God, telling A that the warmth and closeness of that relationship has disappeared.
A, you are help C look more deeply at this situation and to explore different aspects of it.

Now discuss for 5 minutes in your small group.

Conclusion to Role Play
Gather all groups together into the large group.
Each one take 8 minutes to contemplate your previous experience. In the dependent role you played, do you feel you received adequate spiritual care had it really been you in the situation? What would have helped you more? Write down your thoughts.

Now, in the context of this learning environment, share with the group your suggestions. What we learn here will sharpen our skills as wholistic coaches in the Call Center.

Home Assignment
In thoughtful meditation this evening, I invite you to examine your self on these points:
1. How is my relationship with God?
2. How do I wish my relationship with God could be better?

3. What is my most pressing spiritual need?
4. If I am unable to resolve it personally with God, to whom can I go for help? Am I willing to do so?
5. What must I do in my own spiritual life to be a sensitive, ready vessel of hope to those I coach in the Call Center?

Prayer

Prayer is a valuable tool for us to use in Christian caring, but it needs to be used sensitively. It needs to be accompanied with concern and by active listening. You have a small, but valuable book to read as a requirement in preparation for coaching, "The Incredible Power of Prayer" by Roger Morneau. Identify the 6 Dimensions of Intercessory Prayer and the factors that yield success in it. There are other reading requirements that will acquaint you with the opposing powers of addiction and freedom in grace, the world view of spirituality and holistic care, and EGW's admonitions regarding balanced living and ministering to those in deleterious lifestyles.

Discussion Questions

Today we will learn more about prayer through Biblical model prayers, discussion, and praying together.
Many people find it difficult to pray publicly—either in twos or large groups. Why is that?

What happens in the relationship with another person when two pray together?

What are the constructs of "prayer"? Are there styles of prayer?
Some spiritual adherents have written prayers for specific occasions. Is there Biblical precedent for that?

Review some model Bible prayers and define structure (page 41)

Should health care professionals have different prayers for different types of need or blessing?

Define Prayer . . .

Praying for Another

Pair up with someone you know least in the group.
We'll be role playing in this exercise, but we will also be ministering to another's needs. First pray for each other out loud as you begin. . .

Now, share with your partner two worries and two joys that are going on in your life right now. Take about 5 minutes.

Now, each of you pray for the other in light of what you now know. . .

Did you notice a difference in the quality of the prayers? Could you describe the first as maybe "Thin"? And the second as Fat?

It's easy to *tell* people when to pray. It's often very difficult to figure out in a caring situation when is the right time. Have you ever been confronted with the decision to "pray or not pray" with someone?
How did it work out?
What was good/not so good about it?
How could it have been improved?
What will you watch for in future situations?

Well, let's return to the story of you meeting your neighbor in Kroger's . . . What was the prayer you prayed with her? (Group share)

Using the resources from your required reading and personal Biblical study, how might we construct this prayer for your neighbor so that it models the appropriate presentation to God?

[Use easel or illustration board to work this out from front . . .]

How to Introduce Prayer to Another

In the real world of coaching with the time constraint of 15 minutes, the discouragement of the participant, and the complexity of the calling technology, how may you integrate prayerful assistance in your script-based conversation?

You will notice that in the first Assessment there is opportunity to learn the spiritual condition/status. If need is not picked up then, it may appear sometime in the first week of daily calls. Spirituality is mentioned every day for the first 5 days as "spiritual strategies." Each day that the Depression Scale is used is an opportunity. If **Taking Control** is being used, they are being encouraged to seek power from Heaven. Offering to pray with them at the end of each call is written into the script should you sense by cues given that the participant is amenable to that intervention.

Once a relationship between the Coach/Coaching Team and the participant is struck and there is more openness to discuss the difficulties in overcoming an addiction, the Coach may say,

"It sounds as if you are having quite a struggle today (this week), in spite of our conversations and the materials you have at home to guide you. I notice that you have family (spouse, friend, etc.) listed as supportive persons. But do you need a little more moment-to-moment help? Could we talk about spiritual (faith) in your life?"
(If so) "There are some questions I can use to guide us in this area of discussion. Could we use them as we talk together now?
[Proceed with the Spiritual Assessment]

You may not be able to complete both Parts A and B of the Spiritual Assessment during this call. Limit the call to 30 minutes and negotiate to continue at the next call. There is no hurry in this.

Hopefully, each question and topic discussed will lead to personal contemplation between calls. Before you close your record in the computer, flag your record as a spiritual dimension client and make a note in your little dialogue box of what should be done at the next call.

Spiritual Dimension Activities

Find the Thimble

1. In large group discuss cues participants may give to spiritual need. Compose a list to be prepared as a handout to the group.

2. Have a 15-minute break, during which the typed responses are separated on paper approximately 3” X 4”. Hide them about the room. Hide one in a thimble.*

3. On their return, given attendees a worksheet and the complete list of cues. Instruct them to find one hidden cue each.

4. They then spend 15 mins. Alone with their course materials and reflect on a response to give to the cue in hand.

5. They each present their response to the group and get feedback. A typist records the responses and comments/corrections in computer to hand out after activity.

*The individual who found the thimble goes first

.

SPIRITUAL DIMENSION—Application to Support Calls

Coaches are trained to be sensitive to subtle expression of spiritual need. When this occurs, the Spiritual Assessment Record should be used with the following protocol:

1. Coach will identify a spiritual need (from "neediness" of attitude, intensely low confidence/self-efficacy, comments of isolation or helplessness, expressing need for maximum help, etc.) and do the following:
    a. Perform Parts A & B of Spiritual Assessment
    b. Make a summary note that will become a "hot button" to inform status as a Spiritual Care recipient at future calls. Notes may continue in this window r/t spirituality—not to be part of data in record.
    c. Introduce the participant to pastoral counseling option

2. Coach then flags the case record so that Coach Manager may match the participant to a pastoral counselor who will:
    a. Continue with Spiritual Assessment Tool Part C
    b. Summarize the assessment and formulate a Plan of Care
    c. Counsel at least 1 session on the subjects of choices, God's creatorship and purpose for us, forgiveness, hope
    d. Then offer 4 options to participant:
        1. Continue with pastoral counseling by scheduled phone appointment
        2. Refer to a local SDA pastor/church (inform of church programming: support group, health classes, Bible studies, etc.)
        3. Refer back to own pastor with a letter
        4. Terminate participation in the Spiritual Dimension

3. FrameWork Health must make the following assurances for a successful program:
    a. CMATCH and corporate identity is known to the community
    b. Our SDA churches are prepared to receive the individual
    c. There is dialogue in the community from our church to the other Christian churches re CMATCH and FrameWork Health

4. Evaluation will focus on smooth passage through the program, contact and attendance at local SDA church programming or participation in Bible study, and a post-intervention survey of this program completed by the participant.

Resource orientation materials for Pastoral Counselors:

Addiction and Grace by Gerald May, M.D.
Excerpt's from Ellen White's Writings – Temperance
The Incredible Power of Prayer by Roger Morneau

Required reading for Coaches in addition to the above:

Dossey, B. M., Dossey, L. Body-Mind-Spirit: Attending to Holistic Care. (1998). *American Journal of Nursing (98)* 8, pp. 35-38.
Schenk, S. and Hartley, K. Nurse coach: Healthcare resource for this millennium. (2002). *Nursing Forum (37)* 4

PRACTICES THAT IMPROVE YOUR PRAYER LIFE

Scripture references to explore: Mark 13:38; Ephesians 6:18; Philippians 4:6; Colossians 4:2; I Thessalonians 5:17; I Peter 4:7

"While engaged in our daily work, we should lift the soul to heaven in prayer. These silent petitions rise like incense before the throne of grace; and the enemy is baffled. The Christian whose heart is thus stayed upon Christ cannot be overcome." (Messages to Young People, p. 249)

1. **Talk to Jesus (aloud when appropriate) as you go about your activities.**
"Cultivate the habit of talking with the Saviour when you are alone, when you are walking, and when you are busy with your daily labor. Let the heart be continually uplifted in silent petition for help, for light, for strength, for knowledge." (MH 510,511)
2. **Breathe a silent prayer in behalf of each person you meet, and in your prayer claim an appropriate promise for that person (James 5:16 and 2 Peter 1:4)**
As you meet a person – even approaching on the sidewalk – often you will see something that indicates what you could include in your prayer. Perhaps it is a disabled person, one who wears a sad or angry face, a teacher escorting a group of children, a screaming ambulance headed for the E.R., the classroom of students you are entering, the person you will be working with today.
3. **Fill your coming and going with many "thank you's" to God (Ps. 71:8, 14)**
"Cultivate thankfulness. Praise God for His wonderful love in giving Christ to die for us: (MH 492). Thanksgiving and praise should be expressed to God for temporal blessings and for whatever comforts He bestows upon us." (CG 148).
4. **Never eat without a prayer of thanksgiving (Matt. 14:19; 26:26)**
"The bread we eat is the purchase of His broken body. . .Never one, saint or sinner, eats his daily food, but he is nourished by the body and the blood of Christ. The cross of Calvary is stamped on every load." (DA 660)
5. **If unable to sleep, spend the time in meditation and silent prayer (Ps. 63:6)**
Often this is a time to review the events of the day and evaluate our efforts to fulfill God's will. Intercessory prayer can be offered for those who are suffering with pain or disappointment. Plans to manage tomorrow better can be set with help from the Holy Spirit. Stress may be relieved through prayer and singing praise. Memorize promises from the Bible.
6. **Develop an intercessory prayer list alone or with others who meet regularly.**
If your group cannot meet physically together regularly, appoint a time when you each will be praying for others on your lists. Cultivate a close friendship with those on your prayer list if possible. That way the Lord can use you to bless them.

BIBLE PRAYER MODELS

The Lord's Prayer

This prayer was given to and on behalf of Christ's disciples. It serves as a model that refers to and affirms Christ's kingly, or authoritative, status.

<u>Our</u> Father -- our religion must be big enough to include everyone to accompany Jesus (corporate)

<u>Father</u> -- refers to the privilege of sons and daughters (family). Christ is our brother. It demonstrates the relationship we are to have as a *child* to the Father. And if God is "our" Father, then we have a filial relationship to other created beings—people.

<u>Who art in heaven</u> -- God is distinct from other gods. He is the Supreme Power. Our life here on earth should be heaven-focused.

<u>Hallowed be Thy name</u> -- a challenge to holy living. He gives us His name (family name), we must be holy (perfect) even as He is perfect. The later events in this book of Matthew give significance as to how to be perfect=covered with Christ's righteousness through His death and resurrection.

<u>Thy kingdom come</u> -- a spoken desire to have Him come and dwell with us. Christ's disciples and believers today understand this appeal. God's kingdom must be held supreme in the broad scope of earthly living. Today we give up our sovereignty to bless others, make room for others in the kingdom, don't leave others to stumble.

<u>Thy will be done</u> -- submission. "The will of Him that sent Me."

<u>On earth as it is in heaven</u> -- peace, even in the midst of the storm

<u>Give us this day our daily bread</u> -- spiritual food; fresh bread every day for that day (like the manna in the wilderness); trust; dependence on God. We have an obligation to share the bread. Working for others is the kind of yeast that makes the dough we need.

<u>Forgive us our debts (trespasses, sins)</u> -- They stand in the way of our worship and our ministry.

<u>Lead us not into temptation</u> -- I choose not to be on Satan's ground. God can change our desires.

<u>Deliver us from evil</u> -- Be ready for the spiritual battle; be sharp about what tempts us; recognize sin for what it is.

<u>Thine is the kingdom</u> -- We want to see His kingdom realized; be loyal.

<u>The Power</u> -- Omnipotent, always available

<u>the Glory</u> -- my glory is secondary—it all belongs to God, like the sun's rays. As a forgiven disciple I can share in or bask in His glory and be satisfied.

<u>Amen</u> Matthew 6: 9-13

The Pattern

The prayer opens with an establishment of the relationship with the Father and His location and supremeness. Then attribution is given to His authority, followed by His accessibility to us, His personal character, and due reverence toward Him. Then recognize and yield to His better way, request spiritual food and protection, and end again with praise.

Paul's Example of Intercessory Prayer

Ephesians 3:14-21
Example of contrite obeisance: "I bow my knees before the Father. . ." The Jews of that time did not kneel when they prayed. He prays for power on their behalf and the presence of Christ in their hearts. He speaks of rootedness in God's love.
{Refer to triangular graphic, "A Model of Rootedness"]

Prayers of Request/Help-seeking

Psalms 22; 23; 24; 66:18; 104; 90; 91
Habakuk 3:17
John 15:16; 16: 24-27; 17:9. I John 3:22; 5:14, 15. John 15:7
Ephesians 1:2-14; 2:1-10; Philippians 1:6; 4:6, 7

Statements of Encouragement and Motivation

Psalms 103:10-14; Romans 8: 38, 39 -- Dimensions of God's forgiveness
Ephesians 4 - Powerwalking
Ephesians 5:15-20 -- the Christians "walk"
I Corinthians 15:17-22 -- all men are live because Christ died, making our faith of worth
Philippians 4:4-8 - Recipe for anxiety

Promises of Health

Psalm 147:3; Proverbs 3:8; John 6; James 5:16

For Personal Study

I Timothy 2
Acts 17:16-34; 18:4
Study Luke for the prayer life of Christ

Biblical Examples of Compassion

Deuteronomy. 13:17	Deut. 32:36	Psalm 78:38	Psalm 86:15
Jeremiah 12:15	Lamentations 3:32	Zechariah 7:9	Matthew 9:36
Matthew 18:33	Mark 8:2	Romans 9:15	Hebrews 5:2
1 Peter 3:8	Jude 22	James 5:11	Lamentations 3:22

Prayer is meant to bring us in harmony with God; not to change Him, but us.

APPENDICES

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APPENDIX A:

ENCOURAGEMENT MODEL

Developed by Earline Westphal Miller, RN, PhD

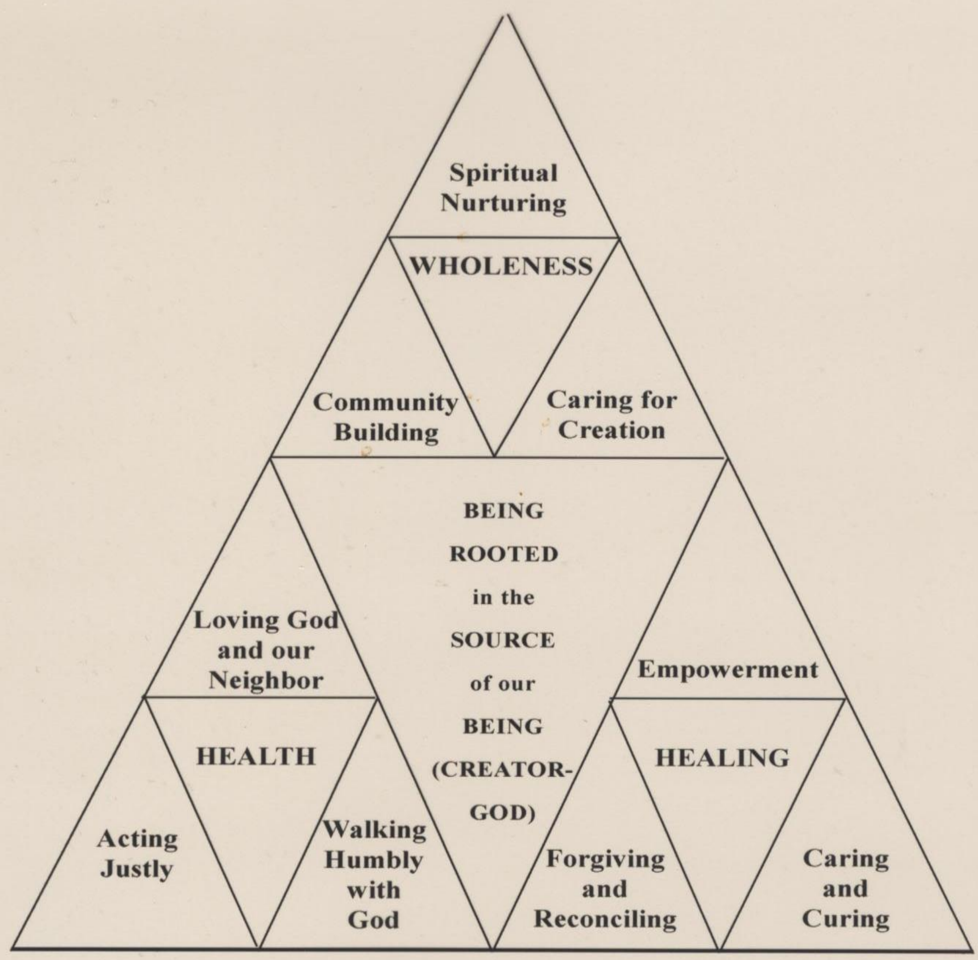
This model illustrates the processes individuals (in this case, caregivers) experience as they move from hurting (bottom) to healing through connecting and interconnecting with others. Visualize an hour-glass-shaped form underlying it to represent the encircling relationship commonly experienced.

TRANSPERSONAL CONNECTEDNESS	**HEALING** Moving on Discovering meaning and purpose Accepting life as it is
	INTERNALIZING CONNECTION WITH THE INNER SPIRIT Developing faith Feeling positive energy Experiencing a spiritual feeling
INTRAPERSONAL CONNECTEDNESS	**INTERNALIZING A CONNECTIONWITH ONE'S OWN HUMANNESS** (Physical, Emotional, Social, and Cognitive) Sensing accomplishment Making decisions Motivating internally Synthesizing self: self-talk Finding options and choices Opening mind Believing in self-worth Recognizing strength Accepting self
INTERPERSONAL CONNECTEDNESS	**DEVELOP CONNECTING RELATIONSHIP** Experiencing acceptance by others Trusting others Sharing with others Seeking a safe environment

Imagine an upward spiraling motion through this model.

[Reference: *Journal of Christian Nursing*, Fall, 1995, p.10]

APPENDIX B:



APPENDIX C:

Tobacco Cessation Assessment Tool

(TCAT)

FrameWork Health, Inc.

This assessment is also posted on Day 1 of Taking Control on the website.

Initial Assessment Discussion: How Do You Make Decisions?
A long time ago, you probably made a choice to experiment with the lighting up behavior , the motions of smoking, and the flavor by weighing the value of learning a new skill and testing your expectations of the experience against distant admonitions about health and potential addiction. At the time you needed to be self-determined—a ruler of your own destiny. (Those are all inherent attitudes in each of us so that we can be successful at independence.) But you were unable to appreciate the power of that little cigarette (or pipe) over your own decision making power. There was a poison in the tobacco that has robbed your brain of normal function related to pleasure and need. It has control of you.

The fact that you are keeping this assessment appointment as the first step toward learning how to quit smoking/tobacco use testifies to your ability to think deliberatively and with rational, conscious thought, rather than reflexively or automatically (as you did when you smoked). As we guide you through this process of renewing and refreshing your life, we are going to rely on your ability to think consciously and reflectively before every activity and before every decision concerning your behavior and health.

We will begin by asking you several sets of questions that will reveal to you and to your coach what areas of attitude and preferences need to be strengthened. The assessment will archive your old behavior patterns with relation to tobacco use. Your coach will help you by being the architect of your new choices, your teacher, and a facilitator of your goal-setting and problem-solving.

Here are some keywords for you to take into your mind-set:
Optimism, Confidence, Empowerment, Teachable.

SO, LET'S GET STARTED!

Your 7-character code ___________

The Location (city/town and state) of your Sponsoring Group

____

Age Group: 18-24 years 25-34 years 35-45 years 46-65 years 66+ years

Gender: M F Prefer not to answer

Marital status: M S D W

Education: Less than HS HS Voc. Tech Some college College

Post-graduate

Race:

Caucasian [A person having origins in any of the original peoples of Europe, the Middle East, or N. Africa]

Black or African American: [Origin in any of the black racial groups of Africa]

Asian: [Having origins in any of the original peoples of the Far East, SE Asia, or the Indian subcontinent]

Native Hawaiian or other pacific islander: [Incl. Hawaii, Guam, Samoa, Fiji, Tahiti]

American Indian or Alaska native

Hispanic

Tobacco Use History

Age began using tobacco:__________ No. of years using _____________

Tobacco method you now use: cigar pipe smokeless cigarettes

Number of quit attempts: __________ Method(s) ________________________________

Intensity of cigarette use over last 6 months: <5 cigs/day (10) 1ppd (11-20) 1-2 ppd 21-30/day 31-40/day

Describe use of other methods ____

Subtotal _________

Nicotine Dependency - FTQ *For smokers*

1. How soon after you wake up do you smoke your first cigarette?	(a) within 5 mins.	3 Pts.
	(b) 6-30 mins.	2 Pts.
2. Is it difficult to refrain from smoking in places where it is forbidden?	(a) Yes	2 Pts.
	(b) No	1 Pt.
3. Which cigarette would you hate most to give up?	(a) first one in am	2 Pts.
	(b) any others	1 Pt.
4. Do you smoke even if you are so ill that you are in bed most of the day?		
	a) Yes	2 Pts .
	b) b) No	1 Pt.
	c)	

Subtotal ___________

1-5 Points = Self-Management; 6-9 Points = Self-Management + Support; 10-15 Points = Intensive Care

Nicotine Dependency - (Kawakami, et al) ***For General Tobacco Users*** (1) (0)
Yes No

1. Have you often had periods of days when you smoked a lot more than you intended to?
Yes No
2. Have you ever tried to quit or cut down on tobacco and found you could not?
Yes No
3. Did you crave tobacco after you quit or cut down on it?
Yes No
4. Did you have any of the following problems when you quit or cut down on tobacco: irritation, nervousness, restlessness, trouble concentrating, headache, drowsiness, upset stomach, heart slow down, increased appetite or body weight, hands shaking, mood depression?
Yes No
5. Did you ever start using tobacco again to keep from having such problems?
Yes No
6. Have you ever continued to smoke when you had a serious illness that you knew made it unwise to use tobacco?
Yes No
7. Did you continue to use tobacco after you knew that it caused you health problems?
Yes No
8. Did you continue to use tobacco after you knew that it caused you mental problems?
Yes No
9. Have you ever felt like you were dependent on tobacco?
Yes No
10. Have you ever given up work or social activities so you could use tobacco?
Yes No

Subtotal ___________
6-10 Points = Significance for group or one-to-one intervention

Reasons for Smoking Scale (12 Points possible for each cluster)

	Strongly Disagree	Mildly Disagree	Agree	Strongly Agree
	1	2	3	4
How much are each of the following characteristic of you?				
(Negative Affect Reduction Smoking) Cluster 1				
When I feel uncomfortable or upset about something, I light up a cigarette.	1	2	3	4
When I feel "blue" or want to take my mind off cares and worries, I smoke.	1	2	3	4

I light up a cigarette when I feel angry about something.	1	2	3	4
(Automatic Smoking) Cluster 2				
I smoke automatically without even being aware of it.	1	2	3	4
I light up a cigarette without realizing I still have one burning in the ashtray.	1	2	3	4
I find myself smoking without remembering lighting up.	1	2	3	4
(Addictive Smoking) Cluster 3				
I get a real gnawing hunger to smoke when I haven't smoked for a while.	1	2	3	4
When I have run out of cigarettes, it is almost unbearable until I can get them.	1	2	3	4
Without a cigarette, I don't know what to do with my hands.	1	2	3	4
(Sensorimotor Smoking) Cluster 4				
I smoke because I like the smell so much.	1	2	3	4
Part of the enjoyment of smoking is watching the smoke as I blow it out.	1	2	3	4
Part of the enjoyment of smoking comes from the steps I take to light up.	1	2	3	4
(Stimulation Smoking) Cluster 5				
Smoking helps me think and concentrate.	1	2	3	4
I smoke more when I am rushed and have lots to do.	1	2	3	4
Smoking helps to keep me going when I'm tired.	1	2	3	4
(Indulgent Smoking) Cluster 6				
After meals is one of the times I most enjoy smoking.	1	2	3	4
I like a cigarette best when I am having a quiet rest.	1	2	3	4
I want to smoke most when I am comfortable and relaxed.	1	2	3	4
(Psychosocial Smoking) Cluster 7				
It is easier to talk and associate with other people when smoking.	1	2	3	4
I smoke much more when I am with other people.	1	2	3	4
While smoking I feel more confident with other people.	1	2	3	4
Subtotal			___________	

Clusters 1 & 3 with high scores are of high concern. Anticipatory Guidance with intervention needed here.

Readiness to Quit

Place an X by the comment that most characterizes your feelings.

I've heard a lot about the damage smoking (chewing) does to your health. I'm, going to have to get serious about quitting one of these days.

Precontemplator

Stop Here if above is checked.

A family member/Good friend just died of lung cancer this year who was only 41 years old. It devastated the family. I'm looking at my options. I would like to learn how I can quit smoking.

Contemplator

I've quit several times. After smoking 5 years this last time, I've started to taper off my cigarettes. I'm down to a pack/day now.

Contemplator

I'm very determined to quit because my doctor told me I must, and I feel so bad.

Ready for Action

Confidence Level	**Strongly Disagree**		**Not Sure**		**Strongly Agree**
1. I feel sure that I am able to quit smoking	5	4	3	2	1
1. Looking back on other attempts I've made to change my life, I feel certain I can carefully follow a program that is designed for me to quit	5	4	3	2	1
3. If I know I'm not in this alone, I feel certain I can quit.	5	4	3	2	1

Subtotal __________

Low Risk = 10-15 points; Moderate Risk = 6-9 points; High Risk = 1-5 points.

Concept of Power					
1. My desire to use tobacco comes from seeing others smoke, the ads in the media, memories associated with a pleasant tobacco-related event or when I am under stress.	5	4	3	2	1
2. My desire to use tobacco comes from a need deep inside, when I begin to feel out of control.	5	4	3	2	1

Subtotal ___________

Score lower than 3 = High Risk

Perceived Stress Scale (modified)

In the last month, how often have you . . .	Always	Freq.	Seldom	Never
1. Felt that you were unable to control important things in your life?	4	3	2	1
2. Questioned your ability to handle personal problems?	4	3	2	1
3. Felt that things were not going your way?	4	3	2	1
4. Been unable to control irritations in your life?	4	3	2	1
5. Felt difficulties were piling up so high you couldn't overcome them?	4	3	2	1

Subtotal ___________

Low risk = 1-10 points; Moderate Risk = 11-15 points; High Risk = 16-20 points

Social Support (It may be wiser to use this section once trust and confidence are established.)

To lend me emotional support I have:

a. more than one other significant person interested in my efforts
b. at least one significant other to help me
c. no one

This person is a non-tobacco user:

❑ Yes ❑ No

1. Whom can you really count on to help you out of a crisis situation, even though he/she would have to go out of their way to do so?
First Name/Relationship to You ____________________________________

2. Whom can you talk with frankly without being careful about what you say?
Name/Relationship to You ____________________________________

3. With whom can you be totally yourself?
Name/Relationship to You ____________________________________

4. Whom can you count on to listen openly and uncritically to your innermost feelings?
Name/Relationship to You ____________________________________

5. Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?
Name/Relationship to You ____________________________________

6. If you have identified someone like this, is this person:

_____ available to you
_____ spouse
_____ other
_____ non-smoker

7. Would you be willing to enter into a contractual relationship with this person for support to quit tobacco use?

❑Yes ❑No

SUMMARY Scores

Risk Scores for Nicotine dependency: FTQ: Kawakami:

Reasons for Smoking: Confidence Level: Readiness to Quit:

Concept of Power: Stress Level: Social Support:

APPENDIX D:

Mini-SPIRITUAL ASSESSMENT

A. Introduction

1.Do you have a spiritual belief system that frames your life?
Discuss what it is . . .

If not, ask: Do you believe there is an all-powerful God in heaven?
If not, ask: Would you like to learn about Him?

If "Yes," state: God, who created this earth and everything on it, in interested in you. In fact, He is able to help you gain victory over nicotine addiction.

If "No" Drop the subject, but leave the door open for a future desire to do so.

Would you like to learn more about the Creator God? (Send _________________, or direct to www.amazingfacts.or g or www.iiw.org . (Or link to local participating SDA church)
If "yes" to a spiritual belief system, ask:

B. Knowledge of God

1. What word or image best describes God to you?

2. Do you have a relationship with God? __Yes __No
If "Yes", ask: Has your relationship with God been helpful to you in the past when you have gone through difficult times? ___ Usually ___ Somewhat___ Never

3. How do you presently feel about your relationship with God?
___ Good ___ Somewhat feel good ___ Not pleased with it ___ Seldom think about it

4. Would you like to know Him better? ___ Yes ___ No

We coaches like to pray with our clients for their success over nicotine addiction. Would you like me to pray with you at the close of each call?
___ Yes ___ No

[If they indicate and interest/need to talk with a spiritual counselor, in any of the following conversations offer that referral.]

APPENDIX E:

SPIRITUAL ASSESSMENT with Care Plan

FrameWork Health Call Center

Interpersonal Relationships, Outer and Inner Resources, Belief Systems

Assessment begins with some general information that forms a framework of the Who?, What?, Why? of outer and inner resources for support and the degree of interaction the individuals have with them. In referring to the NANDA definition of Spiritual Distress, the responses to these questions provide descriptive terms, expected outcomes, and therapeutic interventions for action. Finally, with the establishment of trust and the opportunity of time for the individual to articulate concerns, a more in-depth assessment of uniquely spiritual needs may occur. This tool seeks to provide the flow for that process.

Part A **Psycho-Social-Spiritual Development**

Relationships:

1. Who is the most important person in your life? (no names)
    a. Spouse, intimate friend
    b. Parent
    c. Child
    d. Other: Describe ____

2. To whom do you turn when you need help? ________________________________

3. Is this person readily available to you? ❑ Yes ❑ No

4. In what ways do they help? ____

5. Who or what is the greatest influence in your life? ____________________________

6. Where, or with whom, do you feel most loved? ______________________________

7. What helps you most when you feel afraid or need special help? ________________

____

8. Is there anything or anyone causing you hurt or pain in your life?

____

9. Do feel at peace with your family and/or loved ones? ___ Yes __ No
If not, would you explain.

____

10. If you are going through "hard times" now? ___ Yes ___ No

Is so, where have you found support in going through this?________________________
Comments re: individual/community ties, kinships and friendships noted, quality of life:
____
____

Acuity signs: ❑ undesired isolation ❑ withdrawal ❑ diminished involvement ❑ conflict ❑ depression
Symptomatic suffering: ❑ Behavioral/emotional ❑ Illness/disability ❑ Accident/surgery ❑ Grief

Comments:
____
____
____
____

Part B Belief System, Support

1. Do you consider yourself "spiritual" or religious? ❑ Yes ❑ No
2. What gives your life meaning? ____
3. Do you believe there are 2 powerful forces in the World? Good and Evil? ❑ Yes ❑ No
4. Do you believe in God? ❑ Yes ❑ No

(If the response it "No", proceed to Question # 17.)

5. If yes, what word or image best describes God to you? ______________________

6. Has your relationship to God been helpful to you in the past when you have gone through difficult times? ❑ Usually ❑ Somewhat ❑ Never Please explain:
____

Responses from this question may derive these evaluations:
1) God is rewarding and loving
2) God is teaching me a lesson
3) God is angry and punishing me
4) It is God's mysterious will

7. How do you presently feel about your relationship to God?

____ Feel good about it ____ Mostly feel good about it
____ Not pleased with it ____ Seldom think about it

8. Do you think your relationship with God has anything to do with the quality of your life?
❑ Yes ❑ No

Please explain

____

____

9. What importance does faith or belief have in your life?

❑ Great ❑ Some ❑ Little ❑ No importance

10. Do you have specific beliefs that might influence your health care/lifestyle decisions?

Please explain ____

____

11. Are you involved in discussion groups where they talk about life in general, including ethics, values, religion?

____ I have in the past ____ I am in such a group now ____ I would like to be

____ Never

12. If yes, did/do you find this type of discussion helpful? ❑ Yes ❑ No

13. Have you had a life/religious experience that has influenced you? ❑ Yes ❑ No

If yes, please describe: ____

____

14. What 3 things would you ask God for?

a. ____

b. ____

c. ____

15. Are you part of a spiritual or religious community? ❑ Yes ❑ No

If so: Name ____

Address ____

Clergy ____

Phone # ____

16. Is there support for you there? ❑ Yes ❑ No

REFER TO PASTORAL COUNSELOR IF PARTICIPANT IS AGREEABLE . . .

The following questions relate to those who do not have a faith belief or interest in God. Picking up from Question # 4 of this section.

17. Is there a group of people you really love or who are important to you?

❑ Yes ❑ No

If “Yes”, would you describe the values and beliefs you share?

____

18. Are you involved in discussion groups where they talk about life in general, including ethics, values, or religion?
____ I have in the past ____ I am in such a group now ____ I would like to be
____ Never

19. Do you have specific values/beliefs that might influence your health care/lifestyle decisions?
Please explain
____
____

20. What is your hope for your life?
____
____

21. What have you learned works for you in coping with difficulties?
____

22. Describe your strengths: ____
____

23. Are there questions in your mind about your future? ❑ Yes ❑ No

If "Yes"--- We have a faith-based counseling staff available to discuss those concerns with you.
Would you like to make an appointment for a telephone conversation? ❑ Yes ❑ No

Part C Spiritual Pastoral/Nursing Care Plan

Summary of Data

Expressions of Spiritual Pain

Conditions	*Comments*	*Plan*
Abandonment	_________________________	_____________________
Anxiety	_________________________	_____________________
Broken/distance relationships	_________________________	_____________________
Denial	_________________________	_____________________
Depression	_________________________	_____________________
Grief/loss	_________________________	_____________________
Guilt	_________________________	_____________________
Meaninglessness	_________________________	_____________________
Hopelessness	_________________________	_____________________

Rejection by others		
Rejection by God		

Expressions of Spiritual Strength

Condition	*Comments*	*Plan*
Openness to tell one's story		
Shares doubts & fears		
Searches for meaning		
Reconciliation/forgiveness		
Potential for inner Growth		
Courage		
Trust		
Hopefulness		
Serenity		
Inner peace		
Desire for wholeness		

Short-term Goals: ____

____

Long-term Goals: ____

____

Referral(s) made:

Agency/Organization	*Contact Person*	*Comment*

SPIRITUAL INTERVENTION RECORD

Date	Goals, Plan	Notes	Signature