# AASAP

**Handout developed by Larry Fisher**

## RATIONALE

A. Cognitions (beliefs) drive behavior. This means that how you think about things, what your expectations and understandings are and what your understanding and explanations of what has happened to you in the past drive what you will do in the future.

B. Affect or feelings drive behavior: Cognitions are accompanied by feelings or affect – and affect is accompanied by cognitions. They operate together so it is hard to figure out which comes first. Feelings can cue beliefs and beliefs can cue feelings.

C. Most patients with diabetes have definitive cognitions and feelings about weight, about what caused their diabetes, about their ability to control their diabetes, about their confidence that they can follow through, etc. ,although they may not be able to state them explicitly. For example, many people feel they caused their own diabetes and they feel guilty about it. Many patients believe that their diabetes will be driven by fate and that they cannot make a dent in the progression. Other patients believe that they are not "strong" enough to make the required changes, that they are weak, that they have no self-control around these issues. Others feel that they can conquer their diabetes and bring it into full control if they work hard enough. These cognitions are often coupled with hopelessness, feeling overwhelmed, having low self-esteem, feeling useless and wasteful. Past failures reinforce these cognitions, and, hence, reinforce these feelings. The combination of painful cognitions and feelings lead to diabetes distress.

D. Ambivalence (a personal internal conflict): The result of this experience is the development of considerable amounts of ambivalence. Most people experience different degrees of ambivalence when they approach difficult tasks. The ambivalence is cued by past experience, expectations and feelings. Example: I would like to go to medical school to get an MD on the one hand but on the other, the cost in terms of dollars and energy will be high. I would really like to win the 100 yard dash, but the training required and my fear of losing (self-esteem) creates a dilemma.

E. The result of ambivalence is often displayed as a clouded resistance that is based on both cognitions and affect. The resistance is often camouflaged:

    i. The patient may not be fully aware of the ambivalence.

ii. The patient may not have the language to describe the conflicted experience.
iii. The patient may unconsciously avoid the ambivalence through other excuses that may or may not make sense (I want to do better with my DM, but I fear another failure – so I will get so busy that time will prevent me from doing anything. The ambivalence is not resolved, the behavior just removes the patient from the dilemma.)

**AASAP PROTOCOL**

AASAP is a simple program to help deal with diabetes distress encountered in a program, to enhance performance and to reduce drop-out. AASAP means the following:

**AA = Anticipate & Acknowledge** – this refers to anticipating (expecting) for and then acknowledging/labeling the presence of distress, which can take any number of forms (e.g., discouraged, burdened, overwhelmed, guilty, hopeless, weak, what's the use). It can also be displayed as resistance with no affective overtones (e.g., I am too busy now; my schedule has changed; I am not a computer person; I do not think this will work for me. Many people who are distressed hint at it, but they never put it into words. The first step in dealing with distress is to acknowledge that distress exists and then to define it more clearly and specifically. People feel distress in different ways. Labeling what they may be feeling, reflecting it and having them further describe the experience can be very helpful in providing a language for discussion. Where possible, repeat the words the patient uses and then expand on them.

Sounds like you are feeling ….
That must make you feel ….
You must have felt (reacted) ….
This must have left you feeling ….
How would you describe these feelings?
What other feelings occur?

Once you have identified and been able to label the feeling, the second step is to "harness the ambivalence." Derived from Motivational Interviewing, this is a way of summarizing what is going on by pointing out both of their motivations. It also acknowledges and respects those motivations that pull them away from the program. It is important to acknowledge both sets of motivations and not try to focus only on one set. This theme of ambivalence is crucial to address repeatedly whenever you can, using their language.

So on the one hand you feel that … and on the other hand you feel that …
Example: So on the one hand you really would like to improve your diet (diabetes, etc.), but on the other hand you are afraid that the program won't work for you; you are too overwhelmed with things to make it

work; you feel that you just won't be able to do it; you fear that you might fail again, etc.

**S = Standardize It** – this refers to normalizing the feeling. Many people feel that they are alone and that the distress they feel around their inability to achieve goals is unique to them. This makes them feel even worse. Standardizing their feelings simply means informing patients that most people with diabetes feel this way some times, and that their feelings are not unusual.

Many people with diabetes feel this way ….
This is a very typical reaction to when you start trying to change ….
What you are feeling is very common, I see this in many people I work with.
Does this surprise you? Is this unexpected?
Use self-disclosure – Many people feel this way; I remember when I …

Then standardize the ambivalence as well by normalizing the desire to improve with the road blocks that prevent it from happening:

Example: Most people with diabetes feel this way; they very much want to improve their diabetes, but they often feel that …

*The first three steps of AASAP (Anticipate, Acknowledge, Standardize) form the basics of the program and are used most frequently during clinical encounters and as a part of other aspects of a diabetes care program. The remaining steps are used with patients having particularly difficult problems with distress that require further attention. However, we often include these steps in our diabetes education programs to provide new tools for patients to consider.*

**A = Accept & Understand It** – this refers to two activities that are tied together.

UNDERSTAND IT: First, it is often helpful for patients to understand where the distress comes from, what it is about, and what effect it can have on them and their program of change.

Where it comes from and what it is about: Distress can be seen as an emotional reaction to the struggle that many people experience when they try to change behavior, especially when they have been unsuccessful in the past. Although they may be optimistic initially, in many instances, the old feelings of distress return once they begin the process of change in earnest. Or new kinds of distress emerge when the unsuccessful behaviors occur again. This is hard work and distress also emerges when they do not reach the goals they thought they would reach, when it is harder than they expected, when they cannot seem to get going, when they suffer a set-back, or when the scale or glucose levels do not change as they had hoped. It is a natural reaction! Getting them to respond to the questions below often enables them to gain perspective on what is occurring.

Have you ever felt this way before around your diabetes?
Where do you think these feelings come from?
Why do you think these feelings are happening now?
(For patients who rarely use emotion words or who seem hesitant to verbalize, you might want to give them some alternative examples, e.g., Some people tell us that …)

Helping them to answer these question (*or, better yet, prompting them to answer them themselves*) places these feelings in perspective, makes them think about them rather than just react to them, and it allows them to have a conversation with you about them with language that labels and identifies them more clearly.

What it can do: *In our program, how you feel is as important as what you do!* This means that we want them to be as aware of their feelings as they are of their behavior. Being aware of distress is very important because distress can stop you from achieving goals. Distressed people often feel demoralized, become hopeless and then give up. Attending to or being aware of distress can prevent this from happening. So to be as successful as possible, we need to attend to distress – and not dismiss it. The following statements focus on these effects in an explanatory way. *The goal is for the patient to "get it," to see that these feelings can be destructive for behavioral change and that they are important to include in their behavioral change program. Harness ambivalence here as well as in your discussion by simply pointing out both sides of the motivation.*

What effect do these feeling have on you?
How do you tend to react to these feelings? What tends to happen next?
So there seems to be a sequence here: first this happens, then this, then this, then you feel distressed and want to quit!

ACCEPT IT (reframe it): This refers to viewing distress as something to be expected, as part of the process, not just as a repeat of the old reactions that are so destructive. It comes with the territory! Rather than fighting it, dismissing it, or ignoring it, we suggest that they simply accept it and use the tools of the program to deal with it, as they use the tools to deal with behavioral change. Just because they feel distressed does not mean that they have to respond to it in ways that are harmful to behavioral change. Distress, then, becomes something to be aware of, to understand and to attend to as another goal. This might mean rewarding themselves for smaller achievements, stepping back and seeing where all of this comes from, understanding and placing distress in perspective, using the coach and the phone calls to gain some perspective on the process. The goal here is to accept it – not to fight it, to react to it blindly, or to discount it as if it is not important.

It sounds like even though you really want to make these changes, we also will have to consider how you feel ….

These feelings are important and very real. No sense trying to ignore them.

I guess that trying to make these feelings go away does not work. What else can you do?

So it seems that you can feel this distressed AND still continue in the program, once the feeling makes sense.

I guess that these feelings are a natural reaction to working on something that is hard to do (reframe).

What else can you do to manage them?

**P = PLAN** – This refers, in part, to what was mentioned above – to incorporate distress as part of the plan for behavioral change (e.g., create smaller goals, reward self). Or it may mean developing a plan on how to react to distress if it should come about – For example, one patient began to realize that he would get discouraged every time he planned to exercise, and this blocked his going for a walk. So we used PST to address the distress. Using anticipatory problem solving, he watched for the distress as he prepared for exercise (putting his walking shoes on), and if it occurred (which it often did), he decided that he would look in the mirror and smile to himself. This made him aware of how perceptive he was, that he realized what was happening and that the distress was simply a part of the change program. This re-defined what the distress was, reframed it as something real and manageable, **about which he had control**; and he was free to move ahead as he wished. He called the experience "freeing."

## EXAMPLES OF AASAP INTERVENTIONS

PHONE CONTACT:

- I'm so glad that you have decided to attend our program.
- I know how much you would really like to improve your diabetes management, but I also understand how hard it can be to make some of these changes.
- Sometimes even though people really want to start our program and are very enthusiastic, they often feel later that our program might just be too difficult and overwhelming, that life is too busy, or that it will be hard to find the time to follow through.
- Many people feel this way, so you are not alone. However it's important to be aware that you may feel this way and not be surprised if you do.
- How you feel is an important part of our program. If you start to have these feelings, please let us know. This is to be expected and we can help.

FOLLOW-UP PLANNING: At the end of a session or education program when they have much homework.

*First:* Emphasize that they may be feeling: a need for more personal contact (help) from you (phone calls), a need for more behavioral prompting to go onto the next step, or feeling overwhelmed because some of the work is hard and takes time and planning.

"Many people feel that…" "You may be feeling that…" "Between now and when I call you next, you may feel that…" E.g., "You may feel like you would like more phone calls"…"You may be feeling like this is a lot to do"….

*Second:* Normalize the feeling, inform them that they might expect these feelings even if they do not feel them now. "Many people feel this way, **expect that this may happen"**

*Third:* Then try to work out a plan if they do feel these things (anticipatory problem solving):

a. How to prompt yourself with reminders to monitor or track.
b. What to do if they you overwhelmed behavior change.
c. What to do if they would like more calls from you??? (support?).

If you anticipate this might be a problem, ask them for some options to short-circuit the problem. This third part may not be needed for everyone.

DEALING WITH AMBIVALENCE

1. Emphasize and acknowledge their ambivalence: "I can tell from your voice that you are interested, but you are not sure that this will work for you."

2. Acknowledge their lack of energy for this, not sure it is worth it, can tell that they feel gloomy about this. Very hesitant, Somewhat committed but not sure - thinking about a way to get out of this.

3. Not really sure that this will work, that it is worth the price, burden, effort, no confidence that this will work. May not be worth a try. Makes sense, given their past experience.

4. Start will very small steps, praise achievements, keep in perspective.

5. Do not try and talk them into it! "This might not be helpful anyway." "Maybe you should stop and re-consider this."

6. NORMALIZE!!