Leading Effective Groups in the Look AHEAD Lifestyle Intervention
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The Look AHEAD Lifestyle Counselors' Manual provides detailed outlines of the topics to be covered in group meetings. The manual is concerned primarily with the content of the group sessions. Anyone who has conducted these sessions knows that there is much more to the meetings than the stated content. Each group of 10-20 participants has its own tone and fabric. Some groups are far more productive and engaging than are others, even when examining the same issues. Groups conducted by the same Lifestyle Counselor, using the same material, can differ markedly from each other. A skilled Counselor, however, can work with a variety of different groups and obtain consistently productive results with all.

Purpose of This Chapter

This chapter describes some fundamentals of leading groups in the Look AHEAD Lifestyle Intervention. Undoubtedly, you could conduct group sessions without reading the chapter and do just fine. The topics discussed probably will be most helpful when working with groups or individuals that you find particularly challenging. Many of the topics covered here will be familiar to psychologists and social workers, who read similar materials in graduate school. Hopefully, dietitians, exercise specialists, and other professionals will find some of the suggestions useful. The following topics are addressed:

- Preparation
- The goals and methods of the Lifestyle Intervention
- The role of group treatment in the Lifestyle Intervention
- Establishing group norms
- Conducting group sessions
- Facilitating group interaction
- Distinguishing between the content and process of sessions
- Lifestyle Counselor's relationship with participants and the group

Preparation

Thorough preparation is perhaps the single most important requirement for leading effective groups. Skilled Lifestyle Counselors know the content and structure of each group session inside out. They have internalized the material, are comfortable with it, and can discuss and explain concepts in their own language. They do not read from the manual during a treatment session, any more than Broadway actors read from scripts while performing on the stage. Skilled Counselors have learned their material (and lines) before the group session starts. Thus, they are free to concentrate on the participants in the group. They are aware of participants' needs, of group members' reactions to the material, and of how the session is going. They can adjust their presentation in response to what they see and hear.
The following suggestions may help you prepare for leading group sessions:

1. Read the session materials, both the Participants’ Notebook and the Counselors’ Manual, a couple of times to get an overview.

2. Identify the most important points to be covered in the session. What are the key homework assignments and new topics?

3. Talk through (i.e., talk aloud) the major ideas of the session and how you will describe them or elicit discussion from the group. Such dress rehearsals are very useful. It is particularly helpful to plan how you will begin the session, outlining the agenda for the meeting.

4. Write notes on the Session Highlights, which summarize both the Counselor and Participant manuals. Rehearse the group session working only from the Session Highlights.

**Goals and Methods of the Lifestyle Intervention**

The goal of Lifestyle Intervention is to help participants lose 10% or more of initial weight by reducing their calorie intake and increasing their physical activity (to 175 or more minutes a week). The intervention offers a meal-replacement plan for the first 16 weeks to help group members reach this goal. The program relies principally on cognitive-behavioral therapy (CBT) to help participants modify their eating and activity habits, to set realistic goals, and to cope with lapses and other challenges. CBT is the most effective approach for weight control as determined by dozens of studies. This does not mean that CBT is effective with all participants or that we can be satisfied with its long-term results. However, it is the cornerstone upon which the Lifestyle Intervention is built.

**Goal-Oriented Approach**

The Lifestyle Intervention is very goal-oriented. Participants leave each session with a homework assignment to complete daily until the next session. Homework assignments usually involve changing some aspect of eating, exercise, or thinking habits. Participants monitor (in their Keep Track books) their success in changing behavior and discuss their progress in the following week’s session.

**Group Support**

This goal-oriented, cognitive-behavioral approach is blended with elements of group support. Participants are encouraged to listen to each other, to empathize, and to problem solve with one another. Participants may also discuss their frustrations with their weight or their diabetes management. The recognition that others experience such problems may help some participants feel less alone or abnormal. Such discussions often increase participants’ hope and self-efficacy. These are significant benefits of group sessions.
**Group vs. individual treatment.** Group sessions, in addition to providing social support, may also offer a healthy measure of competition, which can be viewed as positive modeling. Participants who see others losing weight or increasing their activity often think, "Well, if they can do it, I certainly can." A recent study found that group treatment was more effective than individual counseling in inducing weight loss during a 6-month program.

The Lifestyle Intervention combines group with individual treatment to capitalize on the strengths of both approaches. Individual sessions provide participants more personal attention and an opportunity to tailor treatment to their specific needs and preferences. This is particularly important in groups with diverse membership. In addition, individual sessions may better address the variety of personal issues that often arise during the weight-maintenance phase of treatment.

**Not group psychotherapy.** The Lifestyle Intervention does not provide group, psychodynamic psychotherapy. Participants are not encouraged to discuss childhood experiences or the "deep" or "hidden" factors that are purportedly responsible for their obesity. Such discussion may facilitate weight loss in some participants, but it does not appear to be useful for the majority. That is why the program adheres principally to a cognitive-behavioral approach.

**Role of the Group**

Given this rationale for group treatment, what is the group supposed to do? The group's activity could range from simply listening to you lecture to taking full responsibility for conducting the group sessions themselves.

All group members must participate actively in group sessions but, more importantly, outside of the group (in completing assignments). Ultimately, they are the only ones who can change their eating and activity habits. By way of analogy, Tiger Woods could spend months talking to a group of novice golfers about how to play the game. However, unless the group members took to the course several times a month and practiced what Tiger showed them, they would never learn to play. They would be able to talk a good game, but they would never learn the strokes and hand-eye coordination needed to play golf. There is no substitute for practice--of golf strokes--or of eating, exercise, and thinking habits.

Participants in the Lifestyle Intervention must, therefore, be very active outside of group, practicing new behaviors and learning to change old ones. Similarly, participants must be very active in the weekly group sessions, ready to discuss the number of calories they consumed, the number of days they walked, and how they coped with difficult situations.

**Group Interaction**

As a general rule, the more participants talk during a session, the more they value the session. Moreover, groups are the most effective and engaging when participants are
able to listen and respond to each others’ experiences. Thus, rather than lecturing the group or interviewing individual participants, you should encourage participants to interact freely with each other; participants should pose questions to each other, offer suggestions, and share experiences. To use an educational analogy, a well-functioning Look AHEAD group resembles a college seminar, in which each member comes to class having read the assignment and ready to discuss it. The professor (Lifestyle Counselor), by virtue of greater knowledge, facilitates discussion and leads students (participants) to important observations. The seminar contrasts with the lecture hall, in which the Professor is the centerpiece, and students are reduced to nodding heads and note takers.

Establishing Group Norms in the Lifestyle Intervention

All groups have rules and norms that govern group members’ behavior and interactions. Rules are usually stated explicitly, while norms develop over time and are known implicitly. Thus, company rules may state that employees report to work at 9 AM.; however, company norms may compel many to report by 8:30 A.M. Similarly, norms at other companies may habitually tolerate employees arriving 15-30 minutes late.

The consequences of disregarding rules are usually known. The consequences of violating group norms are usually less clear.

Rules in the Lifestyle Intervention

There are few hard and fast rules in the Look AHEAD Lifestyle Intervention. Perhaps the principal one is that participants must interact with each other in a respectful and courteous manner, as they would in any social situation. Offensive language or behavior is not acceptable in group sessions. Another general rule is that participants are expected to attend treatment sessions regularly, principally so they will get the greatest benefit from the program. Clearly, this is not a rigid rule and participants would not be asked to leave the group because of poor attendance. This topic is discussed further in a later section.

The next few sections discuss norms that Lifestyle Counselors should strive to establish in their groups. Some norms must be explicitly discussed with participants, while others can only be modeled.

Confidentiality

In the first group session, you should assure participants that things they say in the group sessions will be held confidential among the Look AHEAD staff members. Counselors should indicate that they will usually share relevant information with other staff members. No information about participants, however, will be communicated to professionals outside of the Look AHEAD study without participants’ written consent.

Lifestyle Counselors should ask participants to respect each others’ confidentiality, as well, and illustrate why confidentiality within the group is so important. Confidentiality
should be protected by asking participants not to disclose the last names of group participants. Thus, an individual’s participation in the program should be confidential, as should what the participant says or does in the group sessions.

The discussion of confidentiality should conclude with the Counselor’s explicitly asking whether participants agree to observe confidentiality. You should periodically remind participants during the course of the program of their pledge to observe confidentiality.

Caring, Safe, and Supportive Atmosphere

Lifestyle Counselors must demonstrate concern and caring for each individual participant. This is central to creating a caring, safe, and supportive group atmosphere.

Participants in the Lifestyle Intervention are generally very supportive of each other; their concern for one another can be truly moving. Thus, participants will usually create a supportive group atmosphere, particularly when they see you model these behaviors.

Groups sometimes contain members, however, who are critical of or insensitive toward other participants. An individual, for example, might say, “I don’t think Judy is really trying and I’m getting tired of listening to her complain.” In such cases, you would need to intervene to show the complainant how to make his point without being hostile or hurtful. Ultimately, you must be prepared to state that such behavior (which occurs very infrequently in groups) is not helpful or appropriate. Outside of the group, you should try to determine the reasons for the participant’s negative comments.

Other participants may feel somewhat shy or uncomfortable in the group because of general discomfort in personal relationships. Such persons, who constitute a small minority, may give out messages of “don’t get too close to me,” or “stop prying.” You should meet with such participants outside of the group and inquire how the participant likes the group meetings and whether you can do anything to increase his or her comfort in the sessions. You will need to establish a particularly strong relationship with such individuals if they are not attached to other group members.

Regular Attendance and Commitment to the Program

Plan to discuss throughout the program the importance of attending treatment sessions regularly. Ask participants what they perceive as the benefit of attending all group sessions.

Regular attendance is critical for at least two reasons. First, numerous studies have shown that the more treatment meetings participants attend, the more weight they lose, and the more weight they keep off long-term. Thus, regular attendance is in the participant’s self-interest.

A second reason is that regular attendance increases group morale and
cohesiveness, which may be associated with a better treatment outcome for all participants. In addition, participants worry about those who are not present; they fear that absent members are having difficulty.

Participants who have to miss a meeting should announce their absence the week before in the group. Then the group will know that the absence is not cause for worry. Ask participants who cannot attend the group because of emergency or illness to call so you can inform the group.

Inform participants at the first group meeting that you will call them in the event that they miss a session. Indicate how you will identify yourself when you call.

Lifestyle Counselors should notify participants 2 or more weeks in advance of their missing a group session. Since participants will model your behavior, it is critical that you attend sessions with the greatest regularity.

**Punctuality**

Lifestyle Counselors must be very punctual in attending group sessions. Plan to arrive 30 minutes before the session to greet participants and measure their weight. You cannot afford to be late to group, lest the participants start to model your behavior.

Group sessions should begin on time -- within 5 minutes of the stated time -- regardless of how many participants are present. Punctual participants should be rewarded for their behavior. Tardy participants should be acknowledged when they come in, but should not be allowed to disrupt the discussion at hand.

Group sessions should also end on time. Many participants have appointments after group and will be unhappy when sessions run overtime.

Groups also should not end early. With so little time available to help participants, all time should be used. When extra time is available, spend it reviewing participants’ eating and activity diaries (i.e., Keeping Track books) in greater detail.

**Appropriate Group Expression**

Participants need to be informed, explicitly and/or implicitly, what constitutes appropriate group behavior; this includes verbal and nonverbal behavior.

Participants should spend the great majority of their time in group discussing their efforts to modify their eating, activity, and thinking habits. However, participants should be given some time in each session, usually at the beginning, to discuss other events in their lives. These events may be positive, such as an upcoming trip to Europe or a new job, or they may be negative, such as the illness of a family member or the loss of a job.

Participants usually enjoy discussing the events in their lives. These discussions often bring them closer together and serve as the basis of friendships which, in turn, strengthen group cohesiveness. Members begin to look forward to the weekly group
meetings in order to see their new friends. Thus, these brief "how-are-you-today" discussions play an important role and give each group its distinctive character. These exchanges are particularly important in the early stages of group formation.

Your task is to determine when such discussion is productive and when, instead, it more resembles social chitchat, which serves primarily to distract participants from the work they need to do.

Only a few minutes can usually be devoted each session to non-weight-related issues. Use your judgment to determine when there is not enough time and when it is too much. You will certainly want to spend several minutes consoling a member who has lost a friend or family member or experienced a similar hardship. But you may need to cut short a person's description of their trip to New Orleans. You could state, “I'm going to interrupt you here and ask that you finish your story after the session. We're running short on time, and I want to hear about your diet diary this week. So, thanks for finishing your story later.”

Nonverbal Behavior

You also will need to establish what constitutes appropriate nonverbal behavior in group. A host of issues need to be clarified including whether it is appropriate for participants to: 1) eat or drink in the group; 2) knit or sew; 3) read their mail or other material; 4) work a crossword puzzle; 5) close their eyes if they are sleepy; or 6) talk to a neighbor while another participant is speaking.

As a general policy, participants should be discouraged from engaging in any behaviors in group that distract them or their fellow participants from the discussion at hand. At some level, all of the behaviors above can be viewed as distracting and potentially disrespectful to the person who is talking at the time. All behaviors of this nature should be discussed with the group; they should not be overlooked.

Being a Good Group Member

Ultimately, one of your key tasks is to teach each participant how to be a good group member who is courteous, listens to others, provides feedback, and talks constructively about his or her own efforts to change behavior. Kelly Brownell's LEARN Program for Weight Management 2000 contains a separate appendix (included at the end of this chapter) that provides participants tips on being a good group member. The material is reprinted with thanks to the author.
Conducting Group Sessions

The content of the Lifestyle Intervention is spelled out in detail in the Look AHEAD Lifestyle Counselors’ Manual. Weekly group sessions cover the content presented in this guide. However, there are different ways of discussing the material.

Participant-Oriented, Not Counselor-Oriented Meetings

Lifestyle Counselors are a focal point of group sessions by virtue of their perceived authority, clinical skills, and knowledge of obesity. They have a number of responsibilities for the group that keep them in the spotlight. Some of these responsibilities have been discussed here, while others are reviewed in the introduction to the Lifestyle Counselors’ Manual.

While Lifestyle Counselors are invariably a focal point of the group, they should not be the focus of the group. Again, group sessions should focus on participants’ efforts to modify their eating, activity, and thinking habits in order to achieve weight control. You should use your expertise to help participants change their behavior, rather than using it to provide extended lectures on the topics presented in the Lifestyle Counselors’ Manual.

Virtuoso counseling. By way of analogy, when a virtuoso violinist teaches students, she first observes and listens to their playing and determines their strengths and weaknesses. She then gives them feedback and suggestions for correcting the problems in their technique. She may model the new technique, but the virtuoso does not spend the whole lesson playing for her students. She asks the students to replay a passage several times until she is confident that they understand the new technique. She then sends them home for a week to practice the new techniques and passages.

Throughout the lesson, she focuses on the students' learning to play the violin more expertly. The spotlight is on the students and their needs, not the virtuoso’s expertise; the latter is taken for granted.

The main goal of the Look AHEAD group session is for the Lifestyle Counselor to examine participants’ behaviors and cognition related to eating and exercise. You are unable to observe most of these behaviors directly and, therefore, must rely on participants' self-reports in their Keeping Track books. Your task is to help participants understand the difficulties that they are having with a behavior, invite suggestions and feedback from other participants, and then work with participants (and group) to develop a solution to the problem. Participants should try to practice the new behavior in the ensuing week and report on progress in the next week's session.

Lifestyle Counselors judge progress on the basis of weight change, but also on the basis of what they see and hear. In this case, seeing is more important than hearing. You must see evidence that participants have practiced their homework assignments; at a minimum, participants must have completed their diet and exercise diaries and other homework assignments. Completion of these tasks suggests that participants have
practiced the behaviors that the assignments are intended to measure. In the absence of seeing completed homework assignments, there is little reason to believe that participants have practiced their new behaviors. And there is no substitute for “practice, practice, practice.”

Socratic Method

Effective Lifestyle Counselors make extensive use of the Socratic method; they ask questions (or offer comments) that lead participants to an understanding of their particular problems, rather than telling participants what their problems are and how to solve them. They help participants to understand the where, what, when, and how of their behavior and to find their own solutions to the problems. This method increases participants' ownership of their problems and helps them assume responsibility for finding solutions.

Formal Presentations

Lifestyle Counselors frequently like to make formal presentations to the group. For example, they might take 5-10 minutes to introduce the topics of lifestyle activity or cognitive restructuring. Keep a couple of facts in mind when lecturing:

First, remember that “brevity is the soul of wit” (i.e., keep it short). Particularly if the material is complicated or somewhat abstract (i.e., cognitive restructuring), participants may have difficulty listening for more than 5-10 minutes at a time. Counselors should continually try to gauge the interest and alertness levels of the group. If interest wanes, use the Socratic method to involve participants more.

Second, as noted earlier, Lifestyle Counselors should: 1) know their material; 2) try to think of relevant examples to bring it to life; and 3) practice their delivery before presenting the material to the group for the first time. Unless you are extremely articulate, you will have difficulty discussing cognitive restructuring without first rehearsing it. And the group session is not the place to rehearse!

Effective Lifestyle Counselors know the content of the material so thoroughly that they do not need to even think about it. Their energies are free to concentrate on the delivery of the material and participants' reactions to it.

Maintaining the Balance Between Individual and Group Needs

As previously noted, Lifestyle Counselors must continually monitor whether participants’ discussions are therapeutically productive or closer to social chitchat. In a similar manner, they must continually balance the needs of the group against the needs of the individuals who compromise the group.

Participants sometimes come to group meetings feeling upset, particularly if they have gained weight or are eating out of control. Or they may become upset during the course of a session. Such participants require attention during the group session. Individual attention should be given in order to help participants feel better and to help
them find solutions to their problems. Individual attention should also be given to demonstrate that the group session is a place where participants can bring their difficulties and get help. The message that the Counselor (or group) wants to convey is “This is a trustworthy and caring group.”

Avoid individual therapy. While Lifestyle Counselors must always be responsive to participants who are in distress, you cannot afford to take more than a few minutes to discuss an individual participant’s problems. You cannot allow group meetings to become a forum in which you do individual therapy with one or two participants each week, while other participants listen in -- sometimes with interest, sometimes not.

Counselors should acknowledge a distressed participant’s upset and suggest that the participant and Lifestyle Counselor meet after the group to discuss the problem further. In addition, you should determine other participants’ reactions to the distressed participant’s problem. Participants often become upset when listening to others; something that they have heard strikes close to home. Thus, it is important to check for such emotional reactions. All of this must be done quickly, however. Otherwise, a majority of group members may lose interest in the session, and all will lose valuable time needed to discuss homework assignments and other issues.

Tone of the Group

Lifestyle Counselors are responsible, particularly in the early stages of treatment, for setting the tone of the group sessions. Participants contribute to the tone as they become more comfortable, but in the beginning, they look to the Lifestyle Counselor. It is impossible to state precisely how the tone of the group is set or what the tone should be; however, the following points should be considered.

Positive regard for participants. Counselors’ interactions with participants, both in and out of group sessions, should be characterized by respect for participants’ individuality, honesty, hard work, and vulnerability (concerning their weight). Counselors should convey, whenever possible, that they care about the well-being and success of each individual in the Look AHEAD Program and will do whatever they reasonably can to help each individual. We have previously discussed the manner by which Counselors can demonstrate their concern for participants.

This tone--of interest, concern, and respect--should be the backdrop against which all group interactions occur. Counselors should verbally reinforce participants who display these characteristics toward their fellow participants and shape more appropriate behaviors in participants who are disrespectful or otherwise inappropriate.

Avoid criticism. Lifestyle Counselors should not express annoyance or frustration toward participants, or disparage them in any way. You may feel frustrated or angry when participants do not adhere to treatment instructions or do not make progress. Counselors also feel annoyed when they are criticized by participants. These feelings are fully understandable and should be discussed with colleagues. These feelings, however, should not be expressed to participants. Your expression of negative feelings could damage participants’ self-esteem and your relationship with them. Counselors should
understand that the frustration, helplessness, and anger that they experience in working with some participants are often reflections of participants’ feelings toward themselves. Counselors need to help participants deal with these negative feelings, not add to them.

Engaging Group Sessions

Lifestyle Counselors should feel free to express a range of emotions in group. Use humor when appropriate, laugh when tickled by a participant’s joke, and express concern when touched by a participant’s sad story. Moreover, you should continually strive to create on upbeat, optimistic atmosphere, in which you continually replenish participants’ hopes that they can learn to deal more effectively with their weight and diabetes.

Lively and productive group interactions keep participants coming back to treatment each week. Group sessions should be fun, while helping participants change their behavior and lose weight. As one participant once remarked, “I hate having my teeth worked on. But my dentist is such a nice person, I go to see him at least three times a year. He makes going to the dentist fun. Can you believe it?”

Facilitating Participation and Group Interaction

Some groups (and sessions) just “seem to click” while others never completely find their stride. Seasoned Counselors frequently know within 15 to 20 minutes of the first group session whether the group will have “good chemistry,” just as some claim to know the chemistry of a first date from an initial “hello.”

While it may be true that “some groups have it and others don’t,” effective Lifestyle Counselors can improve the chemistry of groups “that don’t.” The best time to do this is before treatment begins. The treatment team, whenever possible, should select participants for group treatment with an eye towards participants’ compatibilities and social skills. Try to ensure that each member of the group will have something in common with at least one other member of the group. Members who are very dissimilar from the remainder of the group often feel out of place and are likely to drop out of treatment. You should also be wary of placing a very hostile or withdrawn individual in a group. Such individuals can have a very negative impact on the tone of the group.

Facilitating Group Participation

You also can shape group members’ participation once treatment has begun. Participation can be increased by: 1) telling people that participation is desired and is an important part of the program; 2) asking questions of the group, rather than lecturing; and 3) calling on individual participants to discuss their food and activity records.

Always reinforce participants for talking (appropriately) in group. If participants have a positive experience when they talk, they will want to talk more. People are most likely to feel good about what they have said if you say, “That’s very interesting” or “That’s a good point.” In addition, you can follow up a participant’s comment with another question or comment, indicating that you listened to the participant and were interested.
The last thing you want to do is to criticize what participants say by dismissing their points as wrong or irrelevant. Such actions may reduce participants’ self-esteem and their likelihood of speaking.

If a participant, for example, tells the group that all obese persons have food allergies (which clearly is not true) the Counselor could respond, “Tell me why you think that.” After hearing the response, the Counselor might state, “Well, that’s interesting. Some overweight people may have food allergies but, to the best of my knowledge, most do not. I guess we’ll have to wait for more research on this topic.” Compare this response to: “That’s not true. There’s absolutely no evidence that most obese persons have food allergies. That sounds like misinformation.” The first response lets the rest of the group know that most obese individuals do not have food allergies and conveys this information without demeaning the participant. Counselors must always be aware of their power to damage (or enhance) participants’ self-esteem through seemingly insignificant interactions such as these.

**Facilitating Participant Interaction in “Cool” Groups**

The Counselor should attempt to facilitate participant interaction in groups where it does not spontaneously occur (i.e., “cool” groups). Groups with greater participant interaction are usually more engaging (and enjoyable) for participants and are better attended.

If the group does not warm up during the first session when participants introduce themselves, then more time (as much as 15-20 minutes) should be devoted to this task in the second session. Participants should introduce themselves again, telling a bit more about their families, work, and hobbies. You should try to point out obvious similarities between participants, which can provide the basis for social relationships. A typical comment might be, “So, we have four people here who have teenage children. What do you think is the greatest challenge of living with a teenager? What about those of you who had teens who have left home? Remember what it was like?”

The purpose of such discussion is to show group members that they share more in common than just their diabetes and obesity. Such discussion may also reduce participants’ initial anxiety about having to discuss their weight problem, of which some will feel ashamed. People are usually more at ease discussing “conflict-free” areas of their lives.

“Cool” groups can also be given more time initially to chat about how they like the program. Members frequently find that they have common reactions to the program or that their family members have similar reactions to their participating in the program. Most participants also enjoy discussing other weight loss programs they have been in and how these programs compare with Look AHEAD.

**Joint Task**

Interaction can also be facilitated by assigning participants a joint task. Thus, the
Counselor might say, “Today, we are going to talk about what you can do to adhere to the meal replacement plan. Let’s divide up into pairs and, as a pair, pick the two things that you find the most helpful for adhering to the dietary plan. Write your answers on a piece of paper. We’ll then reassemble as a group and discuss your answers.”

The Counselor may wish to leave the room while participants perform this task. The Counselor’s absence makes the participants take more responsibility for the task and, by extension, for the group session. The room will always get noisy when you step out, but that’s the objective. This experience should bring the group together.

Brief activities outside of the group can also facilitate participant interaction. For example, the group might go for a 10- to 20-minute walk on a pretty day or have a cooking demonstration (if the site has the facility for this). Participants are bound to end up in dyads or triads, engaged in conversation, while performing such activities.

Facilitating Participant Interaction in All Groups

Other techniques help facilitate group interaction once the group has achieved a satisfactory level of trust and comfort. One technique involves making copies of one participant’s diet or exercise diary from the previous week and distributing copies to each group member. Diaries may be distributed anonymously, but participants can identify themselves if they wish. The group as a whole is then asked to analyze two or three consecutive days of the diet diary, commenting on the quantity and quality of food eaten, the places and activities associated with eating, and other pertinent events. This method of instruction provides a great deal of personal attention for the participant whose diet diary is selected. It also enhances the other group members’ powers of observation and analysis, which they can then use in examining their own diaries.

In groups that function particularly effectively, participants can be asked to exchange diet diaries, exercise records, or homework sheets and give each other feedback on their behavior. Participants are usually given 5 minutes to analyze the material. Feedback can be given privately or publicly. If given privately, participants are later called on in group to state what they learned from the feedback they received. If feedback is given publicly, then participants are asked to work with each other in pairs, as other group members listen in and make comments or ask questions, as appropriate.

Role Playing

Role playing can be used to analyze and correct a number of problems, such as unassertive behavior. Often participants having difficulty with a problem find it very useful to see other participants act out the problem in a role play. Once they have seen the problem from a more objective perspective, they can develop and role play an appropriate response.

Similar techniques are often useful in conducting cognitive restructuring. Too often participants are unable to appreciate fully how irrational their self-defeating thoughts are. They can be asked to project their self-defeating, self-punitive thoughts on to another participant and to describe this person’s flaws. Thus, Carol, who was disgusted with herself for not having more will-power to control her eating was asked to turn to another
participant, Beth, and say, "Beth, you are really disgusting. You have absolutely no will
power to control your eating. You are such a failure." Carol was able to realize how
profoundly irrational and self-punitive her self-statements were when she applied them to
another person.

**Projection Versus Empathy**

In listening to participants’ interactions, Lifestyle Counselors should be aware of
the fine line between empathy and projection. Empathy refers to a person's listening
carefully to another in order to achieve an intimate understanding of the person's
thoughts and feelings. Projection, by contrast, refers to the attribution of one’s own
thoughts and feelings to another person.

Participants frequently project on each other when called on to give feedback
about another person’s feelings or to analyze another’s difficulties. You should point out
this tendency toward projection when it occurs, noting that it is very common; we see in
others what our experience allows us to see.

Counselors should help participants to understand that their problems and
experiences may be very different, even though they share the common problems of
diabetes and obesity. The Counselor should model accurate listening and reflecting skills
for participants.

**Lines of Communication in the Group**

In the early stages of treatment, most communications are likely to be from the
Lifestyle Counselor to the group as a whole, or from the Lifestyle Counselor to an
individual participant. Other communications will be primarily from individual participants
to the Lifestyle Counselor. These communications can be represented as follows:

- Lifestyle Counselor → Group
- Lifestyle Counselor → Participant
- Participant → Lifestyle Counselor

Participants interact more with each other in later stages of treatment. However,
they often talk to each other using the Lifestyle Counselor as an intermediary. Thus a
participant might say, “Dr. Smith, I think that Jane should consider not going out to dinner
if she thinks she’ll be tempted to go off the meal-replacement plan.” Dr. Smith is then
supposed to say, ‘Well, Jane, what do you think about Betty’s suggestion?’ These
communications can be represented as follows:

- Participant 1 → Lifestyle Counselor → Participant 2
- Participant → Lifestyle Counselor → Group

The most powerful communications often occur when participants talk directly to each
other. Thus, if participants have not started to talk to each other directly by the seventh
session, you should start to remove yourself as an intermediary. This can be done by
simply telling participants to talk to each other directly. Thus, Dr. Smith might say, “Betty,
tell Jane directly what you think she should do.” If the participant continues to speak to
you even when directed to speak to a group member, avoid making eye contact with the participant. This will force him or her to find another audience – the proper one.

Content and Process in Behavior Change and Group Interaction

Content

Much of the content of the group sessions is spelled out in the Lifestyle Counselors’ Manual. The manual presents topics for the Lifestyle Counselor to discuss and homework assignments for the participants to complete. The actual content of the group sessions consists of the things that the participants (and Lifestyle Counselors) talk about in the group. The content of the sessions should include, in order of priority:

1. Participants’ discussion of their efforts to modify their eating, activity, and thinking habits, as they relate to control of their weight and diabetes. This is achieved by reviewing Keeping Track records each week.
2. Lifestyle counselors’ presentation of new topics, as described in the manual.
3. Participant discussion of other issues related to their weight or diabetes but not directly related to changing eating and exercise habits (e.g., distress about being overweight, experience of prejudice or discrimination against obese people).
4. Participant discussion of other events in their lives (i.e., their families, relationships, crises, etc.)

Most treatment sessions, and particularly the early ones, are very content-oriented. Lifestyle Counselors provide a great deal of information that participants need to absorb and digest.

Process of Behavior Change

Group sessions should remain content-oriented throughout treatment. When participants are not successful in implementing behavior change, however, Lifestyle Counselors need to pay attention to the process of behavior change, rather than to the content of the desired change.

When used in this context, process refers to how participants attempt to change their behaviors and thoughts related to weight control. Process concerns primarily how things are said or done, while content refers to what is said or done. A couple of examples should clarify this distinction.

Example #1. John and Bill both stated in group that they were very pleased with their weight loss during the first week of the meal replacement. Both volunteered that they had lost 3 pounds. When asked how he had lost his weight, Bill indicated that he followed a 1500 kcal diet for all seven days of the week. John, on the other hand, indicated that he had overeaten the first five days of the week, but had fasted the last two days to compensate.
Both men lost weight (**content**), but the manner (**process**) in which they lost it differed markedly. Bill followed an appropriate strategy, while John’s approach was undesirable. The Counselor would have lost very valuable information about John if he had not inquired how John lost his weight.

**Example #2.** When called upon to discuss her efforts to slow her rate of eating, Christine indicated that she had forgotten to concentrate on this behavior during the week. Her Counselor responded that it was the third consecutive week that she had forgotten to do it. The Counselor asked, "What’s giving you trouble with slowing your rate of eating? Do you feel that you don’t have a problem with eating too rapidly?" Christine responded that she did eat too rapidly and volunteered that she would practice eating more slowly in the coming week.

The Counselor could have stopped here, pleased to have received Christine’s promise to slow her rate of eating (**content**). However, the Counselor realized that Christine had given the same promise the previous two weeks. The Counselor knew that it was necessary to help Christine devise a plan of how and when to practice this behavior (**process**). Thus, in the group, Christine picked the three nights that she would practice slowing her rate of eating, wrote them down in her Keeping Track book as a reminder, and indicated how she would slow her rate of eating--by putting her fork down and using a timer.

**Attending to Process in Behavior Change**

Lifestyle Counselors should continually pay attention to the process of participants’ behavior change. It is imperative that participants change their eating and exercise habits in constructive ways that will produce long-term weight control.

Thus, initial process communications should focus on implementing behavior change. A typical example might be, "Mrs. Green, you said that you are going to walk this week. How many times do you plan to walk, and when and where will you do this? How will you remind yourself to walk?"

This communication is not threatening, but it does require the participant to reflect and plan. It is more detailed than the simple content communication of: "Remember to walk this week. It’s really important."

It is particularly important for Counselors (and participants) to pay attention to the process of behavior change when participants are having difficulty. The Counselor needs to know how participants are trying to change their behavior; frequently participants do not have a strategy for behavior change, or they have a maladaptive one.

**Abstract Process Communications**

Some process communications about behavior change are somewhat more abstract. They involve observations about a participant’s pattern of behavior, rather than a single behavior. The Counselor has repeatedly observed behaviors which, while not identical, share common elements. These more abstract process communications can
sometimes be threatening to participants because they ask participants to examine issues that they are unaware of or may be avoiding. The following are examples of process communications:

Example #1. "Mr. Smith, I've noticed that whenever you don't keep your food records, you say that you were 'out of it.' Let's talk about what being 'out of it' involves. Until we can start to understand what happens when you are 'out of it, it's going to be hard for you to keep a food record."

Example #2. "Mrs. Taylor, it seems that whenever you have a really tough week in which you overeat, you don’t come to the group meeting. From what you've told me before, you seem to feel ashamed of your overeating. I can understand you’re upset. What can we do to help you feel ok about coming to group when you’ve overeaten?"

These more abstract process communications should be used very sparingly. They should be reserved for situations in which: 1) participants are clearly having difficulty changing their behavior; 2) other approaches have been used but have failed; and 3) the Counselor is confident that she or he understands the meaning of the participant’s behavior. Such communications are best delivered in individual meetings in which there is ample opportunity to discuss the participant’s difficulties. Communications should address patterns of observable behavior, not the Counselor’s speculations about the participant’s motives.

Group Process

Group process refers to the manner in which group members interact with each other and the Lifestyle Counselor. It also refers to the effect that participants’ communications have on each other or the group as a whole. A few examples should clarify what is meant by group process.

Example #1. Mary came to group and was asked how her efforts to improve her walking program had gone the previous week. She immediately responded that she was very pleased by the compliments that she had received from some friends that she ran into while shopping. She noted that the compliments made her feel great and that she was really happy to be in the Lifestyle Intervention.

The content of Mary’s communication was off topic. Similarly, the process by which she avoided talking about her exercise was inappropriate. As the Lifestyle Counselor learned through further questioning, Mary tried to avoid talking about her exercise, which she had not done, by talking about the compliments that she had received.

Example #2. Three successive participants had just finished describing what good progress they had made in handling difficult eating-related problems. Several other group members complimented the participants on their success. In looking around the room, the Lifestyle Counselor noticed that one participant, Sam, had a frown on his face; he looked upset. The Lifestyle Counselor wondered whether Sam might be upset because he had
been unsuccessful in handling his problems (and because it appeared that the rest of the group was doing so well). The Lifestyle Counselor turned to Sam and asked, "How did you do this week? Did you have to deal with any difficult situations?" Sam immediately said, "Yes, and I was a complete failure."

The Counselor helped Sam to understand why he felt like a failure and showed him that he was not a "complete" failure. The Counselor also noted, "It must have been hard to hear that other people were doing so well. It must have made you feel like there was something wrong with you. You might have thought, 'Why am I having trouble when everyone else is doing so well?'" The Lifestyle Counselor then added, "Everyone has bad weeks; the important thing is to be able to talk about them and to find some solutions to the problems that come up. That's why we have group meetings."

If the Lifestyle Counselor had not paid attention to Sam’s facial expression and had not been sensitive to the possible impact of other participants' reports of success, Sam probably would have gone home upset. Instead, the Lifestyle Counselor recognized his upset, allowed him to verbalize it, and helped him to feel like a part of the group.

This example shows how useful it is for the Lifestyle Counselor to attend to participants during the group session. If the Counselor had been looking through the treatment manual trying to remember what topic to cover next, he or she would have missed out on what was happening with Sam. Lifestyle Counselors can only attend to individual and group process when they are completely familiar with their material.

Group process communications should be used very sparingly in the Look AHEAD Lifestyle Intervention, as should more abstract individual communications. As stated previously, **Look AHEAD Lifestyle Intervention is a group weight loss program, not a group psychotherapy program.**

**Communication With the Group as a Whole**

In some cases, you will need to address issues that affect the group as a whole. This section discusses several types of issues that might arise.

- **The group's adoption of a norm that is damaging to the group's cohesiveness.** Examples include poor attendance, tardiness, or any behaviors that create factions in the group, such as adding new participants to the group or joining two groups together. Established groups may not immediately welcome new members.

  The Counselor's task is to openly discuss the troubling situation, to ask for participant input, and to arrive at some resolution which is acceptable to the participants and Counselor.

- **The group's loss of a member.** When a participant leaves the program, for whatever reason, remaining group members are likely to have reactions to the departure. These may include sadness, worry, or regret. Participants should have an opportunity to discuss their feelings.
A particularly painful challenge in Look AHEAD will be coping with the loss of participants who die during the course of the study. Participants will die as a result of myocardial infarction, stroke, and other complications of diabetes. You will need to provide time during group sessions for participants to discuss their sadness and other reactions. Members also may wish to mourn outside of group, such as by sending a card to the bereft family or attending funeral services. Most deaths probably will occur in the later phases of the study (i.e., follow-up for years 5-12). However, you must be prepared for serious illness and death during the course of the study. This probably will be the hardest aspect of Look AHEAD, compared with other trials in which Lifestyle Counselors may have participated.

- **The group’s experience of strong emotions about some aspect of treatment; the emotions are unexpressed or are expressed inappropriately.** Examples might include dissatisfaction with homework assignments, anxiety about starting the meal replacement, or sadness or anxiety about the group sessions ending after 12 months.

  The Counselor’s task is to facilitate participants’ discussions of their feelings to prevent them from acting out these feelings in unproductive ways. Thus, discussion of participants’ fears about their ability to adhere to the meal replacement might prevent them from binging the week before starting the diet. Discussion of participants’ sadness about group sessions ending may prevent them from leaving the program two to three weeks early to avoid such feelings.

- **Participants’ experience of strong negative emotions toward each other.**

  The Lifestyle Counselor’s task is to help participants express and understand what they are feeling and to determine if their expression of their feelings is appropriate. On rare occasions, Lifestyle Counselors may have to assume the role of a referee, placing themselves between two upset participants. Lifestyle Counselors usually want to take themselves out of the position of being a mediator between participants, but here the role is appropriate.

- **Participants’ experience of strong, negative emotions concerning the Lifestyle Intervention itself or toward a member of the clinical or administrative staffs.**

  Examples might include participants’ annoyance or anger that they are not eligible for weight loss medication or that they have not been provided routine medical care that they wanted.

  **Nondefensive listening.** The Counselor’s primary task is to listen to the participants, without trying to defend the program or its staff. Participants have a right to complain if they are unhappy. People are frequently able to get on with other business once they have been allowed to complain and feel that their complaints have been heard (i.e., taken seriously). Trying to suppress participants’ complaints only increases the tenacity with which they hold to them. Nondefensive listening can go a long way. It feels good to be heard, even if someone cannot fix the problem for you.
The sparing but appropriate use of group process communications will help to keep a group running more effectively. A Lifestyle Counselor’s failure to address critical group issues, as they arise, may not have any immediate negative consequences. But repeated failures to do so are likely to have a negative effect on the tone and fabric of the group.

The Lifestyle Counselor’s Relationship With Participants and the Group

The Lifestyle Counselor’s first task is to communicate respect, care, and concern for the individuals participating in the Lifestyle Intervention. Another central task is to ensure the cohesiveness of the group so that it supports members efforts to change their eating and activity habits. This section discusses, in somewhat greater detail, the Counselor’s relationship with individual participants and the group.

Relationship with Participants

The Counselor should display a number of positive qualities towards participants, including respect for participants’ diversity and individuality, as well as for the pain and sadness that many have experienced with their weight and diabetes. Many participants have struggled for years with their weight, without finding satisfactory ways of understanding or controlling it. Overweight participants will greatly appreciate anything you say or do that communicates that you understand their struggle.

Consistent Interest

One of the most important requirements for working effectively with overweight persons is maintaining consistent interest in participants’ problems and their efforts to deal with them. Participants need to know that the Counselor is interested in them week in and week out, both when they are losing weight and when they are “out of control.” The Counselor needs to stick by participants in difficult times when they may be ready to give up on themselves.

The Counselor’s consistent interest is, thus, a key to successful treatment. Erratic interest is damaging; it suggests that the Counselor’s support cannot be counted on. Conditional interest is also damaging; it suggests that participants should only come for treatment when they are doing well. This is a regretful message, because participants most need to come for treatment when they are having difficulty. That’s when they stand the greatest chance of actually learning something new about themselves and their behavior.

Warmth. Studies of psychotherapy have shown that the Counselor’s display of warmth toward participants positively affects treatment. Thus, if Counselors in the Lifestyle Intervention are naturally warm, they should bring this quality to bear in treatment. Warmth, however, is not enough. Consistent interest and patience in helping participants change their eating and activity habits is critical to the participants’ success.
Maintaining a Professional Relationship

Participants in the Lifestyle Intervention often become very attached to their Lifestyle Counselors. This is very understandable; people become attached to those who help them.

Counselors in the Lifestyle Intervention, in turn, often become emotionally attached to the participants they treat. This is also understandable; Counselors are concerned for their participants, want them to be successful, and invest a great deal of time and energy trying to promote their success.

Look AHEAD Lifestyle Counselors, however, must be sure to maintain a professional relationship with participants. They cannot afford for these relationships to assume a social or personal nature. Nor can they allow themselves to become overly invested in a participant’s successes or failures. These issues are discussed below in greater detail.

- **Friendly relationship, but not friendship.** The Counselor’s relationship with participants is very one-sided; the Counselor devotes a great deal of time and personal attention to participants, but does not expect to receive personal attention in return. The only things that the Counselor can legitimately ask of participants is for them to attend treatment sessions regularly, participate appropriately, and work at improving their eating and activity habits.

  The Counselor cannot ask participants for thanks or admiration because participants are sometimes unable to give these, particularly when they are having difficulty with their weight. Thus, Counselors must keep their personal needs out of relationships with participants. While some participants will certainly express their gratitude for the Counselor’s help, others will not. Counselors who expect such appreciation from all participants will be unable to work effectively with those who do not provide it. That is unfair to these participants.

  Thus, Counselors in the Lifestyle Intervention are supportive and friendly toward participants, but they do not expect friendship from participants.

- **Avoid relationships outside of the group.** Look AHEAD Lifestyle Counselors should avoid relationships with participants outside of the group sessions. Relationships outside of the group interfere with the therapeutic relationship, which the Counselor must preserve in order to be of greatest help to participants.

  By meeting with a participant outside of the group session, the Counselor may change a professional relationship into a social relationship. This is undesirable for several reasons:

  1. The Counselor is more likely to interject his or her personal needs into the relationship as a result of getting to know the participant better. The participant may then worry about the Counselor, if informed of upsetting events, or may grow envious of the Counselor if informed of good news. Both complicate treatment.
2. As the participant gets to know the Counselor better, the Counselor may lose some of his or her authority and therapeutic leverage. The participant may not take the Counselor as seriously, which is ultimately to the participant's detriment.

3. A final reason that the Counselor should avoid outside relationships with participants is because they negatively effect other participants in the group. All participants want to feel that they are special to the Lifestyle Counselor. If participants learn that the Counselor has socialized with a member of the group, the other participants in the group may feel jealous and less valued by the Lifestyle Counselor.

Counselors should feel free to participate in group functions held outside of the clinic. In such cases, the Counselor attends the social function as a member of the group, in the same manner as the other members. This is the only conventional circumstance in which the Counselor should socialize with participants outside of the group.

- **Avoid excessive physical contact.** Some participants request to be hugged when they have lost weight or have had a difficult week; some Lifestyle Counselors routinely hug participants as a way of demonstrating concern for them.

  Counselors should carefully consider their decision to hug participants or make other displays of physical affection. If a female Counselor hugs her female participants, then male participants may also ask for a hug. Similarly, an attractive male Lifestyle Counselor may spend several minutes a week hugging female participants. Hugs always have the potential to cross the line between support and sexual attraction.

  Counselors should know that if they hug a participant once, they must be prepared to repeat the gesture. Otherwise participants will feel hurt (and confused) by the withdrawal of affection.

  **A pat on the back is an excellent way of expressing concern for participants who wish physical contact.** Counselors should also remember that many participants prefer not to have physical contact of any kind.

**Transference Relationship**

The Lifestyle Counselor and the participant have a professional relationship that exists to help the participant lose weight by changing eating, activity, and thinking habits. This is the goal of the relationship.

Participants occasionally experience transference toward the Lifestyle Counselor. This refers to the participant's experiencing thoughts and feelings toward the Lifestyle Counselor that were originally experienced toward significant others in the participant's life (i.e., mother, father, siblings, etc.).
**Positive transference.** Positive transference occurs when the participant transfers positive feelings toward the Lifestyle Counselor. Upon their first meeting, the participant may praise the Counselor’s skills and abilities and go home to tell family and friends. Positive transference is initially very helpful in weight reduction therapy; the participant pays close attention to the Lifestyle Counselor’s suggestions and tries to please the Counselor by changing behavior and losing weight. As treatment progresses, the Counselor must ensure that the participant’s desire for behavior change becomes more internal (i.e., participants wish to lose weight, and to maintain their weight loss, to please themselves).

**Negative transference.** Negative transference occurs when participants transfer negative feelings from earlier relationships to their relationship with the Lifestyle Counselor. Negative transference can make the Counselor’s working (professional) relationship with a participant difficult.

A participant named Bill, for example, grew up with very strict parents who controlled his every move and criticized him. Not surprisingly, Bill came to resent authority. In the Lifestyle Intervention, he reacted very negatively to the Counselor’s requests that he complete his Keep Track book. He frequently challenged the Lifestyle Counselor’s expertise and brought to group sessions newspaper clippings that contained articles challenging points that the Counselor had made.

Marta, the Lifestyle Counselor, realized that Bill was still looking for a fight with his parents; in particular, Bill was looking for a fight that he could win in front of an audience, to boot. Marta realized that her difficulty with Bill had little to do with her and everything to do with Bill. She very wisely decided to stay out of Bill’s fight. She thanked him for bringing in the articles and encouraged him to bring in more. In addition, she met with Bill individually and asked him why he did not like to complete diet diaries. After listening to him, she acknowledged that he had some good points and invited him to propose some new methods of changing his eating and exercise habits. Bill said that he would think about new methods but, in the meantime, would fill out the diet and exercise records.

Marta could have exerted her authority over Bill by challenging the legitimacy of the articles that he brought to group and by demanding that he “complete the diet diaries – or else.” If she had done this, however, she would have played right into Bill’s hands. He would have proved that Marta was “just another jerk with a high opinion of herself.” He would have disrupted the group, and also may have left the group.

**Counter transference.** Lifestyle Counselors will occasionally find that they have strong feelings towards participants; sometimes the feelings are very positive while, on other occasions, may be quite negative. In such cases, Counselors need to determine if the intensity of their feelings is warranted by the participant’s behavior. Marta’s annoyance with Bill was clearly warranted; Bill was doing everything he could to get under her skin.
In some cases, the Counselor may be experiencing counter transference toward the participant. Counter transference occurs when the Lifestyle Counselor’s perception of the participant is distorted by transference; the Lifestyle Counselor transfers elements of his or her own personal relationships to the relationship with the participant.

Lifestyle Counselors should be on guard for counter transference when they experience two distinctly different types of feelings towards participants. In the case of positive transference, Counselors go out of their way to help participants, offering services and professional favors that are not even requested. The Counselor’s self-esteem may become very tied to his or her ability to help the participant. In such cases, the Counselor may wish “to save” the participant.

In the case of negative transference, the Counselor experiences dislike for the participant that is unwarranted by the participant’s behavior. The Counselor may treat the participant in a critical and demeaning fashion or may, instead, withhold attention from the participant. In both cases, the Counselor must ask several questions: “What do I feel for this participant?”; “What am I trying to do (or not to do) to this participant?”; and “How do I want this participant to feel toward me?”

Discussion With Colleagues

Professional colleagues can be of invaluable assistance in discussing participant-Counselor relationships that are complicated by transference or countertransference. As an objective observer, a colleague is free to see the difficulties in the relationship, which the Counselor is too involved in to see clearly. Good colleagues are a tremendous asset to the Counselor when he or she is faced by any number of problems. Lifestyle Counselors are encouraged to develop and participate in peer supervision groups whenever possible.

Conclusions

This chapter is intended to build upon skills you already have in treating obese individuals. If you have never led group sessions before, don’t sweat the details on group process, counter transference, and related topics. As you begin your first groups, focus on the most important issues. These are to enter each group with a firm grasp of the materials and of your agenda for the meeting, to focus on participants and their completion of weekly homework assignments, and to engage participants when introducing new topics. Try with each individual to convey your respect, care, and concern.

All Lifestyle Counselors, no matter how long they have been practicing, benefit from periodically reviewing their treatment sessions with another professional. You will meet weekly with Look AHEAD treatment staff to discuss participants’ progress but you also may want to meet at regular intervals with one of your colleagues to discuss your own progress in leading group sessions or working with individual participants. It’s great if you can find a senior counselor to review occasional tapes of your sessions. Or you and
other members of the Lifestyle Intervention team can trade off providing each other peer supervision.

In addition to obtaining supervision, Lifestyle Counselors are encouraged to improve their knowledge and clinical skills by reading works on obesity, the treatment of obesity, and the practice of individual and group cognitive behavioral therapy. The recommended readings provide a good starter course.

Recommended Readings


Introduction to the Look AHEAD Lifestyle Counselors’ Manual

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General Overview

The Look AHEAD Lifestyle Program is a manual-based protocol for weight management in Type II diabetics. The protocol allows for individual tailoring of the intervention to the needs of each participant. This section of the counselors’ manual provides detailed descriptions of common strategies that might be used to individually tailor the intervention in response to sub-optimal compliance with various aspects of the program, and in response to poor weight loss or poor weight maintenance. The figures that are included in this section represent illustrations of the decisions that should be made when participants fail to meet various weight loss goals or behavioral goals. Some of the strategies described as potential solutions to problems of sub-optimal compliance and/or poor weight loss are called “toolbox” strategies and they are labeled as Level B or Level C intervention options. Toolbox strategies are used when a participant is having difficulty following some aspect of the Look AHEAD Lifestyle Program and is not meeting weight loss goals. These toolbox strategies are viewed as special programs that may require additional resources for implementation. These strategies can be used in either group or individual sessions. However, since there will be more time for attending to individual needs during individual therapy, it is likely that the counselor will use these strategies during the individual sessions that occur at four week intervals.

Algorithms are used to provide illustrations of the decision-making process for tailoring treatment to the unique needs of each participant. The algorithms operationally define specific types of compliance problems that signal opening the toolbox (Level B and C interventions) and explicitly describe the most common intervention options that should be considered to resolve the problem as quickly as possible. It is assumed that the counselor will have some flexibility in selecting tailoring strategies and that the participant will have input on intervention options that are selected.

The Counselors’ Manual will include a section called “Optional Handouts for Individual Sessions.” The handouts available are as follows:

- The Look AHEAD Progress Summary
- Reach For Your Goal
- The Decision Balance
- What if the Scale Doesn’t Budge?
- The Look AHEAD Problem Solver
- Make a Plan
- Cutting Calories Worksheet
- The Food Guide Pyramid
- Rate your Plate

The counselor should be familiar with these handouts and use only the handouts appropriate to meet the individuals’ needs and tailor treatment.
The first section, **General Conceptual Framework**, illustrated on page 5, describes the basic conceptual scheme for the individual tailoring approach during the first six months of intervention. This approach uses a social problem-solving concept in which a problem is identified, a solution is found, and the strategy is tested for a specific period of time. If the solution effectively resolves the problem, then the strategy is continued until consistent behavior change is observed. If the solution is unsuccessful after a specific time period, e.g., four weeks, the strategy is terminated. A new option for solving the problem is then selected and tested for a specific period of time. It is anticipated that much of the individual tailoring of treatment will be conducted in the individual sessions.

The next section, **Primary Problems of Sub-optimal compliance**, describes the approaches individually tailoring treatment for three of the most significant problems that interfere with effective weight management: 1) poor attendance, 2) sub-optimal compliance with the dietary program, and 3) sub-optimal compliance with the physical activity program. These three problems are significant obstacles for successful lifestyle behavior change and weight loss. For each problem, an operational definition is specified.

When a specific problem is first identified, standard practice interventions (Level A), e.g., problem-solving or increased counselor contact, are employed. If the adherence problem is associated with poor weight loss, the toolbox (Levels B and C) may be opened and a plan of action is initiated. As shown in the general conceptual model, potential solutions should be selected in response to an analysis of the most probable barriers that are causing the problem. Tailoring strategies are grouped into three classes (Levels A, B, and C) based upon the cost and time requirements associated with different options. Generally, options from Level A will be tested, then options from Level B, and finally from Level C, though this sequence is not mandated. Options from Level A are considered to be interventions that are components of Standard Care and these interventions will not be tracked as toolbox strategies. Options from Level B are common toolbox strategies that are designed to enhance Standard Care. The options from Level C are toolbox options that often require additional resources and should ordinarily be used when other less expensive and time-consuming strategies have been attempted without success. The final section, entitled **Common Problems of Sub-optimal compliance**, describes intervention options related to five common problems that often interfere with successful weight management.

The study coordinating center will track the events that open the toolbox in order to alert centers about the occurrence of problems very quickly (in the event that the site does not recognize the problem). A coding system will enable the study coordinating center to track: 1) the target problem that opened the toolbox, 2) the toolbox options used, and 3) resolution of the problem. In the algorithms that are attached, toolbox options that are in bold print are those that will be tracked in the computer tracking system. By systematically following the same decision rules, it will be possible to improve compliance and intervene quickly in order to remove obstacles to success. Finally, by tracking this process, it will be possible to empirically evaluate the efficacy of different “clinical decisions” or at least to translate these “clinical decisions” into a set of behavioral strategies that can be objectively described.
In some cases, the participant may reject all options that are provided to them. For example, the person may refuse to initiate meal replacements and the Look AHEAD meal plan or referral to a specialist. In such cases, motivational enhancement methods should be employed to facilitate acceptance of the clinical recommendation. Repeated rejection of toolbox options should be brought to the attention of the Study Coordinator, Supervisor of the Lifestyle Intervention at the site, and/or the Principal Investigator.

**General Conceptual Framework: During 1st six months**

The individual tailoring approach uses social problem solving as a model for modifying unique problems as they occur during the intervention. This approach assumes that the process of changing behavior will be a collaborative effort between the participant and the counselors.

**Step 1: Problem Identification.** For each problem that is identified, it will be important to establish that the participant agrees that there is a problem. The participant and the counselor must also agree on the definition of the problem. This problem then becomes a target for intervention.

**Step 2: Brainstorming.** The next step is brainstorming, or developing a list of potential solutions to the target problem. In general, the types of solutions for the Look AHEAD program will fall into one of three categories: dietary, exercise, or behavioral/psychological. Behavioral analysis can often be used to facilitate the development of a wide variety of potential solutions. The algorithms that are provided in later sections are common examples of solutions that have been found to be useful in clinical practice for weight management. It is very important to provide an environment that promotes the consideration of a wide variety of possible solutions.

**Step 3: Cost/Benefit Analysis.** The next step is to help the person select a strategy that will be acceptable to the participant and will also be likely to effectively resolve the problem, resulting in better compliance and weight loss. To conduct a cost/benefit analysis, the counselor and participant must consider the perceived benefits and costs associated with each possible solution. It is important to remember that each person will value costs and benefits differently, e.g., for a wealthy person a cost of $10 is not a significant obstacle, but for a poor person, this same cost may be an obstacle of considerable magnitude. Therefore, it is important to carefully observe (i.e., listen to the person and carefully reflect on their intended meaning) the person as they evaluate costs and benefits so that the therapist can avoid applying his or her values, as opposed to those of the participant. Also, it is important to avoid immediately endorsing the “most obvious” solution or a solution that is favored by the counselor. Failure to heed this principle will lead to ineffective problem solving due to stifling innovation, and preventing the participant from making a personal decision to implement the strategy that is selected.

**Step 4: Selection of a plan.** The next step is to select a plan of action. The plan of action is typically written down and may take the form of a behavioral contract or an action plan (Refer to optional handouts). It is important that the intervention plan have the following elements: 1) target behavior/problem, 2) well-defined goal, 3) detailed plan of action that is tailored to the unique situation of the individual, 4) a specified period during which the
effectiveness of the plan will be evaluated, and 5) a specified target goal that is clearly defined in objective terms.

**Step 5: Evaluation of Effectiveness.** After the specified time period (which will usually be no more than 4 weeks; which is the time between individual sessions), the intervention strategy will be evaluated to determine if it effectively achieved the predetermined goal. If the strategy was successful, then the solution will typically be continued. If the strategy was unsuccessful, the process of behavior change, problems of implementation, etc. should be evaluated and new intervention options should be examined. The counselor and participant should repeat the five steps of problem-solving to establish a new intervention to resolve sub-optimal compliance problems and to establish the expected rate of weight loss.

To assist the counselor in making decisions, three levels of interventions have been established for each problem. As shown in the figure on the next page, these intervention options are grouped as Levels A, B, or C. Each level of intervention requires differing levels of cost and resources. In general, strategies from Level A will be used first, followed by toolbox options from Levels B and C. The description of the three levels of intervention options are presented so that you can see why a given intervention was judged to be listed in Levels A, B, or C.
General Conceptual Framework: During 1st six months

Target Behavior here. Definition here.
For example - Attendance

Intervention Options:
Level A: Standard Practice
1. Commonly used strategies, e.g., problem-solving, social support, etc.
2. Low cost options
3. Efficacy can be tested in a few weeks
4. Tailored to individual

Level B:
1. Enhancement of Standard Care
2. Minimal to low cost
3. Efficacy can be tested in a four week period
4. Tailored to individual

Level C:
1. Used after Level A & B options found to be ineffective
2. More costly than Level B options
3. Efficacy can be tested in a four week period
4. Tailored to individual

Evaluate most probable factor that may be causing failure to meet weight targets:
1. Dietary
2. Exercise
3. Behavioral/ psychological

Select one or more options
Present Option(s) to Participants
Develop a specific plan of action with time limit
Continue Strategy
Improving?
YES
NO
Re-examine options
Evaluate Process & Problems (e.g., other obstacles to successful behavior change)
Primary Problems of Sub-optimal compliance

This section describes three problems of sub-optimal compliance that are viewed as primary concerns for the Look AHEAD Lifestyle Program. If a participant is not adhering to the program by failing to: 1) attend sessions on a regular basis, 2) follow the dietary program at least 75% of the time, or 3) meet exercise goals at least 75% of the time, then the actions described should be implemented. These three problems were selected for emphasis because research has found that successful weight management requires regular contact and long-term modification of dietary/eating habits and physical activity. In the algorithms that are included in this section, the emphasis is upon intervention options that relate directly to the target problem. It is recognized that other problems may contribute to sub-optimal compliance with any of these target behaviors. In such instances, we offer five common adherence problems that present obstacles to successful weight management. Algorithms for these common problems are presented in the final section.
Significant attendance problem

Significant attendance problem, as defined by:

1. Missing 2 consecutive group (or group and individual) sessions or missing 3 out of 4 sessions for unjustified reasons*

*Note that after each missed session, the individual therapist should contact the participant to arrange a make-up session or have contact by telephone or email

Intervention Options:

Level A: Standard Care
1: Problem-solving
2: Schedule one or more telephone or email contacts (between sessions)

Level B:
1: Develop a plan to provide transportation to group session
2: Develop behavioral contract for individual
3: Develop contingency contract/token economy for group
4: Pay for parking

Level C:
1: Provide childcare
2: Referral to psychologist

Select one or more options

Present Option(s) to Participants

Develop a specific plan of action with time limit

Continue Strategy

YES

Improve?

NO

Evaluate Process & Problems (e.g., other obstacles to successful behavior change)

Re-examine options

Evaluate specific aspects of attendance problem or other obstacles to establish tailored intervention:

1. Economic factors
2. Transportation problems
3. Motivation for adherence
4. Child care problems
5. Emotional/Psychiatric problems
Significant Attendance Problem

I. Significant Attendance Problem:

A significant attendance problem is defined by missing two consecutive group sessions, one group and one individual session, or 3 out of 4 sessions for unjustified reasons. It is important to remember that the protocol requires the individual counselor to make contact with the participant to arrange a make-up session or have contact by telephone or e-mail after each missed session.

Therefore, if the person meets the criteria for a significant attendance problem, they have not complied with efforts to attend make up sessions.

II. Significant attendance problem with adequate weight loss:

If the attendance problem is not associated with poor weight loss, select one or more of the interventions listed under Level A in the algorithm. These options include:

Level A:

1) **Problem solving.** Problem solving identifies reasons the participant is having problems with attendance and ways that those problems can be fixed (Refer to the Look AHEAD Problem Solver in the optional handout section). The five steps of the problem solving process are:

   1. **Problem Identification.** This step would involve a discussion with the participant concerning what is causing the attendance problem. An example of a problem would be the participant’s belief that they do not have enough time to get to the meetings on time, and they do not want to arrive late.

   2. **Brainstorming.** This step would consist of the counselor and the participant coming up with possible solutions to this problem. Do not stop at what may be seen as a good solution. Instead, let the participant come up with as many solutions as they can. Possible solutions to “not having enough time to get to the meeting” may be: a) arranging to get off work early on meeting nights, or b) if not working, schedule more time in the day to get to the meetings.

   3. **Cost /Benefit Analysis.** This step involves writing down both the pro’s and the con’s of each of the possible solutions. This will help to outline which solutions may work better than others.

   4. **Selection of a Plan.** The participant decides which of the possible solutions they would like to try. At this time, a date is set (somewhere from 2 to 4 weeks) when the participant will return for evaluation of the plan.

   5. **Evaluation of Effectiveness of Plan.** This step is usually completed at the next individual session. However, when participants miss sessions, the effectiveness of tailored interventions should be evaluated at the next group or individual session, i.e., one week later. This step involves discussing with the participant whether the plan was effective. If the plan was effective, continue with the plan. If the plan
was not effective, repeat the problem solving process, by brainstorming for other possible solutions to the problem. This process could occur in either group or individual sessions. In group sessions, the counselor may enlist the input of other group members to provide suggestions for coming to meetings regularly on time.

2) **Scheduling one or more telephone or e-mail contacts between sessions.** If lack of motivation or social support is a likely cause of an attendance problem, additional contact may be a useful strategy. Goals should be very short-term and specific. For example, “tomorrow I will ask my boss to adjust my work schedule to allow me to come to group on time.” Call or e-mail the participant between sessions to remind them of their goals, and to give support when they reach them. If they are still having problems, discuss any obstacles that the participant may have and continue with the problem solving to remove obstacles. If the person successfully meets the attendance goal, the counselor should provide enthusiastic positive feedback and plan for another short-term goal.

In summary, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the options and try some alternative interventions. More frequent contact is sometimes needed to provide short-term attainable goals that can be reinforced by the counselor. Using the principle of shaping, goals can be gradually increased and the time between contacts can be increased.

**III. Significant attendance problem with poor weight loss:**

If the attendance problems are coupled with poor weight loss, you should identify specific aspects related to the attendance problem. These five aspects are listed on the algorithm and are addressed under the Level B and Level C treatment interventions. Below is a description of five factors that often cause a person to miss sessions and the interventions designed to improve attendance.

**Levels B and C interventions for specific aspects of an attendance problem:**

1) **Economic factors.** There may be financial or economic barriers for participants in the lifestyle change program. For example, some people will have to pay for the parking while attending treatment sessions. This cost could be an obstacle for regular attendance. One way to remove this barrier would be to find ways to pay for the parking. This solution may be relatively inexpensive and could help to increase attendance. There may be other economic obstacles and the counselor should be open to discussing this sensitive issue. Some participants may feel uncomfortable bringing up this issue, so the counselor must ensure that proper and careful attention is paid to this matter.
2) **Transportation problems.** Some people may not have reliable transportation to sessions. If this is a problem, the counselor may want to work with the participant and the rest of the group to develop a plan for transportation to the group sessions. This solution might include one of the other members of the group offering to give the person a ride or it might involve developing a reliable method for getting to the clinical site.

3) **Motivation for adherence.** Adhering to the program may be a struggle for some participants. Effective ways to create motivation would be to either work with the individual and develop a behavioral contact specifically for the participant, or to work with the group in developing a contingency contract/token economy for the group. For example, prizes could be awarded to each member of the group on nights that everyone attends and is on time. This intervention may help to motivate individual members, and may create a sense of responsibility among the entire group.

4) **Childcare problems.** A first step to take in solving this problem would be to ask the participant if they know of any family or friends that may be willing to help with childcare while the participant is attending treatment sessions. If this is not a possibility, the counselor should turn to local organizations that will be willing to watch the kids, using toolbox funds to pay for the service. If a large number of participants have problems with childcare, the site may be able to provide on-site childcare.

5) **Emotional/Psychiatric problems.** Emotional or psychiatric problems are best handled by a referral to a psychologist. This will allow the participant to receive the treatment needed and could improve attendance if the emotional/psychiatric problem is resolved.

For each strategy, remember to develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems that might cause attendance problems. Finally, re-examine the options and try some alternative interventions. For some of the strategies, it might be useful to incorporate behavioral contracting for another target behavior (e.g. self-monitoring or physical activity), to provide money for transportation, parking, childcare, etc. By using the behavioral contracting approach, the participant can earn the money used for removal of barriers related to attendance, as opposed to having the money simply "given to them". Attention to such concerns will boost the morale of the participant and empower them to overcome life problems that are associated with financial difficulties.
Sub-optimal compliance with the dietary program

**Poor compliance with dietary program, as defined by:**
Less than 75% compliance with prescribed dietary program (portion controlled diet, structured meal plan, other).

**Present Option(s) to Participants**
Develop a specific plan of action with time limit

**Intervention Options:**
Level A: Standard Practice
1: Problem-solving
2: Schedule one or more telephone or e-mail contacts (between sessions)

**Level B:**
1: Develop a behavioral contract
2: Initiate a structured meal plan (if initial plan was portion-controlled)
3: Initiate a portion-controlled diet (if initial diet was structured meal plan)
4: Direct person to specific websites
5: Provide dietary videotapes

**Level C:**
1: Referral to dietitian for consultation
2: After month 4, reintroduction of portion controlled diet
3: Home visit by dietitian
4: Referral to psychologist
5: Schedule family to be seen by psychologist to assess social support, etc.

**Evaluate specific aspects of compliance or other obstacles to establish tailored intervention.**
1. Self-monitoring
2. Behavioral contracting/homework
3. Nutrition knowledge deficits
4. Binge eating/overeating
5. Emotional/Psychiatric Problems

**Select one or more options**

**Continue Strategy**

**Improve?**

**Select one or more options**

**NO**

**Evaluate Process & Problems (e.g., other obstacles to making changes in eating)**

**Use Algorithms for specific problems to address these aspects of compliance.**
Sub-optimal compliance with the dietary program

I. Sub-optimal compliance with the dietary program:

Sub-optimal compliance with the dietary program, whether it be meal replacements, the Look AHEAD meal plan, or self-selection of foods is defined by less than 75% compliance with the prescribed program (as evaluated by Look AHEAD staff). To assess compliance, the staff should evaluate the number of days that the person followed the dietary prescription and calculate the percentage of days that the participant met established criteria for compliance. These criteria will differ depending upon the dietary prescription for an individual, i.e., calorie goal and type of diet (meal replacements, Look AHEAD meal plan, or self-selected diet).

II. Sub-optimal compliance with the dietary program with adequate weight loss:

If the dietary compliance problem is not coupled with poor weight loss, select one or more of the interventions listed under Level A in the algorithm. These options include:

Level A:

1) Problem Solving. Problem solving in this situation would involve a discussion of the possible barriers to compliance with the dietary program. The five steps of the problem solving process are:
   1. Problem Identification. This step would involve a discussion with the participant concerning what is causing sub-optimal compliance with the dietary program. An example of a problem would be the participant feeling they do not have enough time to prepare healthy meals.
   2. Brainstorming. This step would consist of you and the participant coming up with possible solutions to this problem. Do not stop at what may seem to be a good solution. Instead, let the participant come up with as many solutions as they can. Possible solutions to “not having enough time for food preparation” may be: a) prepare food the night before, b) schedule more time in day for meals, or c) always make a little extra so there will be leftovers to be used at other meals.
   3. Cost/Benefit Analysis. This step involves writing down both the pros and the cons of each of the possible solutions. This will help to outline the solutions that are viewed as most likely to be effective and to be followed.
   4. Selection of a Plan. Of the possible solutions, the counselor and participant decide which intervention they would like to implement. At this time, a date is set (somewhere from 2 to 4 weeks) where the participant will come back for evaluation of the plan.
   5. Evaluation of Effectiveness of Plan. This step is often completed at the next individual session, though the time to evaluate effectiveness could occur before that meeting. This step involves
discussing with the participant how the plan was implemented, and if it was effective. If the plan was effective, continue with the plan. If the plan was not effective, start back through the problem solving process, brainstorming for other possible solutions to the problem.

2) **The scheduling of one or more telephone or e-mail contacts.** If lack of motivation or social support is a likely cause of dietary sub-optimal compliance, additional contact may be a useful strategy. Goals should be very short-term and specific, for example, eating breakfast according to their meal plan every day at 7:30. Call or e-mail the participant between sessions to remind them of their goals and to support them when goals are reached. If they are still having problems, discuss any obstacles that the participant may have and continue with the problem solving to remove obstacles. If the person successfully meets the dietary goal, the counselor should provide enthusiastic positive feedback and plan for another short-term goal.

In summary, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process of behavior change and consider other obstacles to dietary compliance. Finally, re-examine the options and try some alternative interventions. More frequent contact is sometimes needed to provide short-term attainable goals that can be reinforced by the counselor. Using the principle of shaping, goals can be gradually increased, and the time between contact can be increased.

**III. Sub-optimal compliance with the dietary program combined with poor weight loss:**
Poor weight loss, during the first six months, is defined as:
1) a rate of weight loss less than 1% of total body weight per month
2) maintenance of body weight (± 2 lbs.) for 2 consecutive months or,
3) a weight gain (> 2 lbs.) over a 1-month period.

Specific obstacles that are not directly related to the dietary program may be an obstacle to compliance, and those behaviors must be addressed. Common obstacles are:
1) inconsistent self-monitoring
2) failure to follow behavioral contracts or other homework assignments
3) nutrition knowledge deficits
4) binge eating/overeating problems that are not reported or,
5) emotional/psychiatric problems that result in low motivation or behavioral disturbances that interfere with successful weight management

Algorithms that are specific to resolving these problems are noted in this section. If further evaluation reveals that the sub-optimal compliance with the dietary program and the poor weight loss is not related to these “common problems”, one or more of the intervention options listed under Level B should be considered for individual tailoring of the intervention.
Level B:

1) **Develop a specific behavioral contract.** Refer to the optional handout section for handout(s) that can be used in creating a behavioral contract. The contract would include a specific action, behavior, or goal that the participant agrees to change. This will include a start date and any initial steps that need to be taken. The counselor and the participant will include in the contract any roadblocks that may come up and ways to handle those roadblocks. It will also include things to do to help make success more likely. To enhance motivation, resources from the toolbox can be used as incentives to provide rewards for behavior change.

2) **Initiate a structured meal plan.** This type of meal plan outlines what, when, and how much food should be eaten at each meal or snack. Be sure to work with the participant in structuring the meal plan so that it becomes one that the participant can easily adapt to a particular schedule.

3) **Initiate meal replacements.** This type of diet provides the participant with meal replacements and pre-packaged foods and snacks that are to be eaten as described in Session 3 of the Participant Notebook. At least one meal will usually consist of a nutritional drink/shake/snack. A stronger program is to replace two meals with meal replacements. These meal replacements will be provided with no charge to the participant.

4) **Direct person to specific websites.** There are several websites that supply the reader with an abundant amount of information on nutrition. These websites can help the participant learn more about nutrition, portion control, serving sizes, healthy recipes, and weight loss in general. Research websites first before presenting them to the participant to ensure that the site is current, has correct useful information, and will benefit the participant. (The coordinating center may want to identify appropriate websites.)

5) **Provide dietary videotapes.** There are several videotapes available that focus on weight loss, nutritious foods, moderation of food intake, and many other topics related to a dietary program. Review some tapes to ensure that the tape has information that will be useful to the participant, and to ensure that the tape provides accurate and up-to-date information. (The Coordinating Center may want to acquire useful exercise videotapes.)

After selecting a strategy, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. In general, interventions from Levels A and B should be initiated before considering the use of one or more of the Level C interventions.
Level C:

1) **Referral to dietitian for consultation.** A dietitian can meet with the participant and further assess compliance problems related to the dietary program. From the results of the dietary consult, the dietary program may be modified to better suit the needs of the individual participant.

2) **After month 4, reintroduction of meal replacements.** Reintroduce the meal replacement option to the participant. Explain to the participant in how meal replacements work and discuss with them the rationale behind them. The reason for waiting until after month 4, is to allow the participant enough time to sample alternative and less costly options for reducing calorie intake.

3) **Home visit by dietitian.** This option is useful to identify problems in the home, which may be the result of the sub-optimal compliance. The dietitian can make suggestions to the participant about ways to change/organize the kitchen to make compliance easier.

4) **Referral to psychologist.** A referral to a psychologist can be made to help in determining possible psychological or behavioral factors that may be the reasons for sub-optimal compliance.

5) **Schedule a family member to be seen by psychologist to assess social support.** Family and/or social support can be a great benefit to someone trying to lose weight. Lack of social support may be part of the cause of sub-optimal compliance. Also, family members or close friends may be able to provide additional information that might explain sub-optimal compliance.

Whenever a strategy is selected, remember to develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If they do not improve, evaluate the process and other obstacles that might cause problems related to adherence with the prescribed dietary program. Finally, re-examine the options and try alternative methods if the intervention that was selected was ineffective. After repeated failure of a variety of interventions, it will be important to assess the overall pattern of noncompliance and determine if there is a more fundamental or basic cause of failure to adhere to the program guidelines. In such cases, it will be useful to seek guidance from the multidisciplinary team at each site or from the Look AHEAD core advisory team.
Sub-optimal compliance with Physical Activity program

**Intervention Options:**
Level A: Standard Practice
1. Problem-solving
2. Schedule one or more telephone or e-mail contacts (between sessions)

**Level B:**
1: Develop a plan for a friend to exercise with the participant.
2: Develop a specific behavioral contract
3: Provide walking tape, exercise video, etc.
4: Referral to exercise class (at site)

**Level C:**
1: Provide appropriate clothing, shoes, orthotics, etc.
2: Referral to exercise psychologist
3: Enrollment in a health club
4: Purchase/lease exercise equipment
5: Provide personal trainer
6: Referral to psychologist

Evaluate specific aspects of noncompliance or other obstacles to establish tailored intervention.
1. Self-monitoring
2. Behavioral contracting/homework
3. Injury/Medical problem
4. Emotional/Psychiatric Problems

**Continue Strategy**

**Improve?**

**YES**

Develop a specific plan of action with time limit

**NO**

Re-examine options

Evaluate Process & Problems (e.g., other obstacles to following the physical activity program)

Use Algorithms for specific problems to address these aspects of poor compliance.

**Continue Strategy**

**Present Option(s) to Participants**

Select one or more options
Sub-optimal compliance with Physical Activity Program

I. Sub-optimal compliance with physical activity program

A participant is considered to be noncompliant with the physical activity program, when the participant performs below 75% of the prescribed physical activity goals across a four-week period.

II. Sub-optimal compliance with physical activity program with adequate weight loss

If the participant is having difficulty meeting the goals of the physical activity program, but has adequate weight loss, select one or more of the options from below.

Level A:

1) Problem solving. Find out why the participant is having a problem meeting the physical activity goals. Have the participant make a daily schedule, and suggest when and where some physical activity could fit into his/her schedule. Explain that it will be easier to follow through with the physical activity requirements if they are planned out ahead of time.

   1) Problem Identification. Have a discussion with the participant in which he or she identifies the problem that is preventing compliance with the physical activity program. For example, lack of motivation or bad time-management could be problems that result in sub-optimal compliance.

   2) Brainstorming. Have the participant brainstorm, so that they come up with many possible solutions for the identified problem. The counselor may have to assist in this process, but should allow the participant to come up with solutions by themselves. Possible solutions may include making out a daily schedule for poor time-management and rewards for compliance. Using toolbox money for rewards may be applicable.

   3) Cost/Benefit Analysis. Have the participant make out a list of the costs and benefits associated with each solution. After they have completed this task, have them review their list to find the solution with the least cost and most benefit.

   4) Selection of a Plan. Select the plan with the most benefit and least cost to the participant and set a time in the future for plan evaluation (preferably 2-4 weeks from plan selection).

   5) Evaluation of Plan Effectiveness. Evaluate the results of the plan implementation. If there is an improvement, have the participant continue with the plan. If there is little or no improvement, repeat the problem solving steps to come up with other possible solutions to the problem.

2) Schedule one or more telephone or e-mail contacts: If lack of motivation or counselor support is a likely cause of exercise sub-optimal compliance, additional counselor contact may be a useful strategy. Goals should be very short-term and specific, for example, walking for 20 minutes immediately
after work. Call or e-mail the participant between sessions to remind them of their goals, and to support them when they reach them. If they are still having problems, discuss any obstacles that the participant may have, and continue with problem solving to remove obstacles. If the participant successfully meets the exercise goal, the counselor should provide enthusiastic positive feedback and plan for another short-term goal.

In summary, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the options and try some alternate interventions. More frequent contact is sometimes needed to provide short-term attainable goals that can be reinforced by the therapist. Using the principle of shaping, goals can be gradually increased and the time between the contact can be increased.

III. Sub-optimal compliance with the physical activity program combined with poor weight loss

Poor weight loss during the first six months is defined as:
1) The participant’s rate of weight loss is less than 1% of total body weight per month.
2) The participant maintains his/her body weight (± 2 lbs.) for two consecutive months.
3) The participant gains more than two pounds in weight, over one-month. When a participant meets any of the above criteria, evaluate possible causes. The following problems are commonly associated with sub-optimal compliance, and should be routinely evaluated as causes of this problem. Specific algorithms have been developed for tailoring treatment to resolve these problems.
   1) Inconsistent Self-monitoring
   2) Failure to adhere to Behavioral contracting/homework assignments
   3) Emotional/psychiatric problems

Algorithms for tailoring the lifestyle behavior modification program for these specific problems are provided in this section. If further evaluation reveals that the sub-optimal compliance with the physical activity program and the poor weight loss are not related to the above aspects, one or more options listed under Level B should be considered as a strategy for tailoring the individualized intervention.

Level B:

1) **Develop a plan for a friend to exercise with the participant.** If it appears that social support might enhance compliance with the exercise program, ask the participant if they have a friend that would be able to exercise with them. Explain that for many people, it is more enjoyable to exercise with a buddy that is there to support, encourage, and motivate them to meet their goals; it is also more fun when there is someone else there doing it with them.
2) **Develop a specific behavioral contract.** Refer to the optional handout section for a behavioral contract template. The contract will include goal behavior(s) for the participant to list, and a space to fill in the specified time within which the goal behavior must take place. **The participant should also list the behaviors necessary to attain the goal (e.g. the days of the week, time of the day, and minutes of exercise).** Next, the participant should list the roadblocks that might come up, the ways in which they will be handled, and the behaviors that would make success more likely. Finally, the participant should list ways in which the counselor could help them to succeed. The counselor should review the contract with the participant by discussing the specific tasks delineated and the time frame in which they should be completed. Have the participant come up with a reward for meeting their goals. The reward should not be food! Examples of rewards for compliance could be buying movie tickets, a book, or a shirt (or anything that is a treat to the participant). The counselor and the participant must sign and date the contract, making it official.

3) **Provide the participant with an exercise video or walking tape.** If the participant needs instruction or structure to help them follow the prescribed physical activity program, the counselor may provide them with an exercise video or walking tape.

4) **Refer the participant to an exercise class.** If the participant needs a more structured physical activity program, refer them to an exercise class.

For all of these strategies it is important to develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy, but if the participant does not improve, evaluate the process and consider other problems as potential causes of sub-optimal compliance. Finally, re-examine the options and try some alternate interventions.

Generally, it is best to try Levels A and B first. If there is only limited improvement, the counselor should consider the Level C interventions as the next set of behavioral strategies for a tailored intervention.

**Level C:**

1) **Provide appropriate clothing, shoes, orthotics, etc.** If the participant is unable to purchase appropriate exercise apparel and this is an obstacle for compliance, provide these items for them using resources from the toolbox.

2) **Referral to an exercise physiologist.** If the participant needs advice on the right physical activity program for them, refer the participant to an exercise physiologist.
3) **Enrollment in a health club.** Inform the participant about the option of joining a health club. Discuss the costs and benefits, and refer the participant to a club that will be convenient for them to attend.

4) **Purchase/lease exercise equipment.** If the participant would rather exercise at home, discuss the option of purchasing or leasing exercise equipment. Also, refer them to the used exercise equipment stores.

5) **Provide the participant with a personal trainer.** If the participant needs more one-on-one attention, provide them with a personal trainer to help with a physical activity program that will be right for them.

6) **Referral to a psychologist.** If the participant is still unable to comply with the physical activity requirements, discuss the possibility of referral to a psychologist. This referral should be for evaluation of alternative explanations for sub-optimal compliance.

Whenever a strategy is selected, remember to develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy, but if the participant does not improve, evaluate the process and other possible causes of sub-optimal compliance. Finally, re-examine the options and try some alternate interventions.

**Common Problems of Sub-optimal compliance**

In addition to the three Primary Problems of Sub-optimal compliance, five common problems of sub-optimal compliance were selected for detailed discussion of tailoring the lifestyle intervention. These problems are: 1) self-monitoring (dietary and/or physical activity); 2) behavioral contracting/homework; 3) nutrition knowledge deficits; 4) emotional/psychiatric problems; and 5) binge eating/overeating. Each of these common problems may determine (or partially determine) poor weight loss and/or sub-optimal compliance related to attendance, dietary program, or physical activity program. If the staff at a site decides that these problems are determining poor weight loss or primary problems of sub-optimal compliance, then the algorithm for those common problems of sub-optimal compliance should be followed.
**Sub-optimal compliance with self-monitoring**

Poor compliance with Self-monitoring as defined by:

2. Failure to self-monitor eating or physical activity (or bring monitoring forms to therapy) for 2 consecutive weeks or 3 out of 4 weeks

Toolbox Options:

**Level A**
1: Problem-solving in group or individual sessions
2: Schedule contact via telephone/email (between sessions)

**Level B**
1: Try a new self-monitoring method
2: Develop specific behavioral contract
3: Structure time for recording

**Level C**
1: Recruit family support for self-monitoring
2: Referral to psychologist

Evaluate Process & Problems (e.g., other obstacles to adequate self-monitoring)

Present Option(s) to Participants

Select one or more options

Develop a specific plan of action with time limit

Improve?

YES

NO

Continue Strategy
Sub-optimal compliance with self-monitoring

I. Sub-optimal compliance with self-monitoring

Sub-optimal compliance with self-monitoring is defined by the failure to self-monitor eating behavior/dietary intake or physical activity (or failure to bring monitoring forms to therapy) for two consecutive weeks, or three out of four weeks. If a participant fails to self-monitor for even one week, the counselor should emphasize the importance of this component of the program and set a goal to bring self-monitoring records to the next session.

If a participant meets this criterion, select one or more options from the following:

Level A:
1) **Problem solving in group or individual sessions.** Discuss the benefits of self-monitoring with the participant, and stress how important it is that he or she monitor as soon after eating or exercising as possible. If it is inconvenient for them to bring a Keep Track record with them, suggest using temporary index cards or napkins to make records of their food consumption. They can then transfer the information to their Keep Track records at the end of the day. In group or individual sessions, discuss any obstacles that the participants are having and provide possible solutions and problem solving techniques.

1) **Problem Identification.** Have a discussion with the participant in which the participant identifies the problem that is preventing their compliance with the self-monitoring requirements. For example, lack of motivation or forgetting to bring the booklet with them could be problems that result in sub-optimal compliance.

2) **Brainstorming.** Have the participant brainstorm, so that they actually come up with possible solutions for themselves. The counselor may have to assist in this process, but should allow the participants to come up with solutions by themselves. For example, participants could put the Keeping Track record in their briefcase or purse before going to bed. Using toolbox money for rewards may be applicable.

3) **Cost/Benefit Analysis.** Have the participant make out a list of the costs and benefits associated with each solution. After they have completed this task, have them go back over their list to look for the solution with the least cost and most benefit.

4) **Selection of a Plan.** Select the plan with the greatest benefit and least cost to the participant and set a time in the future for plan evaluation (preferably 2-4 weeks from plan selection).

5) **Evaluation of Plan Effectiveness.** Evaluate the results of the plan implementation. If there is an improvement, have the participant continue with it. If there is little or no improvement, go back through the problem solving steps, starting with brainstorming, to come up with other possible solutions to the problem.
2) **Schedule one or more telephone or e-mail contacts.** If lack of motivation or support is a likely cause of sub-optimal compliance with self-monitoring, additional contact may be a useful strategy. Goals should be very short-term and specific, for example, monitoring eating behavior and dietary intake within 20 minutes of meal completion. Call or e-mail the participant between sessions to remind them of their goals, and to support them when they reach them. If they are still having problems, discuss any obstacles that the participant may have, and continue with problem solving to remove obstacles. If the participant successfully meets the self-monitoring goal, the counselor should provide enthusiastic positive feedback and plan for another short-term goal.

Once a strategy has been selected, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If he or she does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the options and try some alternate interventions. If the participant is still noncompliant with self-monitoring, select one or more of the following options:

**Level B:**

1) **Try a new self-monitoring method.** If the participant is having problems with the current method of self-monitoring, propose a new method. Perhaps self-monitoring using a checklist of foods may be more convenient and less time-consuming for the participant. He or she may also prefer to self-monitor using a computer. Ask the participant if he or she can think of alternate easier ways for them to self-monitor. Remind them that the most important thing to record their meals and snacks as soon as possible after they eat them.

2) **Develop a specific behavioral contract.** Refer to the optional handout section for a behavioral contract template to follow. The contract will include goal behavior(s) for the participant to list, and a space to fill in the specified time within which, the goal behavior must take place. The participant should also list the behaviors necessary to attain the goal (e.g. putting their Keeping Track record in their purse or brief case the night before in order to meet the behavioral goal of bringing their Keeping Track record with them everyday to work). Next, the participant should list the roadblocks that might come up, the ways in which they will be handled, and the behaviors that would make success more likely. Finally, the participant should list ways in which the counselor could help them to succeed. The counselor should go over the contract of compliance with the participant. Review the specific tasks that the participant must complete to meet the goals, within a specific time period. Have the participant come up with a reward for meeting their goals. The reward should not be food! Examples of rewards for compliance could be movie tickets, a new book, or a new shirt (or anything that is a treat to the participant). The counselor and the participant must sign and date the contract, making it official.
3) **Structure time for recording.** If it appears that the participant is having problems with time management, have them make out a daily plan that designates time to self-monitor throughout the day.

For all of these strategies, it is important to develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy, but if he or she does not improve, evaluate the process and other problems such as sub-optimal compliance.

Generally, it is best to try Levels A and B first. If there is only limited improvement, the therapist should consider the Level C interventions as the next set of behavioral strategies for a tailored intervention.

**Level C:**

1) **Recruit support from family or friends for self-monitoring.** If it appears that support from family or friends might enhance compliance with keeping track, ask the participant if he or she has a friend or family member that could remind them and encourage them to keep track accurately and persistently.

2) **Refer to a psychologist.** If the participant is still unable to comply with the keeping track requirements, discuss the possibility of referral to a psychologist. This referral should be for evaluation of alternative potential causes for sub-optimal compliance that are not apparent. For example, the participant may be depressed or experiencing some other psychological difficulty.
Sub-optimal compliance with behavioral contracting/homework

Poor compliance with behavioral homework assignments, as defined by:
1. Unsuccessful completion of homework assignments, e.g., implementation of behavioral contracts for two consecutive weeks or 3 out of 4 weeks.

Toolbox Options:
Level A
1: Problem-solving in group or individual sessions to identify barriers to compliance
2: Schedule contact via telephone/email (between sessions)

Present Option(s) to Participants
Select one or more options

Level B
1: Utilize motivational enhancement strategies
2: Allow participant to custom design homework assignment (may use group to assist)

Level C
1: Referral to psychologist

Evaluate Process & Problems (e.g., noncompliance with assignments)
Re-examine options

Present Option(s) to Participants
Select one or more options

Develop a specific plan of action with time limit

Improve?

YES

Continue Strategy

NO
**Sub-optimal compliance with behavioral contracting/homework**

I. **Sub-optimal compliance with behavioral contracting/homework**

Sub-optimal compliance with behavioral contracting/homework assignments is defined as failure to complete homework assignments for two consecutive weeks or 3 out of 4 weeks. Behavioral contracts could be a part of the individually tailored program, or they could be one aspect of the Standard Lifestyle Change program.

If a participant meets the above criteria, select one or more of the options below.

**Level A:**

1) **Problem-solving in group or individual sessions.** Discuss the benefits of the behavioral contracting and homework with the participant and stress the importance of completing the assignments as instructed by the group leader. In group or individual sessions, discuss any obstacles that the participants are having and provide possible solutions and problem solving techniques.

2) **Problem Identification.** Have a discussion with the participant in which he or she identifies the problem that is preventing their compliance with the behavioral contracting/homework. For example, lack of motivation or bad time-management could be problems that result in sub-optimal compliance.

3) **Brainstorming.** Have the participant brainstorm, so that they actually come up with possible solutions for themselves. The counselor may have to assist in this process, but should allow the participants to come up with ideas by themselves. Possible solutions may include making out a daily schedule for poor time-management and rewards for compliance. Using toolbox money for rewards may be applicable.

4) **Cost/Benefit Analysis.** Have the participant make out a list of the costs and benefits associated with each solution. After they have completed this task, have them go back over their list to look for the solution with the least cost and most benefit

5) **Selection of a Plan.** Select the plan with the most benefit and least cost to the participant and set a time in the future for plan evaluation (preferably 2-4 weeks from plan selection).

6) **Evaluation of Plan Effectiveness.** Evaluate the results of the plan implementation. If there is an improvement, have the participant continue with it. If there is little or no improvement, repeat the problem solving steps to come up with other possible solutions to the problem.

2) **Schedule one or more telephone or e-mail contacts.** If lack of motivation or support is a likely cause of sub-optimal compliance with behavioral contracting/homework, additional contact may be a useful strategy. Goals should be very short-term and specific, for example, setting aside 30 minutes
every day after work to complete homework. Call or e-mail the participant between sessions to remind them of their goals, and to support them when they reach them. If they are still having problems, discuss any obstacles that the participant may have and continue with the problem solving.

Next, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the options, and try some alternate interventions.

II. **Sub-optimal compliance with behavioral contracting/homework with poor weight loss**

Poor weight loss during the first six months is defined as:
1) The participant’s rate of weight loss is less than 1% of total body weight per month.
2) The participant maintains his or her body weight (± 2 lbs.) for two consecutive months.
3) The participant gains >2 pounds in weight over one month.

When a participant meets any of the above criteria, select an option from below.

**Level B:**

1) **Utilize motivational enhancement strategies.** Ask the participant to reflect on the reasons they joined the study and reasons for wanting to lose weight and control their diabetes. They should reflect on the negatives of having diabetes and the positives of improving their condition. The costs and benefits of behavioral contacting and homework should also be tied into the discussion.

2) **Allow the participant to custom design homework assignments.** Ask the participant for input. Find out what types of assignments the participant thinks would be useful and relevant. Use the group to assist and participate in a discussion. Evaluate suggestions based on relevance, usefulness, and effort.

Develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the options and try some alternate interventions.

Generally, it is best to try Levels A and B first. If there is only limited improvement, the therapist should consider the level C intervention.
Level C:

1) **Referral to a psychologist:** The psychologist should examine other potential obstacles or problems that are interfering with compliance. This referral should be for the evaluation of alternative potential causes for sub-optimal compliance that are not apparent such as depression or other undiagnosed mood disorders.
Sub-optimal compliance due to nutrition knowledge deficits

Poor compliance due to Nutrition Knowledge Deficits*, as defined by:
1. Inaccurate concept of food portions
2. Poor shopping skills
3. Poor food preparation skills or recipe modification skills
4. Poor label reading skills

*Despite provision of nutrition education in the standard Lifestyle Behavior Modification group and individual therapy program

Toolbox Options:
Level A
1: Provide written information to enhance knowledge
2: Refer to internet nutrition websites such as www.nutrition.gov

Present Option(s) to Participants

Level B
1: Consultation with dietitian for assessment of specific knowledge deficit

Level C
1: Dietary counseling to provide specific training/education
2: Schedule a session with family member(s) to manage food selection/preparation problems

Select one or more options

Develop a specific plan of action with time limit

Present Option(s) to Participants

Evaluate Process & Problems (e.g., other obstacles to compliance with dietary program)

Re-examine options

Improve?

NO

YES

Continue Strategy

Poor compliance due to Nutrition Knowledge Deficits + Poor weight loss during first six months as defined by:
1. Rate of weight loss less than 1% of total body weight per month
2. Maintain body weight (± 2lbs.) for 2 consecutive months
3. Weight gain (>2 lbs.) over a 1 month period
Sub-optimal compliance due to nutrition knowledge deficits

I. Sub-optimal compliance due to nutrition knowledge deficits

Criteria:
If provision of nutrition education in the Standard Lifestyle Behavior Modification group and in individual sessions has been provided, and the participant still meets the criteria below, then dietary problems may be caused by nutrition knowledge deficits, as defined by:

1) Inaccurate concept of food portions: The participant does not have an accurate concept of what constitutes a serving size.
2) Poor shopping skills: When the participant goes to the grocery store to buy food, he or she makes unwise choices.
3) Poor food preparation skills or recipe: The participant does not have knowledge that is required to prepare healthy meals.
4) Poor label reading skills: The participant does not know how to read and understand the nutritional information on food labels.

If a participant meets the above criteria, select one or more options from the following:
Level A:
1) Provide written information to enhance the participant’s knowledge. Give the participant some supplemental material about food portions, shopping for nutritious foods, healthy recipes, food preparation, and reading food labels.

2) Refer the participant to the Internet. There are many web sites that have helpful nutritional information, recipes, and advice. Two such web sites that would be valuable resources for the noncompliant participant are www.nutrition.gov, and www.eatright.com (by the American Dietetic Association). The counselor should also tell them to try and find other potentially useful web sites that may help them learn more about nutrition.

Next, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If he or she does not improve, evaluate the process and other problems that might result in poor adherence to the prescribed dietary program. Finally, re-examine the options below and try some alternate interventions.

II. Sub-optimal compliance due to nutrition knowledge deficits with poor weight loss

Poor weight loss during the first six months is defined as:
1) The participant’s rate of weight loss is less than 1% of total body weight per month.
2) The participant maintains his or her body weight (± 2 lbs.) for two consecutive months.
3) The participant gains >2 pounds in weight, over a one-month period of time
When a participant meets any of the above criteria, select an option from below

**Level B:**

1) **Consultation with a dietitian for an assessment of specific knowledge deficit.** Refer the participant to a dietitian, so that an assessment can be made to find out the specific areas of nutritional knowledge that are problematic for the participant.

Develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If he or she does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the previous option, and try some alternate interventions. Generally, it is best to try Levels A and B first. If there is only limited improvement, the therapist should consider the Level C interventions.

**Level C:**

1) **Dietary counseling to provide specific training/education.** If none of the above methods are successful, refer the participant to a dietitian for more extensive training and education. The dietitian should cover both general and specific areas of nutrition, as well as any areas that are problematic for the participant.

2) **Schedule a session with family member(s).** If a participant has limited control over shopping and meal preparation, it may be useful to meet with family members who serve this function to enlist their support for adhering to a healthy dietary program.
Emotional/Psychiatric Problems

Emotional/Psychiatric problem as defined by symptoms of:
1. Depression
2. Anxiety
3. Substance Abuse
4. Personality Disorder
5. Significant relationship problems, e.g., marital conflict, separation, divorce

Toolbox Options:
Level A
1: Assess severity using questionnaires
2: Advocate contact with PCP to discuss problem

Present Option(s) to Participants
Develop a specific plan of action with time limit

Select one or more options

Emotional/Psychiatric problem + Poor weight loss during first six months as defined by:
1. Rate of weight loss less than 1% of total body weight per month
2. Maintain body weight (± 2lbs.) for 2 consecutive months
3. Weight gain (>2 lbs.) over a 1 month period

Level B
1: Develop a behavioral contract that targets obstacle/barrier
2: Schedule session with family to discuss problem
3: Referral for psychological evaluation

Level C
1: Referral for psychological treatment
2: Referral to PCP for medication trial

Re-examine options

Evaluate Process & Problems (e.g., non-compliance)

Improve?

YES

Continue Strategy

NO
Emotional/Psychiatric Problems

I. Emotional/Psychiatric Problems:
   Emotional/psychiatric problems can be defined by symptoms of depression, anxiety, substance abuse, personality disorder, and/or significant relationship problems such as marital conflict, separation, or divorce.

II. Emotional/Psychiatric problems with adequate weight loss:

   If the emotional/psychiatric problem is not coupled with poor weight loss, select one or more of the interventions listed under Level A in the algorithm. These options include:

   Level A:
   1) **Assess the severity of the problems using questionnaires.** Questionnaires will be available for assessing severity of emotional/psychiatric problems.

   2) **Advocate contact with the PCP to discuss the problem.** By advocating contact with the primary care physician (PCP), you can encourage the participant to seek help from their health care provider. This approach is preferable over neglecting a small problem that may grow to be a greater problem.

   Next, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. Finally, re-examine the options and try some alternative interventions.

III. Emotional/Psychiatric problems with poor weight loss:

   Poor weight loss during the first six months is defined as:
   1) a rate of weight loss less than 1% of total body weight per month
   2) maintenance in body weight (±2 lbs.) for 2 consecutive months
   3) a weight gain (>2 lbs.) over a 1-month period.

   If the participant is experiencing an emotional/psychiatric problem and is having problems with poor weight loss, the therapist should turn to the options listed on the algorithm under Level B. The following is a brief discussion of each of these options:

   Level B:
   1) **Develop a behavioral contract that targets obstacle/barrier.** The participant’s emotional/psychiatric problems are interfering with adherence and/or weight loss, resulting in sub-optimal compliance with the program. Behavioral contracts can serve to motivate specific behavior change. Work together with the participant in creating a behavioral contract that is endorsed by the participant and the therapist. Refer to the optional handouts for a template that can be used in creating a behavioral contract. The contract would include a specific action, behavior, or goal that the participant agrees to
change. This action plan should include a start date and any initial steps that need to be taken. The counselor and the participant will include in the contract any roadblocks that may come up and ways to handle those roadblocks. It should also include strategies to facilitate success. For example, if depression is resulting in a lack of motivation to attend group meetings, the counselor would want to structure the participant’s schedule for the days of the meetings. If the participant is having problems with their spouse or significant other, the counselor may want to bring that person for a discussion of the problems.

2) **Schedule session with a family member to discuss problem.** Support from the family could help the participant to manage emotional or psychiatric problems more effectively and could help them to better adhere to the weight loss program. The family may not be aware of the problems that have been identified. This discussion may help them support the efforts made by the participant and teaches them to watch for triggers that may lead to poor adherence. It may be advisable to involve the staff psychologist in this session.

3) **Referral for psychological evaluation.** The psychologist will be trained in handling emotional and psychiatric problems and can help to get the participant back on the right track. Addressing the emotional/psychiatric problems may help to promote better adherence to the program and to ultimately yield greater weight loss. Furthermore, if a number of strategies have been tried and none of them have been effective, referral to a psychologist may be helpful.

Next, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance.

**Level C:**

1) **Referral for psychological treatment.** The severity of some emotional or psychiatric problems may be such that they cannot be managed in the context of the Look AHEAD Lifestyle Intervention Program. In such cases, it may be advisable to refer the participant to regularly scheduled psychotherapy sessions.

2) **Referral to the PCP for medication trial.** Some emotional/psychiatric problems can be alleviated through the use of psychotropic medication. Find out if the participant's problem can be improved through medication and make the proper referral so that the medication is dispersed under proper supervision.
3) Binge Eating/Overeating

Binge eating/overeating as defined by:
1. Episodic eating of large amounts of food in a relatively short period of time or.
2. Eating throughout the day in an unscheduled pattern that is a larger amount than prescribed

Toolbox Options:
Level A
1: Problem-solving in group or individual sessions
2: Prescribe three meal/day pattern of eating

Select one or more options

Binge eating/overeating + Poor weight loss during first six months as defined by:
1. Rate of weight loss less than 1% of total body weight per month
2. Maintain body weight (± 2lbs.) for 2 consecutive months
3. Weight gain (>2 lbs.) over a 1 month period

Level B
1: Referral to a psychologist or dietitian
2: Develop specific behavioral contract

Level C
1: Referral to PCP for medical evaluation

Present Option(s) to Participants

Evaluate Process & Problems (e.g., non-compliance)

Select one or more options

Continue Strategy

Improve?

YES

NO
Binge Eating/Overeating

I. Binge Eating/Overeating:
Binge eating/overeating is defined by episodic eating of large amounts of food in a relatively short period of time or eating throughout the day in an unscheduled pattern. The amount of food consumed is larger than what is prescribed by the dietary program of Look AHEAD.

II. Binge eating/overeating with adequate weight loss:
If the binge eating/overeating is not coupled with poor weight loss, select one or more of the interventions listed under Level A in the algorithm. These options include:

Level A:
1) **Problem solving.** Problem solving would help to identify reasons why the participant is having problems with binge eating/overeating and ways that those problems can be resolved. The five steps of the problem solving process are:
   1) **Problem Identification.** This step would involve a discussion with the participant concerning what is causing the binge eating/overeating. For example, the participant may feel so hungry when they get home from work that they immediately begin snacking on high calorie food items.
   2) **Brainstorming.** This step would consist of the counselor and the participant coming up with possible solutions to this problem. Do not stop at what may be seen as a good solution. Let the participant come up with as many solutions as they can. Possible solutions to “snacking after work” may be such things as: a) eating a healthy snack before leaving work to help curb their appetite until dinner, b) not buying ready made snack items, so there will be nothing available for consumption, or c) purchasing low-calorie snack foods that are prescribed by the dietary plan.
   3) **Cost/Benefit Analysis.** This step involves writing down both the pro’s and the con’s of each of the possible solutions. This will help to outline which solutions may work better than others.
   4) **Selection of a Plan.** This is where the participant decides which of the possible solutions they would like to try. At this time, a date is set (somewhere from 2 to 4 weeks) where the participant will come back for evaluation of the plan.
   5) **Evaluation of Effectiveness of Plan.** This is done at the next visit and involves discussing how the plan went and if it was effective. If the plan was effective, continue with the plan. If the plan was not effective, repeat the problem solving process, brainstorming for other possible solutions.

2) **Prescribe a three meal/day pattern of eating.** For persons who eat less than three times a day, discuss different schedules of eating with them and the effects of restrictive eating and hunger stemming from a calorie restricted diet.
Help them plan one week of eating three meals per day. Use problem solving to remove obstacles that prevent achieving this goal.

Next, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other factors that might lead to binge eating/overeating. Finally, re-examine the options and try some alternative interventions.

III. Binge eating/overeating with poor weight loss:

Poor weight loss, during the first six months, is defined as:
1) a rate of weight loss less than 1% of total body weight per month
2) maintenance of body weight (± 2lbs.) for 2 consecutive months
3) a weight gain (>2 lbs.) over a 1-month period.

If the participant is experiencing problems related to binge eating/overeating and is having problems with poor weight loss, you should consider options listed on the algorithm under Level B and C. The following is a brief discussion of each of these options:

Level B:

1) **Referral to a psychologist or dietitian.** There are many psychologists who are trained in the treatment of binge eating disorder and binge eating associated with obesity. Two techniques that have been proven to work are Cognitive-Behavioral Therapy and Interpersonal Therapy. Cognitive-Behavioral Therapy is an action-oriented therapy that promotes an examination of self-defeating beliefs and other irrational thoughts and beliefs that have been contributing to the disorder. Manuals are available that help the counselor to provide effective cognitive-behavioral therapy to bulimics. Interpersonal Therapy emphasizes resolution of emotional problems in order to modify emotional triggers for overeating/binge eating.

A dietitian could examine the participant’s pattern of eating and prescribe a structured meal plan that has been tailored to that specific participant’s nutritional need.

3) **Develop specific behavioral contract.** Behavioral contracts can serve to motivate specific behavior change. The counselor should work together with the participant in creating a behavioral contract that is mutually agreed upon. The optimal handout section provides a template that can be used in creating a behavioral contract. The contract would include a specific action, behavior, or goal that the participant agrees to change, which includes a start date and any initial steps that need to be taken. The counselor and the participant will include in the contract any roadblocks that may come up and ways to handle those roadblocks. It will also include things to do to help make success more likely.
Next, develop a specific plan of action with a specified time limit. If the participant improves, continue with the strategy. If the participant does not improve, evaluate the process and other problems such as sub-optimal compliance. Only after trying levels “A” and “B” without any improvement should you go on and try level C.

**Level C:**

1) **Referral to PCP for medical evaluation.** Medical treatments are available and can help to control problems with binge eating/overeating. A medical evaluation will help to determine the severity of the problem and what step needs to be taken next to alleviate the problem. The participant may be experiencing a mood disturbance or impulse control problem. Some medications, such as selective serotonin reuptake inhibitors (SSRI's), have been found to be useful for such mood and impulse control disturbances. There are also a variety of medications proven to be effective for various obsessive compulsive, impulse, and anxiety disorders. In such instances, referral to a primary care physician is suggested.
Preface

Congratulations on serving as a Lifestyle Counselor in the Look AHEAD study. You might not plan to tell your grandchildren about Look AHEAD but it is a historic undertaking. The study represents the first randomized trial to assess whether intentional weight loss decreases mortality. Researchers have long known that weight reduction improves blood pressure, blood glucose, lipids and other risk factors. No study, however, has assessed whether weight loss reduces mortality by decreasing heart attack, stroke, and related complications. Look AHEAD will answer this critical question and inform public policy concerning the benefits of weight loss.

This introduction provides an overview of the Look AHEAD study and a guide to the Participant and Counselor Manuals that will be used to implement the first 24 weekly sessions of the Lifestyle Intervention. The document includes selected excerpts from the Look AHEAD protocol and the study’s Manual of Operating Procedures.

Acknowledgements

The Lifestyle Intervention used in Look AHEAD was developed by a team of dietitians, exercise specialists, physicians, and psychologists who were selected from the 16 sites that are participating in the study. Members of this Lifestyle Intervention subcommittee include:

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<thead>
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The subcommittee designed the Lifestyle Intervention after conducting an extensive review of the literature on diet, physical activity, and behavior modification for weight control. Bonnie Gillis, R.D., M.S. (University of Pittsburgh) drafted the
Participant Manual and Mara Vitolins, Dr.PH., M.P.H., R.D. (Wake Forest University) and Monica Mullen, M.P.H., R.D. (University of Pennsylvania) drafted the Counselor Manual. John Jakicic, Ph.D. chaired the Manuals Subcommittee that reviewed and edited these drafts, and Judy Bahnson, M.Ed. and Mara Vitolins from the Look AHEAD Coordinating Center at Wake Forest University further prepared the manuals for publication and distribution. Don Williamson, Ph.D. wrote the chapter on Tailoring Treatment and Thomas Wadden, Ph.D. that on Leading Effective Groups.

The Participant and Counselor manuals include concepts, strategies and materials that have been used in previous weight loss trials, including the Trial of Nonpharmacologic Interventions in the Elderly (TONE) and the Diabetes Prevention Program (DPP). Their contribution is acknowledged with thanks to the investigators and staff involved.

Look AHEAD Materials

Key aspects of the Look AHEAD design, rationale, and operations are described in two documents:

1. The Look AHEAD Protocol
2. The Look AHEAD Manual of Procedures (MOP)

These are the official references for how the study should be conducted. As described later, Lifestyle Counselors have some flexibility in implementing the treatment protocol. However, you should not modify the protocol in significant ways, such as having participants attend group sessions every other week, rather than weekly, during the first 26 weeks. Such a change would constitute a protocol violation. Familiarize yourself with both the Look AHEAD protocol and the Manual of Procedures. The Principal Investigator or Program Coordinator at your site can provide copies of these materials and answer any questions you have about the protocol and its implementation.

All participants in the Lifestyle Intervention will receive a Participant Manual (or “Notebook”). These Notebooks are user friendly, providing a summary of key concepts, as well as weekly assignments to help participants develop new eating and activity habits. Each chapter of the Participant Notebook has a corresponding chapter in the Counselor Manual that provides suggestions for discussing the materials in the treatment sessions. You will need to be as familiar with the Participant Notebook as you are the Counselor Manual.

Section 1:
Introduction and Overview

The Look AHEAD Study

The primary objective of Look AHEAD is to examine, in overweight volunteers with type 2 diabetes, the effects of a 4-year, intensive weight loss intervention that combines diet, physical activity, and behavior modification. The results of the Lifestyle
Intervention will be compared with those of a control group in which participants are provided usual medical care (by their own primary care physicians), as well as several lectures on diabetes care. This latter group is referred to as Diabetes Support and Education. The primary comparison between the two groups will be in the incidence of serious cardiovascular events (i.e., myocardial infarction and stroke). Other outcomes include cardiovascular disease risk factors, diabetes-related metabolic factors and complications, and the cost-effectiveness of the Lifestyle Intervention. Participants in the study will be followed for approximately 5-7 years after completing the 4 year treatment program.

Participants will be approximately 5,000 volunteers with type 2 diabetes who are 45-75 years of age and are overweight or obese (body mass index $\geq 25 \text{ kg/m}^2$). Each of the 16 sites will recruit and randomize approximately 312 participants over an initial 2.5-year period. To be accepted into the study, applicants must successfully complete a behavioral “run in” which consists of keeping food and activity records for 2 weeks.

**Goals of the Lifestyle Intervention**

The study-wide goals of the Lifestyle intervention are to:

1) induce and maintain a mean reduction in initial weight of at least 7% (across the 2,500 participants at the 16 sites).

2) increase physical activity to a mean of at least of 175 minutes per week (across the 2,500 participants at the 16 sites).

**Weight Loss Goal**

The study goal of achieving a minimum mean loss of 7% of initial weight was selected because it is believed to be safe, effective, and achievable. *Individual participants will be instructed to aim for a loss of 10% or more of initial weight,* the goal for weight reduction also recommended by an expert panel from that National Heart Lung and Blood Institute. This 10% goal is appealing because it is easily grasped by participants. Simply take the first two numbers of the current weight, reading from left to right; that is a 10% loss. Thus, a 10% loss from a starting weight of 230 lb, would be 23 lb, the first two numbers of 230.

*Individual participants are encouraged to lose as much weight as they can, provided that they lose at a safe rate (i.e., an average of 1-2 lb a week) and do not reduce below a body mass index of 21 kg/m\(^2\) (i.e., normal weight).* Participants should not be discouraged from losing more than 10% of initial weight. The greater the number of participants who lose 10% or more of initial weight, the more likely we will be to meet the study wide-goal of achieving a mean loss of at least 7% of initial weight. In addition, studies indicate that larger weight losses are associated with greater improvements in obesity-related health complications, as well as with the maintenance of larger weight losses at follow-up.
We know from previous studies that many participants, despite their best efforts, and yours, will not reach the 10% weight loss goal and that a minority will not reach even the study-wide goal of at least a 7% reduction in initial weight. These individuals will need your extra support and encouragement. In all cases, they should be congratulated for their accomplishments, rather than being criticized for not reaching the weight goal. The Lifestyle Intervention includes a special “Toolbox” that suggests additional interventions for individuals who do lose at least 1% of initial weight per month. The Toolbox is described in the chapter on Tailoring Treatment.

**Physical Activity Goal**

The Look AHEAD physical activity goal is to reach and maintain a minimum of 175 minutes of activity per week (by the end of the first 6 months). The recommended activity will consist of brisk walking, although participants will be allowed to select other aerobic activities. Only bouts of activity 10 minutes or longer will count toward the 175 minute a week goal. Participants also will be encouraged to increase their lifestyle activity (throughout the day) by using stairs rather than elevators, parking further away from mall entrances, and reducing reliance on energy-saving devices. Increases in lifestyle activity will be tracked by the use of pedometers. Participants’ eventual goal will be to walk 10,000 steps or more per day. This total represents the combination of both their planned activity (i.e., 175 minutes a week) and their increased lifestyle activity.

As with the weight loss goal, participants will be encouraged to exceed the activity goals described above. This is particularly true of individuals who enter the study already exercising 175 minutes a week. We hope such individuals will increase their activity well beyond 175 minutes a week.

Increased physical activity will be critical for helping participants maintain their weight loss; it is the single best correlate of weight loss maintenance. Increased activity also is associated with a reduced risk of cardiovascular disease, regardless of whether the individual is fat or thin.

**Section 2:**

**Overview of the Lifestyle Intervention**

**Duration and Format of Treatment**

All participants in the Lifestyle Intervention will receive 4 years of intensive treatment, as described below:

**Phase I: Weight Loss Induction**

- Months 1-6: Weekly treatment visits.
- Months 7-12: Every-other-week visits.

**Phase II: Intensive Weight Loss Maintenance**
Months 13-48: Minimum of one on-site visit per month; minimum of one contact by phone, mail, or e-mail per month.

**Phase III**, which lasts from 5 to 7 years, depending when participants enter the study, will consist primarily of follow-up visits to determine whether participants have experienced any adverse health complications. Participants will meet with a Lifestyle Counselor at least twice a year during this follow-up phase. More treatment visits will be included if additional resources are obtained. At present, the study budget can only support two visits per year.

**Group and Individual Sessions**

During the first year, the Lifestyle Intervention will be implemented using a combination of both group and individual treatment. During the first 6 months, participants will meet individually, once a month, with their Lifestyle Counselor who will follow their progress for the entire 4 years of treatment. The other 3 weeks of the month, they will attend a group session that will include 10-20 participants. During months 7-12, participants will continue to meet individually with their Lifestyle Counselor once a month and will attend 2 group sessions (spaced every other week). Group sessions during the first year will be “closed.” The same group of 10-20 participants will begin and end treatment together; no new members will be admitted to the group after the first week or two. Closed groups build cohesiveness and allow for a structured curriculum in which one week’s lesson builds on the preceding one.

We selected this mixed format because it combines the strengths of individual and group treatment. Group treatment provides important social support, an opportunity for participants to learn from each other, and a group norm against which participants may judge their progress. Individual meetings provide greater attention to specific participant needs and an opportunity to tailor treatment. Individual meetings should help ensure that no participants slip through the cracks, as sometimes occurs in group programs. The treatment format selected is similar to that used in TONE.

**Years 2-4.** During years 2-4, treatment will be provided primarily on an individual basis, with participants meeting (on site) with their Lifestyle Counselor once per month and having an additional contact once a month by telephone, mail, or e-mail. (The Look AHEAD budget allows Lifestyle Counselors to devote 2 hours a month to the care of each participant.) We chose individual meetings for this phase of treatment given findings that attendance of group sessions deteriorates markedly after 1 year. Participants also usually have more diverse treatment needs during the weight maintenance phase, needs that can be best met in individual sessions.

During years 2-4, participants will have an opportunity to attend some group sessions. Sites will have the option of scheduling “reunion” group meetings and, if they wished, could offer an ongoing “open-group” meeting that included any participants who had finished the first year of treatment. In addition, sites will offer periodic “refresher” groups for participants who have regained weight. As currently planned, these groups
will meet for 6 to 8 consecutive weeks and provide participants a structured meal plan that will help them reverse any weight regain. Refresher groups may be offered up to three times a year, in September, January, and May, times at which people frequently wish to recommit to weight control.

**Dietary Intervention**

To induce weight loss during the first year, participants who weigh less than 250 lb will be asked to consume 1200-1500 kcal/d while those weighing more than 250 lb will be prescribed 1500-1800 kcal/d. These calorie levels should induce a loss of approximately 1 lb a week for the first 16 weeks. For participants who do not achieve this rate of loss, levels may be reduced to 1000-1200 kcal/d and 1200-1500 kcal/d, respectively. The composition of the diet will be consistent with that recommended by the American Diabetes Association/American Dietetic Association.

**Meal Replacement Plan.** In order to help as many participants as possible lose 10% or more of initial weight, the Lifestyle Intervention includes the use of a meal replacement plan. Meal replacements, in the form of “shakes” and “nutrition bars,” help people lose weight by providing portion-controlled servings with a known energy content. Several studies found that persons who were prescribed meal replacements lost 1.5 to 3 times as much weight as individuals who were prescribed a diet of conventional foods with the same calorie goal. This is because overweight individuals consistently underestimate their calorie intake by 40% to 50% when they consume a diet of conventional table foods. (Average-weight individuals also underestimate their intake, typically by 20% or more.) Additional studies found that giving participants structured meal plans, which specified the foods they were to eat, significantly increased weight loss compared with having participants consume a self-selected diet.

Participants in Look AHEAD will be encouraged to follow a meal replacement plan for the first 4 months of the study. The plan combines three daily servings of a meal replacement (used to replace breakfast, lunch, and a snack) with an evening meal of conventional foods (or a frozen food entrée combined with fruits and vegetables). Participants will choose from meal replacements products including Slim-Fast, Glucerna, OPTIFAST, and HMR (Health Management Resources). Calorie levels will range from 1200-1800 kcal/d, depending on participants’ initial weight.

One of your principal goals as a Lifestyle Counselor will be to encourage participants to adhere as closely as possible to the meal replacement plan. This should help them lose 10% or more of their initial weight. Participants will have the option of replacing one meal a day for the entire 4-year program. The minority of individuals who choose not to use meal replacements will be encouraged to follow the Look AHEAD structured-meal plan that provides menus of conventional foods for breakfast, lunch, dinner, and snacks. These menus can be tailored to individual preferences. Persons who decline the use of these menus will consume a self-selected diet of conventional table foods, consistent with the calorie goals described previously.
Tailoring Treatment/Toolbox

Similar to the Diabetes Prevention Program, the Look AHEAD Lifestyle Intervention includes a Toolbox that provides additional treatment options for participants who need assistance in attending treatment sessions, meeting the weight loss or activity goals, or coping with personal problems. As described in another chapter of this manual, there are specific criteria for “opening” the Toolbox and for selecting an appropriate intervention. The Toolbox represents one component of the intervention’s effort to tailor treatment to the needs and preferences of individual participants.

Section 3:
Guidelines for Implementing the Lifestyle Intervention

Multidisciplinary Team

Each group of 10 to 20 participants will be treated by a team of two Lifestyle Counselors, preferably with different professional backgrounds. Thus, a registered dietitian might be paired with a behavioral psychologist or an exercise specialist. Health counselors, diabetes nurse educators, and social workers may also serve as Lifestyle Counselors. The pairing of providers with complementary professional backgrounds should ensure that the team is optimally prepared to deal with the variety of clinical issues that may arise. The commonality among the Lifestyle Counselors is that all will have experience treating obese individuals, and preferably have conducted a group intervention, similar to that used in Look AHEAD.

Each treatment team will include a research assistant who will support the Lifestyle Counselors by scheduling participants for visits, collecting homework assignments, and performing similar tasks. (Some sites may elect not to include a research assistant and instead provide Lifestyle Counselors more time to perform these duties themselves.)

For each group of participants, one Lifestyle Counselor will be identified as the “anchor” provider and the other as the “adjunct” provider. The anchor provider will attend all group sessions during the year of treatment. The adjunct provider will attend 4-6 group sessions during the first 6 months and 2-4 during the second 6 months. Optimally, the adjunct provider will lead group sessions that capitalize on his or her expertise. Thus, a psychologist who was the adjunct provider might attend sessions that addressed cognitive restructuring or stress management. All providers, however, must be thoroughly familiar with all aspects of the treatment protocol and be able to lead all of the group sessions.
As currently planned, two lifestyle interventionists will be responsible for the treatment of approximately 60 participants. If participants were treated in groups of 10 persons, then 6 treatment groups would be required as shown below:

<table>
<thead>
<tr>
<th>Groups</th>
<th>Provider A</th>
<th>Provider B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anchor</td>
<td>Adjunct</td>
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<tr>
<td>2</td>
<td>Adjunct</td>
<td>Anchor</td>
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<td>3</td>
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<td>4</td>
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<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>Adjunct</td>
<td>Anchor</td>
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Provider A would be the Anchor Provider for Groups 1, 4, and 5 and Provider B the Anchor Provider for Groups 2, 3, and 6. The two Counselors would similarly split duties as Adjunct Providers. For each group of participants, Provider A would serve as the Individual Counselor (to conduct monthly individual meetings) for half of the participants and Provider B would take the other half. As currently envisioned, these two Lifestyle Counselors would be responsible for treating these 60 patients for the entire 4 years of the treatment program. Sites may choose to organize their lifestyle teams differently, both in terms of providing short-term and long-term care. Sites should, however, strive to provide continuity of care for participants, as well as the opportunity for Lifestyle Counselors to work together on multiple occasions.

**Multiple teams.** Each site will enroll approximately 312 participants over the 2.5 year enrollment period, half of whom (N = 156) will be assigned to the Lifestyle Intervention. Thus, sites will need to create additional lifestyle teams in years 2 and 3, as more participants are entered into the study. Again, sites are encouraged, over time, to assemble a group of interventionists that includes at least one registered dietitian, one behaviorist (i.e., psychologist or masters of social work), and one exercise specialist. If these individuals cannot be hired as full- or part-time staff, they should be retained as consultants. A mental health professional, in particular, will be useful for assessing depression, life stress, and other complications that are likely to occur in some participants over the course of the study.

Lifestyle Counselors will be identified by the Principal Investigator (PI) and Program Coordinator at each site. One Counselor should be designated as the “lead” or “senior” Counselor at the site. The lead Counselor, with the Program Coordinator and PI, should decide the composition of the lifestyle teams that are assembled.

**Lifestyle Resource Core**
Counselors in Look AHEAD will be supported by a Lifestyle Resource Core. This Core will be comprised of members of the Lifestyle Intervention Subcommittee and, at all times, will include a registered dietitian, an exercise specialist, a psychologist, and a physician (or nurse practitioner). The Lifestyle Core will serve four important functions:

1. Members of the Lifestyle Resource Core will be available 1.5 hours each week, at a set time, to take phone calls from Counselors (from any of the 16 sites) who have questions about a specific component of the protocol. Questions also may be submitted by e-mail, with a response to be provided within a set time. Questions and answers that are relevant to all sites will be e-mailed to all Lifestyle Counselors.

2. Each of the 4 members of the Lifestyle Resource Core will host a monthly conference call (of approximately 60 minutes) that will include Lifestyle Counselors from 4 sites. Thus, the 16 sites will be divided into four regional groups, with a member of the Resource Core serving as the leader of each group. This monthly conference call will provide an opportunity to discuss implementation of the protocol, participant progress, and any concerns that Counselors have.

3. The four members of the Lifestyle Resource Core will have a monthly conference call in which they review the data from each site concerning participants’ weight losses and physical activity. These are the data that will be collected weekly on all participants using a computerized tracking system. The Look AHEAD Coordinating Center will prepare a monthly report of each site’s success in reaching weight loss and activity goals. The Lifestyle Resource Core will review these data to determine if any sites are having difficulty reaching the study goals. Conference calls will be scheduled to assist sites whose participants are not meeting the minimum study goals. Members of the Lifestyle Resource Core may also visit sites, as part of regularly scheduled site visits to be conducted by the Look AHEAD Coordinating Center at Wake Forest University.

4. The Lifestyle Resource Core will be responsible for producing additional treatment materials for Look AHEAD. This will include developing the bi-weekly group sessions to be used from weeks 27-52 during the first year of treatment, drafting treatment protocols for years 2-4 of the intervention, and continually reviewing and updating all treatment materials. As a Lifestyle Counselor, you can assist the Lifestyle Resource Core by sharing materials that you have found helpful with your participants or by suggesting topics to be included in future lessons.

Treatment Standardization

As noted earlier, Look AHEAD is being implemented at 16 sites nationwide. All sites will employ the identical criteria for selecting participants and the identical outcome measures for assessing participants’ progress. The same uniformity is required in implementing the lifestyle intervention. This uniformity will ensure that all participants receive the same intensive program of diet and exercise modification that will help them lose 10% or more of initial weight. Several steps have been taken to standardize the delivery of the Lifestyle Intervention. These are briefly described below:
1. Counselors’ Manual. This manual provides Lifestyle Counselors detailed outlines of the topics to be covered in both the individual and group treatment sessions. The manual describes the content of the materials to be discussed, as well as methods of covering the content. For example, participants could learn about the benefits of exercise by having the Counselor simply list these for group members. Alternatively, the Counselor could ask the group, “What do you think are the benefits of exercising?” The latter approach is usually more engaging for participants. Regardless of the approach used, the Counselor must cover the “content” about the benefits of exercise.

It is essential that you adhere to the Counselors’ Manual as closely as possible. This will ensure, for example, that participants enrolled in Look AHEAD in Baltimore receive the same instruction and homework assignments at the 5th week of the program that participants in Los Angeles receive at week 5.

2. Central Training. The Lifestyle Intervention Subcommittee will conduct a 4-day training at least once a year (for the first 3 years of the study) that will provide Counselors a detailed review of the Participant and Counselor manuals. This will include examining principles and techniques of behavior change, methods to facilitate group interaction, the importance of completing homework assignments, and tips for working with challenging participants. Moreover, the training will underscore the importance of adhering to the intervention protocol.

Counselors who are unable to attend the Central Training must complete several steps prior to treating participants. They must:

a) study the Participant Notebook and the Counselor Manual, as well as familiarize themselves with the Look AHEAD protocol and the Manual of Operations;

b) work closely with the site’s lead Lifestyle Counselor until the latter believes that the new interventionist is ready to treat participants. This should include observing a senior Counselor conduct at least 3 consecutive group sessions (with the same group of participants) and sitting-in on several individual sessions;

c) review audio- and video-taped materials from the Central Training.

3. Weekly Staffing Conference. At all sites, lifestyle teams should have a weekly staffing conference that has at least two objectives. The first is to review the treatment protocol for the upcoming week to determine if it presents any special challenges. Counselors can share ideas concerning how to cover the topics. This review should include a discussion of the previous week’s protocol and whether there were any problems with its implementation. The second objective of this meeting is to review participants’ progress. This includes reviewing group members’ success in meeting weight loss and activity goals, as well as their attendance of treatment sessions. This is also a time to discuss participants who need additional help in reaching the study goals or perhaps in coping with stressors at home or work.
The weekly staffing will probably last 1-2 hours, depending on the number of participants the lifestyle team is treating at any given time. The staffing may be divided into “protocol” and “participant” meetings if the Counselors prefer. This weekly conference may be attended by all staff who are involved in the participants’ care. Attendees may include the program coordinator, study physician, diabetes nurse educator, and study investigators.

4. Peer Supervision. An excellent way for Counselors to assess their adherence to the treatment protocol (i.e., Provider Manual) is to periodically audiotape their individual or group sessions and to then listen to them to determine compliance to the written protocol. Peer supervision provides an even better approach. The Lifestyle Intervention Subcommittee recommends that, at least once every 6 weeks, each member of a Lifestyle Intervention team tape one group session and one individual session. The two interventionists on the team would then swap tapes and listen to each other’s sessions. Using a Protocol Adherence Checklist (PAC), supplied by the Lifestyle Intervention Subcommittee, the providers would rate each other’s adherence to the protocol. They would meet to review their ratings (and other observations) with each other. These meeting also would provide an excellent opportunity for interventionists to discuss challenging participants. Copies of the PACs would be forwarded to the Lifestyle Resource Core for review.

Section 4:
Overview of Session Materials

This first installment of the Counselors Manual contains detailed outlines for conducting weekly individual and group sessions. A total of 24 session outlines are provided which are to be implemented over 26 weeks. The Lifestyle Intervention Subcommittee anticipated that, because of holidays or inclement weather, treatment sessions would not be held for 2 weeks out of the first 26. Individual sites can schedule the 24 sessions (over 26 weeks) at their discretion.

Group sessions have been designed to require a total of 90 minutes. This includes 15 minutes before the session to weigh participants, with 75 minutes for the actual group meeting. The first individual session is expected to last 45-50 minutes and subsequent individual sessions approximately 25 minutes.

Session Outlines

All of the session outlines follow the same general format described below. The first three items require preparation before sessions begin.

1) Objectives:

This identifies what the participants will learn during the session.
2) **To Do Before Session:**

   This section lists materials you will need to prepare prior to the session. Preparing for the sessions includes, for example, writing name tags for the participants, obtaining the necessary audiovisual equipment, and having a basket or box in which participants can deposit their Keeping Track booklets (in which they will have recorded their food intake and physical activity).

3) **Weigh in:**

   Participants should be weighed prior to beginning all group and individual sessions. Those who are late for group should be weighed after the session. Procedures for weighing participants are discussed at the end of this section.

4) **Welcome and Homework Review:**

   Sessions typically begin by reviewing the completion of homework assignments from the previous week. This component of the session is essential for evaluating participants’ progress in modifying their eating and activity and for identifying problem areas. The Counselor Manual offers suggestions for conducting this weekly review but feel free to develop your own format.

5) **New Topics:**

   Each weekly session introduces a new lesson on some aspect of nutrition, physical activity, eating habits, or cognitive restructuring. These materials include suggestions for how to present the ideas. You may need occasionally to adjust the session content to better meet participants’ needs and abilities.

6) **Homework:**

   At each session, participants are assigned homework to help them acquire the skills described in the new materials. This might include trying to limit activities while eating (e.g., not watching television) or to increase lifestyle activity by using stairs more often. Each week, participants also will record their food intake and physical activity in their Keeping Track booklets. Regular self-monitoring is the backbone of the lifestyle intervention. It is the first priority if participants do not have time to complete all of their homework assignments.

7) **Close:**
This section contains information on how to end the session and any issues related to activities of the next scheduled session (e.g., sign-ups for individual sessions).

**Format of the Session Outlines**

Each weekly outline describes the structure of the session and the content of the materials that you should cover. In addition, suggestions are provided on how to deliver the materials, typically in an interactive fashion by asking participants questions.

The first five sessions of the Counselors’ Manual also provide narrative descriptions of what you might say to participants in conducting an individual or group session. These narratives are offered as examples, particularly for Counselors who are new to conducting weight loss groups. You are not expected to use the specific words or examples provided in the narratives. Narrative material in the first five sessions is presented in italics.

**Covering the Session Topics**

The session outlines provide a blueprint for conducting the group and individual sessions. Your challenge as a Lifestyle Counselor is to bring these blueprints to life by leading sessions that are productive, engaging, and enjoyable for participants. This will require you to be thoroughly familiar with the content of the materials so you can focus on delivering the concepts and on participants’ reactions to them. Suggestions for leading effective groups are discussed in another chapter of this manual.

One-week window. Inspection of the first 24 session outlines reveals that they vary in length and in the number of topics covered. You may feel that some sessions have too much material and others too little. In cases in which you do not have time to cover all the topics in a session, you have two options. The first is to cover the omitted material in the following week’s session or, potentially, to cover it the week before if you are aware of the time crunch in advance. Thus, you will have a window of plus or minus (+1) one week for covering the topics in the manual.

The second option involves prioritizing the topics in each session which you should do routinely in preparing for group meetings. Always identify the most important topics to address in the session and make sure they are covered. You can summarize in a few sentences information on topics of secondary importance, invite participants to review the corresponding materials in the Participant Notebooks, and have them bring questions to next week’s session.

As noted previously, the Look AHEAD protocol requires that Lifestyle Counselors adhere to the treatment protocol as closely as possible to ensure uniformity across the sites. Thus, we want all 2,500 participants in the Lifestyle Intervention to receive the same treatment. Clearly, however, you will need flexibility in implementing the protocol.
Measuring Participants’ Body Weight

For participants, body weight is likely to be a key outcome measure of the intervention. It also is a key study goal. The Lifestyle Intervention Subcommittee recommends that Lifestyle Counselors themselves weigh participants rather than having a research assistant or medical technician perform this task. The weigh-in gives you a look at the participant’s progress during the week. Particularly if the participant has not lost weight, a 1-minute interaction at the scale can alert you to any difficulties that participants are having, whether with their eating and activity habits or with stressors at home or work. You may decide to encourage participants to discuss their difficulties in the group session or to speak with you after the meeting. By weighing participants, you begin the session informed of each participants’ status.

Procedures for weighing. Procedures for weighing participants are described in chapter 16 of the MOP. The scale should be set to read in kilograms. Every effort should be made to weigh participants under the same conditions from week to week (i.e., same time of day, wearing similar clothing, shoes removed, etc). Weight should be measured twice on each occasion. Ask participants to stand still in the middle of the scale platform with head erect and eyes looking straight ahead. Record the weight in kilograms to the nearest 0.1 kg as indicated on the digital display. Ask the participant to step off the scale and check that the digital display returns to zero. Repeat the measurement and record the weight.

Place for weighing. Patients should be weighed in private to allow you and the participant to discuss weight or related issues. If a private room is not available, a screen may be used to enclose the scale. You will need to speak in a whisper to maintain the participant’s privacy.

Responding to Weight Change.

Some participants become nervous when being weighed. A few will remove all jewelry, their belt, and other non-essential clothing in hopes of showing a weight loss. It helps for Counselors to maintain a calm, low-key attitude during the weigh-in; it should serve as a model for participants.

Participants also may display a range of emotional reactions in response to their weight change. A large weight loss is often greeted by elation, while a weight gain (or no change in weight) is often met by disappointment or frustration. You probably have your own ways of responding to participants’ weight change and their emotional reactions. The following suggestions also may be helpful:

Let participants respond first. After you have told a participant her weight change, allow her to respond first. If, for example, the participant exclaims, “That’s great, 3 pounds! I can’t believe it,” you could respond, “I can see how pleased you are. Congratulations.” If you know the participant has been working hard to keep food and activity records, you could add, “It looks like keeping food records has really paid off this
week. Congratulations!” In short, you want to acknowledge the participant’s pride and pleasure, while making a connection between behavior change and weight change.

It is important not to rejoice too loudly with successful participants. They will be sensitive to the absence of your compliments on future occasions when they have not lost weight. Similarly, less successful participants may become envious.

**Empathize with disappointment.** In response to weight gain, most participants express disappointment and sometimes incredulity. In such cases you could respond, “I can understand your disappointment (frustration, etc.).” The next step, however, is to determine whether the weight gain makes sense to the participant. You can ask, “Does the weight gain make sense to you in terms of your eating and activity habits this past week?” Some participants will acknowledge that they ate too much at a series of social events and that the weight gain is not unexpected. You will want to problem solve with these individuals, making a plan for handling such social situations in the future. Also reiterate the importance of getting right back to recording food intake and physical activity.

The toughest cases are those in which participants report that they adhered perfectly to their diet and activity plan but still gained weight. Here it is important to empathize with their disappointment; imagine how you would feel if you had worked hard and gotten no reward. In addition, you can acknowledge that the scale is a poor measure of eating and activity habits. Shifts in water weight, particularly in women, can increase (or decrease) body weight significantly. The brief discussion at the scale should conclude with your efforts to restore the participants’ self-efficacy and positive expectations (i.e., that they can continue with their self-monitoring and that the scale will eventually reflect their efforts). If participants do not lose weight for several weeks, but report excellent adherence, a different approach is needed, as described in the Toolbox.

**Do not criticize participants.** A cardinal rule for Lifestyle Counselors is not to criticize participants or impugn their integrity. For example, it would be easy to dismiss as inaccurate a participant’s report that he had consumed only 1200 kcal/d, all 7 days of the week, but had gained 2 pounds. A Counselor might be tempted to say, “That’s impossible Mr. Smith. If you ate 1200 kcal/d, you would have lost weight this week.” The Counselor cannot know for sure what Mr. Smith ate. He also may not know that Mr. Smith stopped taking a diuretic or another medication that affects body weight. Even if the Counselor is factually correct, he is correct at the cost of the participant’s self-esteem. He has essentially accused the participant of lying, which can only harm the participant-provider relationship. Instead of being confrontational, the interventionist could say, “That must be perplexing to you, Mr. Smith, to have eaten so little and to have gained weight. I can’t explain it. Let’s meet after group for a few minutes and review your records to make sure they are as accurate as possible. I know you want to lose weight, so let’s see what we can do together.” This response raises the possibility that Mr. Smith’s records are inaccurate but does so in an effort to help, not criticize the participant.
Section 5:
Conducting Individual Session

Individual sessions with participants serve several important functions in the Lifestyle Intervention. First and foremost they should facilitate a strong therapeutic relationship (or bond) with participants. This relationship is often the glue that keeps participants in a treatment program, particularly a long intervention such as Look AHEAD. To this end, the individual meetings should be a source of enjoyment for participants. They should look forward to seeing you, not only because you help them control their weight and diabetes, but because you remember to ask about their children, how they like their new job, or if their mother is feeling better. Most participants need to feel that you are interested in them as a person, not simply as a study subject. Plan to spend a few minutes of each individual session getting to know the participant.

The sessions also provide an opportunity to assess at monthly intervals how participants like the program and how they are progressing. Participants prepare for individual sessions by reviewing two homework sheets, “How Are You Doing?” and the monthly “Progress Summary.” Lifestyle Counselors prepare for the session by printing summaries of the participant’s weight loss and physical activity for the preceding month, as recorded in the Tracking System. They may also want to talk with other staff members who are treating the participant.

Tailoring Treatment

A key goal of the individual sessions is to tailor treatment to the participant’s specific needs or preferences. For example, participants who during the first 4 months decline the use of both the meal replacement plan and the structured meal plan will need help in selecting a diet of conventional table foods, consistent with their preferences. You will need to ensure that they count calories carefully, and check to see if they feel out of place with other group members, the majority of whom will follow the meal-replacement plan.

For participants who do not meet the monthly goals for weight loss and physical activity, the individual session will provide an opportunity to problem solve, set new goals, and to plan new strategies for behavior change. The Toolbox, described in the chapter on Tailoring Treatment, provides detailed algorithms for choosing appropriate interventions for participants who do not lose a minimum of 1% of initial weight per month, who miss several treatment sessions, or who are experiencing disruptive life events that are hampering their progress in the program. The Toolbox is discussed in a separate chapter in this manual.

Sessions 0A and 0B
The first individual session will occur after participants have been randomized to treatment and before they attend the first group session. Session 0A is likely to be your first meeting with the participant, unless you assisted with subject recruitment and screening. This session is described in detail in the Counselor Manual. The principal goals are: to begin to develop an alliance with participants; to explain the purpose, format, and requirements of the treatment program; to invite participants to discuss their reasons for joining the program; to answer any questions they may have; to have participants taste the meal replacement products; and to prepare participants for the first group meeting. This first meeting is expected to last 45 to 50 minutes.

You may schedule an additional individual visit with participants whom you think need or would like one. Session 0B could be offered to participants who had lots of questions about the program or were concerned because of their past failures that they were not going to succeed in Look AHEAD. A second visit could also be offered to participants who have a long wait until the first group session. (No participant should have more than a 1 month wait from the time of Session 0A to the first group session.)

Required session. All participants are required to complete Session 0A. In cases in which participants are randomized to treatment immediately before the first group session, Session 0A may be completed on the same day as the participant’s first group session. Session 0B is optional, to be offered at your discretion. You may offer additional individual sessions (i.e., 0C, 0D, etc) as needed.

Worksheets.

All of the individual sessions contain worksheets that can be used to stimulate both the participants’ and your thinking about their progress. The worksheets should provide “talking” or “thinking” points for you to discuss during the sessions. In some cases, you might ask participants to complete a worksheet at home and bring it to the next session. Thus, you might have participants who were returning for Session 0B complete a worksheet in preparation for that visit.

Refrain from having participants complete a worksheet on their own, during an individual session, while you sit waiting for them to finish. Such an exercise is likely to detract from rapport building. You and the participant could complete a worksheet together but, again, do not let the physical act of writing out answers prevent you from focusing attention on the participant. The goal of these sessions is for participants to feel supported, understood, and appreciated -- not to have them complete written assignments.

Later Individual Sessions

Additional individual sessions are scheduled during the first 6 months at weeks 5, 9, 13, 17, and 21. During these weeks, group sessions will not be held. Most individual sessions probably will be scheduled during the regular group session time. Thus, if the group met from 5:30 to 7:00 P.M. on Thursdays, the Anchor and Adjunct Providers could both schedule participants from 4:00 – 7 P.M. This 3-hour block would provide each
provider time to meet with each of 5 participants for 25 minutes. Together the two providers could see all 10 members of a group in this 3.0 hour block (with a half hour for run-over time). Alternatively, participants could be scheduled for individual meetings any time during the week that was convenient to participant and Lifestyle Counselor.

**One-week window.** Scheduling constraints at some sites may make it difficult for all participants to have an individual visit in the same week. This is particularly true if a site chooses to conduct groups with as many as 20 persons rather than 10. **Thus, sites have a window of plus or minus one week (+1 week) for conducting the individual visits.** Thus, the session 5 visit could be scheduled at weeks 4, 5, or 6. Efforts should be made to maintain participant visits at 1-month intervals, thus, consistently scheduling participants for a week-early or week-late visit. Thus, a participant would be scheduled for visits at weeks 4 and 8 rather than at weeks 4 and 10, even though week 10 is within the ±1 week window for week 9.

**Conducting later individual sessions.** The Counselors’ Manual offers suggestions for conducting later meetings. In most cases, you might begin by reviewing two forms, “How Are You Doing?” and the “Progress Summary.” Participants will be asked to review these forms prior to attending the sessions. This will help them identify their accomplishments in the past month and set new goals for the coming month. You may want participants to jot down a few notes in response to these two forms but, again, these assignments should not become laborious. You do not want participants to arrive at meetings feeling guilty because they have not completed homework assignments. As stated previously, individual meetings should be affirming and enjoyable for participants, regardless of whether they have met the study goals.

**Participant Rescue**

Small numbers of participants are likely to drop out of treatment, whether because of scheduling conflicts, life stressors, disappointment with their outcome, or an antipathy to group sessions. Your goal is to retain all participants in the study, even if they stop attending treatment sessions. Such individuals would be asked to participate in the yearly assessment visits, similar to persons in the usual-care condition.

We would like to retain all participants in the lifestyle intervention, even if this requires offering the option of attending only individual treatment sessions. The frequency of such visits, could be decreased from weekly to bi-weekly or even monthly. Thus, you have the flexibility to provide participants whatever form of treatment is needed to retain them in the study. Before offering participants special arrangements, you will want to review these cases with other members of the lifestyle team.

It is also important to remember that this is a long-term intervention – 4 years of weight reduction therapy with up to a 7-year follow-up period. **For participants who decline all offers of treatment, and withdraw from the program, be sure to leave the door wide open.** Indicate that you would be happy to work with them anytime they are ready to focus again on weight control. You may wish to follow-up with a card or note every 3 to 6 months to wish the participant well.
This latter intervention speaks again to the importance of developing and maintaining a strong personal relationship with participants. Materials developed by the Look AHEAD Recruitment and Retention Subcommittee provide additional suggestions for retaining participants in the program. These may include simple gestures such as sending participants birthday and holiday cards.

Section 6: Conducting Group Sessions

This first installment of the Counselors’ Manual contains detailed outlines for conducting group sessions during the first 26 weeks of the program. Another chapter in this manual offers suggestions for Leading Effective Groups. Thus, the present section reviews only a few key issues in conducting group sessions.

Interactive Group Sessions

Group sessions in Look AHEAD should be highly interactive. As a general rule, the more participants talk during a session, the more they enjoy and value the meeting. Participants should leave meetings feeling that they have discovered new things about their eating and activity habits, have helped others with their problems, or have otherwise contributed to the group.

You can facilitate subjects’ participation by keeping your lecturing to a minimum. Even when you introduce a new topic, you can do so by posing questions to participants, rather than by simply giving them facts and figures. Help participants show how much they already know about a topic rather than showing how much you know.

Reviewing Homework

All participants should have an opportunity to talk in sessions by reviewing their Keeping Track records with the group. Review of self-monitoring forms is a central focus of the group sessions because the records show what behaviors participants have actually acquired, compared with those they have been encouraged to acquire. Efforts to change behavior should be anchored by participants clearly articulating the behavior they are trying to adopt and then making a plan of when, where, and how they will practice the new behavior. Particularly when participants have had a difficult week, they should leave group with a well-defined plan of behavior change.

In reviewing homework, you will usually want participants to focus on specific issues, particularly if you have limited time and want to hear from several participants. This is best accomplished by asking specific questions. For example, you might say, “John, tell us about your walking program last week. How many times did you walk and for how many total minutes?.” This is preferable to more open-ended questions such as, “John, so how was your exercise last week?” The latter question may elicit responses such as, “It was pretty good. I liked it.” Neither you nor other group members know what John did unless you ask further questions, which takes more time.
New Material

Each group session includes the introduction of one or more new topics. It would be easy to conduct the sessions as a series of mini-lectures in which you judged your success by how well you presented the material. We have already discussed the importance of presenting new material in an interactive fashion. Of equal importance is ensuring that participants are actually using (adopting) the new concepts presented. One of your principal tasks as a Lifestyle Counselor is to maintain a sense of continuity from one session to the next. This includes reminding participants of topics that were introduced in prior weeks and determining how they are progressing with behavior change in these areas.

Most participants will be knowledgeable of the basic concepts of diet and activity that will be presented in the Lifestyle Intervention. They will know what they should do. Your task is to help them discover how to do it. This is rarely achieved by simply presenting new material.

Practice, Practice, Practice

In order to lead participant-oriented groups, as described above, you will need to have a thorough grasp of the agenda for each session and of the concepts to be reviewed. This will allow you to focus on the participants and their needs. Such mastery is achieved by reviewing the protocol several times before the meeting, rehearsing aloud some of the sections, and talking with your co-leader, if two providers will lead the session. You should have internalized the session materials so well that you do not need to bring the Counselors’ Manual to group. The last thing you want to do is read from the manual while conducting the session. Can you imagine your dentist reading from a textbook in order to perform your root canal!

Provider Outlines. A set of Provider Outlines has been created to help you lead group sessions. For each session, the outline lists all topics to be covered in the session and provides space for you to make notes to yourself. In addition, the outline presents the full text of the Participant Notebook for the session. This will allow you to refer to materials in the Notebook without having to hunt through a separate manual. We suggest that you take only the Provider Outlines to group sessions.

Session Notes

It is extremely useful to keep notes on each participant from session to session to remind you of a various issues including who was absent the prior week, who did not complete their food records, or who was called on in the previous session to review their homework. You will want to make sure that everyone gets equal “air time” over a 2-3 week period. Session notes are very helpful to this end. Perhaps the easiest method of note taking is to have a single sheet of paper that lists each group members name with a space below it to record a few notes. Such note taking can often be done during group or immediately after.
Missed Treatment Sessions

Participants who miss a group or individual session should be contacted immediately after the session to determine what prevented them from attending. Preferably the Lifestyle Counselor should call the participant, although the research assistant, or even Program Coordinator, could in cases in which the Counselor was unable. This should be a friendly call that expresses concern for the individual, without inducing guilt or defensiveness, as the following statement might, “Hi. Mrs. Smith. This is Judy Jones from the Look AHEAD program. I was calling to see why you didn’t come to group tonight.” A safer approach would be, “Hi. Mrs. Smith. This is Judy Jones from the Look AHEAD Program. I noticed you weren’t at group tonight. I was calling to make sure you were feeling ok.”

Tell participants at the first or second group meeting that you will call them if they miss group unexpectedly. Indicate how you will identify yourself to whoever answers the phone. To protect confidentiality it is usually best to say, “Hi. This is Judy Jones calling. Could I speak with Mrs. Smith please?” This greeting does not disclose that Mrs. Smith is participating in the program, information that she may not wish to share with all family members.

Missed sessions should be rescheduled, as soon as possible, as a brief individual visit of 10-15 minutes. If this is not possible because the participant is ill, out of town or otherwise unavailable, then the make-up visit should be conducted over the phone and the participant mailed the necessary materials (i.e., Keeping Track booklet, etc). You should be aware of the possibility of reinforcing participants for missing visits by offering individual meetings. If this becomes a problem, it should be discussed at one of the regularly scheduled individual meeting.

Section 7: Health and Safety of Participants in the Lifestyle Intervention

All participants (i.e., lifestyle intervention and usual care groups) who are accepted into Look AHEAD will attend an introductory lecture that discusses the causes of and care for type 2 diabetes be provided an introduction to the causes of and care for type 2 diabetes be provided an introduction to the Medical care of participants in the Lifestyle Intervention will be provided by their own primary care physicians. Look AHEAD staff will provide only emergency care.

All study participants

Nonetheless, lifestyle interventionists and other treatment staff must be attentive to possible health complications that could result from participants dieting or increasing their physical activity. In particular, participants who take insulin, sulfonylurea, or certain other anti-diabetic agents could experience hypoglycemic episodes while dieting. Precautions must be taken to prevent this occurrence.
Blood Sugar Monitoring

Before session 3, when participants begin the meal-replacement plan or otherwise restrict their calorie intake, all participants who take insulin, sulfonylureas or other agents potentially associated with hypoglycemic episodes will be required to self-monitor their blood sugar for a minimum of 1 week. Information provided by these records will be used by the study physician to determine how much to reduce participants’ medication prior their dieting at week 3. Current plans call for these participants to self-monitor their blood sugar, starting the day after the first group session. The study physician will review participants’ records when they are returned at week 2 and then decide how much to reduce the medication dose. These participants may be required to monitor their blood sugar at other times to determine if further reductions are needed.

Working with medical and nursing staff.

This example illustrates the need for lifestyle interventionists to communicate regularly with the study physician and the diabetes nurse educator to ensure that participants receive appropriate monitoring and care. Plan to meet regularly with these colleagues and seek them out immediately if you have concerns about a participant’s health.

Exercise Intervention

Participants in the Lifestyle Intervention will be encouraged to achieve and maintain a minimum of 175 minutes a week of walking or related activity. Participants will be encouraged to walk at a brisk but comfortable pace, consistent with a Borg Rating of Perceived Exertion of 10-13. Ultimately, we are more concerned about the duration than the intensity of participants’ activity. Two points, however, must be considered.

All participants, prior to randomization, will undergo a graded maximal exercise test to determine that they are free of conditions that would contraindicate their participation. The results of this test will be used to identify an upper limit for heart rate, above which participants should not exercise. This upper limit is particularly important with individuals who have a history of myocardial infarction or stroke. The Coordinating Center at Wake Forest University will serve as a central reading site for all of the exercise tests. The Coordinating Center will forward to each site’s Program Coordinator an exercise prescription (i.e., recommended heart rate range) for each participant at your site. Be sure to review the prescriptions for all of your participants prior to the 0A visit. This will be an appropriate time to discuss any limitations or concerns about a participant’s physical activity. Speak with your site’s exercise specialist or study physician if you have any questions about a participant’s activity prescription.

Foot care. Patients with diabetes are at marked risk of developing complications with their feet.
Preface to the

Look AHEAD Lifestyle Counselor’s Manual:

Months 7-12

Prepared by the Look AHEAD Weight Loss Intervention Subcommittee

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Preface to the Look AHEAD Lifestyle Counselor’s Manual:
Months 7-12

I. Introduction and Acknowledgments

Congratulations on completing the first 6 months of the Look AHEAD intervention. This is a major accomplishment for you, as it is for the many participants that you have helped reach this point. We hope you have taken a moment to reflect on your work with pride and satisfaction. You have made a difference in the lives of numerous people, who are now enjoying improved health and mobility as a result of your work together. Well done!

This manual provides detailed guidelines for leading treatment sessions during the next 6 months; it is similar to the Lifestyle Counselor’s Manual you followed for the first 6 months. Each chapter reviews the materials to be covered for a given individual or group session. This Preface provides additional information about the structure, content, and implementation of the treatment sessions. In addition to reading it, you may want to review the chapters on Tailoring Treatment and Leading Effective Groups that are included at the back of the Lifestyle Counselor’s Manual (Months 1-6). These materials probably will be of greater use now than they were 6 months ago.

The treatment protocol for months 7-12 was developed by the Look AHEAD Weight Loss Intervention Subcommittee, after completing a thorough review of the scientific literature on methods to facilitate long-term weight control. Delia West, Ph.D., Co-Chair of the Weight Loss Intervention Subcommittee, chaired the Manuals Subcommittee that produced the materials, working from drafts prepared by Michael Lowe, Ph.D. These individuals have our sincere thanks and appreciation, as do other members of the Manuals Subcommittee including Linda Delahanty, R.D., Ed Gregg, Ph.D., Andrea Kriska, Ph.D., and Don Williamson, Ph.D. We thank Robert Jeffery, Ph.D., Shirki Kumanyika, Ph.D. and particularly Rena Wing, Ph.D. for...
II. Goals of Program for Months 7-12

The principal objective of the lifestyle intervention for months 7-12 is to continue to help participants meet the goals of losing $\geq 10\%$ of initial weight and exercising $\geq 175$ minutes/week. Some participants will have already met these goals. Treatment, for them, will focus on maintaining these achievements or seeking further weight loss or increases in physical activity. Participants who have not met the study’s weight and activity goals should be encouraged to do so and will be offered advanced toolbox options to this end. These options are reviewed in chapter 25 of this manual, as well as in supplemental materials (i.e., materials describing the use of orlistat and other interventions).

Change in group sessions. Group sessions during months 7-12 may have a different feel and tone than those the first 6 months. This is because most participants will lose weight very slowly, if at all, during the second 6 months. This is particularly true for persons who have already lost 10% of initial weight. Reasons for the reduced rate of loss are not entirely understood but may include compensatory biological responses to weight reduction (e.g., decreases in leptin and resting energy expenditure), as well as participants’ suboptimal adherence to their diet and exercise regimens. Regardless of the cause, the effects of slower weight loss are well known. Some participants will report frustration or disappointment that they cannot lose weight, despite working hard to do so. In short, participants often feel that their efforts are not as fairly rewarded during the second 6 months as they were during the first 6 months.

Addressing slower rate of weight loss. The reduced rate of weight loss will require you, at some point during months 7-12, to address several issues with group members.
1. The first is to acknowledge patients’ potential disappointment or frustration. It is important to let participants express these feelings and to empathize with them -- repeatedly.

2. The second need is to “normalize” the slower rate of loss by explaining that it is observed with all methods of weight reduction -- whether diet, exercise, weight loss medications, or surgery. In addition, the reduced rate of loss signals an important shift in treatment. It is now time for participants to learn the skills needed to maintain a weight loss rather than to lose weight. Maintaining a weight loss is a very active process, and requires a different set of skills than losing weight. Note that most participants have been in numerous weight loss programs. Few, however, probably have had the chance to participate in a program that will teach them how to keep the weight off. This is a major strength of Look AHEAD and should be emphasized as a very positive point.

3. The third need is to ensure that group sessions continue to be engaging and entertaining for participants. This can be accomplished by periodically shifting the focus to non-weight related issues that can unite group members, in the same way that they originally were united in the quest of weight loss. They could unite by participating in a group walk (for the American Cancer or Multiple Sclerosis societies), planning a special night out that includes cooking a low-calorie meal, volunteering together at a soup kitchen, or having a guest speaker discuss a special topic (such as stress management). Such activities should be used when needed to re-energize group sessions.

In summary, the goal of treatment sessions during months 7-12 is to foster participants’ continued adherence to their diet and exercise goals so that they meet the study goals in these areas. It may be necessary, however, to introduce new topics and methods of learning to ensure that participants remain engaged in these efforts, despite the slower rate of weight loss.
III. Structure of Treatment: Months 7-12

During the first 6 months of the program, participants attended 3 group sessions per month and 1 individual session. From months 7-12, they will attend only 2 group sessions a month and 1 individual session. The official Look AHEAD study protocol indicates that participants will be offered 2 group sessions a month but must only attend 1 session to remain in compliance with the protocol. This provision was included because of previous findings that attendance of treatment sessions declines after the first 6 months of intervention.

We suggest that you tell participants that there will be 2 group meetings and 1 individual meeting each month and that they should attend all 3 meetings. Do not present attending only 1 group session a month as an option. Aiming for 2 group sessions will increase the likelihood that participants attend at least 1, the minimum that is required. This is similar to giving participants a goal of losing 10% of initial weight, with the hope that aiming high will help the majority reach the official study goal of losing at least 7% of body weight.

Fostering participant autonomy. The rationale for reducing the number of monthly group sessions from 3 to 2 should presented in a positive manner. Indicate that participants, by their hard work, have acquired many of the tools needed for weight control. They are ready to take an important step, which is to assume greater responsibility for their weight management, just as students take greater responsibility for their education when they move from middle school to high school and potentially on to college.

Participants will take more responsibility for their weight management on the week that they do not attend a group session. As discussed in session 26, they will learn to review their weight, eating, and activity habits on their own, during a weekly at-home check in. These are behaviors that successful weight loss maintainers practice regularly. Participants in Look
AHEAD will learn them during months 7 to 12 of the program.

**Monthly individual sessions.** Monthly individual meetings with participants will be increasingly important during months 7-12. Some patients will require more advanced toolbox options (i.e., weight loss medication or more intensive diet and exercise interventions) and others may have their first significant dietary lapse, with accompanying weight gain. Thus, it is essential that patients attend their monthly individual sessions. Missed visits should be rescheduled promptly (with telephone contact the day of the missed visit).

Use individual sessions to strengthen your rapport with participants. Always inquire about their family members, work activities, and any special occasions. These sessions, however, must have clear objectives. You should review participants’ weight, eating, and activity records from the previous month, problem solve any difficulties that arose, and select goals and behavioral strategies for the coming month. Monthly worksheets are provided to this end.

No matter what the participant’s progress in the previous month, find something positive to discuss, even, if only the participant’s decision to come to the session. Participants should leave sessions with goals and plans, but also with a renewed belief that they can succeed.

**IV. Content of Treatment: Months 7-12**

The lessons for months 7-12 present several new concepts including information about the differences between losing weight and maintaining a weight loss, eating a low-energy density diet, coping with dietary lapses, improving body image and self-esteem, and expanding exercise options. Participants should benefit from these lessons.

Some participants, however (as well as lifestyle counselors themselves), may occasionally note that the sessions are repetitive or do not break new ground. This criticism is valid in some respects. Sessions will continue to emphasize the importance of participants’
recording their food intake and physical activity, as well as identifying cognitive and behavioral methods of coping with barriers and lapses. A significant part of each session should be devoted to having at least a few participants report their calorie intake and minutes of physical activity from the preceding week. This will underscore, to all participants, the importance of continuing to track these events.

**Hearing versus doing.** This point addresses a fundamental goal of treatment sessions which is to determine whether participants are practicing the behaviors that they hear about in group. By way of analogy, participants would never learn to play tennis or golf if they merely came to group sessions and listened to you describe the strokes they should use. They would only learn to play by actually getting out and practicing. Similarly, participants must practice at home the eating and activity habits (and other behaviors) they discuss in group sessions.

Just as tennis players and golfers can improve their playing with coaching and continued practice, participants in Look AHEAD should use the second 6 months of the program to further develop their weight control skills. They can experiment with new ways of ensuring that they practice four cardinal behaviors: 1) exercising > 175 minutes or more a week; 2) a eating a low-fat, low-calorie diet; 3) recording their food intake and physical activity; 4) and weighing themselves (at home) weekly or more frequently. These behaviors seem so simple and, yet, are so hard for most participants to practice long term. This is a central goal for months 7-12 of the lifestyle intervention -- to help participants adopt these four behaviors, as well as to continue efforts to modify negative thoughts associated with dietary and exercise lapses.

**Additional content.** The Weight Loss Intervention Subcommittee wants Lifestyle Counselors to cover the materials in this manual in the manner they are presented. The subcommittee believes that this will ensure the best outcome for the majority of participants.
Lifestyle counselors, however, must always rely on their professional judgment and skills to decide when they should modify their presentation of the treatment materials in order to address the needs of a particular group session. This might include discussing some topics in the manual only briefly or, as noted previously, introducing some new supplemental materials. For example, additional materials on eating a low-fat diet could be distributed, as could recent articles (from newspaper, magazines or journals) on a relevant topic, such as the health benefits of exercise or suggestions to reduce stress through meditation or time management. Such materials should supplement rather than replace the materials in the manual. The Lifestyle Counselors Manual should never handcuff your efforts to lead effective group sessions. But, it also should not be disregarded in favor of each of the study’s 16 sites choosing to “do their own thing.”

V. Challenges in Leading Groups During Months 7-12

You may find it more challenging to lead group sessions during months 7-12 than during the first 6 months. Several factors, noted previously, may come into play.

- **Reduced patient satisfaction because of slower weight loss or weight loss plateau.** As noted, you must acknowledge and try to “normalize” the reduced rate of weight loss. Expand the focus from weight to the many improvements that participants have experienced in their health, mobility, and quality of life.

- **Group heterogeneity.** Weight loss groups usually enjoy a sense of camaraderie, intimacy, and unity (i.e., homogeneity) during the first several months of treatment. This results from their common goals and achievements (i.e., losing weight and improving health), as well as their adherence to the same treatment regimen. Patients, for example, enjoy discussing how they like the liquid meal
replacements or how they have made them more palatable.

Groups become more heterogeneous during months 7-12. Some participants continue to lose weight, most have reached a plateau, and a few begin to regain lost weight. Similarly, participants follow a variety of dietary regimens during this time; some will continue to replace two meals a day with a liquid supplement while others will consume only table foods. In addition, as a result of participants knowing each other better, they may share more personal aspects of their lives, including problems with finances, family members or work. Some individuals may share more problems with the group than it can really handle. All of these factors can make it harder to find common ground in group.

It sometimes helps to acknowledge how the group has changed and that participants may be consuming different diets or trying to master different skills. This is particularly true when two patients describe very different experiences, one after the other. But try to find common ground by eventually bringing the group’s attention back to the four cardinal behaviors that are the foundation of successful weight control (i.e., exercising > 175 min/week, consuming a low-calorie, low-fat diet, recording eating and activity, and monitoring weight regularly). As discussed previously, also find new non-weight-related activities to re-unite group members in quest of a common goal. Having group members, for example, participate in a 5 K walk may provide a great bonding experience.

- **Lack of novelty.** We have discussed the possibility that participants will complain that group sessions do not provide new ideas or are not as exciting as they were the first 6 months. Use suggestions discussed previously to address
such concerns.

- **Competing pressures and priorities.** Attendance of group sessions typically falls after the first 6 months of treatment. This decline may be attributable to the factors described above, as well as to participants’ reports that they “just can’t find the time” for group because of competing demands.

  Reiterate that regular attendance of group sessions predicts maintenance of weight loss; attending treatment sessions will help participants maintain their improvements in health, mobility, and quality of life. Indicate that you know participants want to be successful. Why wouldn’t they attend group sessions if this will improve their chances of success? Surely they would exchange a couple of hours a week of television (or similar behavior) for maintaining their weight loss.

VI. **Facilitating Treatment Adherence During Months 7-12**

It may help to use analogies to describe the process of losing weight versus maintaining a weight loss. Buying a house is a good one for most participants. In buying a home, most people work hard for several years to save money for the down payment. But the hard work is rewarded by those first weeks and months in their new home. Few things are more exciting or rewarding. Losing weight is similarly gratifying during the first few months.

As every homeowner knows, however, owning a house does not end with the down payment. Every month, you have to pay the mortgage. In addition, you have to make occasional repairs to the roof, plumbing, electrical system, or what ever else needs attention. No one likes paying the mortgage or fixing these other problems. But, we do it because we want to keep our homes.
Attending treatment sessions after the first 6 months is analogous to paying the monthly mortgage. The sessions may not be as exciting or gratifying as those during the first 6 months. But patients need to attend to keep their weight loss. Why would anyone choose to forfeit their weight loss by not attending group sessions?

Put a premium on patients attending treatment sessions regularly. Ask participants to announce to the group in advance if they must miss an upcoming session. Similarly, inquire at group sessions about any unexpected absences and call absent members immediately after group to schedule a make up visit. Place a similar premium on arriving at meetings on time.

**Rewarding attendance and other positive behaviors.** You may want to acknowledge (and reward) participants for attending treatment sessions regularly, adhering to other behavioral aspects of the program, or meeting the study’s weight and physical activity goals. Consider the following options:

**Completing the program:** Provide participants a certificate for completing the first 6 months of the intervention, months 7-12, and all subsequent years. These certificates can be provided to all patients who remain in treatment at a given time, regardless of the extent of their participation, or could be given only to those who meet certain criteria.

**Meeting study goals:** You may also wish to provide certificates to acknowledge that participants have met key study goals. These could include losing first 5% and then 10% of initial weight. Certificates could also be provided at 6-month intervals to celebrate participants’ success in maintaining their weight loss (perhaps within 2 percentage points of their lowest weight loss). A similar set of certificates could be used to acknowledge achievement of activity goals.

**Attending treatment sessions:** Acknowledging and even rewarding attendance of
treatment sessions would appear to be a particularly good investment. During months 7-12, for example, you could provide a $25 gift card (redeemable at a book store, video club, or department store) for participants who attended all individual and group sessions. Individuals who missed only one session might receive a $20 certificate and those who missed only two sessions a $10 or $15 award. Attendance is a good behavior to reward because participants potentially have more control over it than they do their weight. Gift cards could also be provided for meeting and maintaining study goals, as described above.

**Acknowledging positive behaviors.** Funds to purchase gift cards and similar prizes are available from the toolbox. It is just as important to acknowledge and support successful participants as it is to assist those who are struggling. During months 7-12, group sessions may increasingly focus on persons who need help in overcoming dietary lapses or in finding the motivation to exercise regularly. While you want to support these individuals, you do not want to let their problems dominate every group session or overshadow the significant efforts of participants who are doing well, as a result of faithfully adhering to the program. Make sure that you celebrate the successful participants, as well as support those who struggle.

VII. **Patient and Provider Experiences: Mirror Images During Months 7-12**

Patients’ and lifestyle counselors’ experiences often parallel each other during months 7 to 12. Knowing this in advance should help you remain maximally supportive and effective. Two important parallels include:

**Enjoying the program.** As noted previously, participants usually enjoy the first 6 months of treatment. Steady weight loss and improvements in health keep them motivated and happy. Working with patients is similarly gratifying for lifestyle counselors during this time. It’s great to see them succeed and feel that you have contributed to their progress.
As discussed earlier, the reduced rate of weight loss after the first 6 months can be disappointing for participants; those who gain weight become discouraged. Lifestyle counselors’ emotional reactions can mirror participants. It is hard to see patients struggle with their weight or physical activity and tougher yet when you seem unable to help them from one session to the next. Both participants and lifestyle counselors can doubt their abilities at such times.

**Working just as hard.** Obese individuals frequently remark that maintaining their weight loss takes just as much effort, if not more, than losing weight. To lose weight, for example, it is not essential to exercise; dieting is far more effective in the short-term. But to maintain a weight loss, participants almost certainly have to exercise and for at least 175 minutes a week. Similarly, patients must continue to watch their calorie intake; a few slips and it feels like the pounds come back over night. Thus, participants must work hard, not to lose more weight, but just to keep it off. The rewards of maintaining a weight loss (i.e., seeing no change on the scale), pale in comparison to those for losing weight (i.e., seeing the scale go down, having clothes fit better, receiving compliments from friends).

Lifestyle counselors have to work just as hard, and usually harder, during the second six months of the program, than during the first six. This is a direct consequence of the greater challenges that patients experience during this time. As they struggle with their weight, so you will sometimes struggle to find ways to help them.

**VIII. The Care and Feeding of Lifestyle Counselors**

We recommend that you keep the following thoughts in mind during months 7-12 to ensure that you provide the best possible care for your participants. As you’ll see, taking care of yourself will help ensure that participants receive your best care.

**Protect patients’ self-esteem.** As discussed earlier, during month 7-12 some participants
will gain weight or stop keeping their food and activity records. Most will be upset with themselves at such times, but others may appear indifferent or even light hearted. The latter individuals are often frustrating to work with because they don’t seem to care or to try to help themselves. Even individuals who do try, however, can be frustrating when they are unsuccessful, despite their and your repeated best efforts.

Be careful not to express your possible frustration by criticizing participants, either directly or indirectly. Criticism rarely produces weight loss. Instead, it is more likely to hurt patients’ feelings and make them feel that you don’t believe them or like them.

When you are feeling frustrated that patients are not progressing, remember three points.

1. The participants are far more frustrated than you are; they look to you for support at such times.

2. The fact that participants periodically struggle with their eating, physical activity, or weight is not a reflection of your professional competence or a challenge to your authority. Don’t take it personally when participants fail to adhere to the extensive diet or exercise regimen that you devised in your last individual meeting.

3. Protect patients’ self-esteem, particularly when they are having difficulty. Participants will long remember and appreciate that you treated them respectfully and compassionately. Too often obese individuals have been criticized or insulted by a society that worships thinness and dislikes fat.

Meet with colleagues regularly. Plan to meet weekly with members of the lifestyle intervention team to discuss both the implementation of the treatment protocol and participants’ progress during months 7-12. Team meetings are increasingly important in later months. Use them to review all participants’ progress. Celebrate those who are successfully exercising,
adhering to their diet plan, and maintaining their weight loss. Try to identify the factors that are contributing to their success.

With individuals who are gaining weight or having other difficulties, take turns presenting these individuals, at length, to the team. Spend 15 minutes or more discussing the individual’s prior weight loss and exercise histories, family or work difficulties, adherence to the program goals, and specific barriers. Try to get a picture of the whole person, beyond his or her eating and activity habits. Describe the interventions that you have tried with the participant. Then invite the team members to share their thoughts about the patient and any suggestions for intervening in a new manner. It is remarkable how colleagues, who have more distance from the participant than you, can often see matters in a different light and offer simple but helpful suggestions.

Team meetings, as well as one-to-one meetings with colleagues, are also a good time to share your feelings about some of your participants or about your work. This is the time to discuss feelings of frustration with a patient who does appear to be trying or feelings of disappointment or sadness for individuals who are having tough times in their personal lives. This is also a good time to discuss any unusual occurrences in group, such as patients coming late, not attending, or not completing homework assignments. Talk these feelings and issues through with your colleagues so that you don’t inadvertently unload them on participants.

Read the literature. Reading the scientific literature on weight control can help you keep your own work with participants in perspective. Just as it’s important for patients to have realistic expectations about how much weight they can lose, it’s important for you to have reasonable goals for your work. How do you judge if you are doing an excellent job or just an ok job? This evaluation is usually based on several factors including your reliability in seeing
patients, recording in the Tracking system, and attending staff meetings, as well as the strength of your rapport with patients (which keeps them in the study).

You may also use participants’ weight losses as another indicator of how you are doing. Here is where it may be helpful to know how your long-term results compare with those of the “experts,” who have published studies in this area. You may want to start by reading the results of the Diabetes Prevention Program (New England Journal of Medicine 2002;346:393-403) which used an intervention similar to that being used in Look AHEAD. Much of the literature suggests that long-term weight loss is hard to achieve (e.g., Wadden & Foster, Medical Clinics of North America 2000;84:441-461), although findings of the National Weight Control Registry indicate that participants can be successful if they practice the four cardinal behaviors described previously (Wing & Hill, Annual Review of Nutrition 2001;21:323-341). Read the literature to put your own work in perspective, as well as to find inspiration and new ideas.

IX. Working with Your Lifestyle Resource Core

You also have a very valuable aid in your Lifestyle Resource Core (LRC). Use the monthly phone calls to share success stories, as well as to garner suggestions for helping participants. In addition, provide your LRC leader feedback about months 7-12 of the Lifestyle Counselors’ Manual. The Weight Loss Intervention Subcommittee welcomes your comments and will undoubtedly amend this manual in response to feedback that we receive. Please also share with your LRC leader any supplemental materials that you or members of your intervention team develop. We would like to review all materials to determine if they should be shared with all of the sites.

We wish you every success in working with your participants and look forward to our continued collaboration on their behalf. Good luck and best wishes!