Chapter 5
The CTNA Feedback Session

This chapter will illustrate the process and structure of a CTNA feedback session. The first section will discuss the overarching conceptual framework on which a feedback session is based. The subsequent sections will describe the methods for conducting a CTNA feedback session.

CTNA Feedback Conceptual Basis

In order to conduct a CTNA feedback session, a clinician must understand the CTNA conceptual basis. As reviewed in the background literature, CTNA is based on three primary approaches. The first is therapeutic/individual models of psychological assessment, primarily from the work of Dr. Constance Fischer and Dr. Stephen Finn. Second are recommendations from authors on the provision of neuropsychological test feedback. Third, the principles of Motivational Interviewing (MI) as reflected in the personalized feedback report and the format for providing information, which is termed "Elicit–Provide–Elicit."

Therapeutic/Individualized Models of Psychological Assessment

The primary components of these models that form the basis for CTNA are that psychological assessment and feedback are (1) a collaboration between tester and examinee, (2) open and flexible with a mutual sharing of information, (3) consider patient opinions about the nature of testing results, (4) view testing results in the context of the patient's life, and (5) see the test results as a "snapshot" of the patient's life and general functioning, and that test results are tools that are used to help understand a patient holistically.

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Neuropsychological Test Feedback Recommendations

The next component of the model includes recommendations from authors for giving neuropsychological test feedback that is applicable, useful, and relevant to patients (Armengol et al., 2001; Gass & Brown, 1992; Pope, 1992). These include the following principles: (1) the purpose of neuropsychological testing and the results should be reviewed in plain, simple language understandable to the patient, (2) test results are examples of functioning and behavior that may contribute to understanding other life areas, (3) results are termed as strengths or weaknesses compared to available standard norms, and (4) test results can help develop useful and applicable treatment plans that consider the domains of functioning assessed.

Motivational Interviewing Principles (Miller and Rollnick, 2002)

The final component includes specific methods from MI. The first is the framework for providing feedback termed "Elicit–Provide–Elicit". Second, MI describes specific verbal skills for interacting with patients in a patient-centered and directive manner, termed OARS (*open-ended questions, affirmations, reflections, and summarizations*). Third, MI provides specific recommendations for dealing with resistance and includes various directive and nondirective strategies all designed to "roll with resistance." We will elaborate on these concepts in greater depth.

MI is a patient-centered and directive form of counseling designed to enhance patient's internal motivation to make changes in problematic behaviors. Originally developed to treat patients with alcoholism, MI represented a paradigm shift from the traditional "confrontation of denial of approach." In this approach, patients with alcoholism are assumed to be in denial about the effects of alcoholism on their lives. Therefore, a counselor's job is to "break the denial" through highly challenging and sometimes harsh methods of making patients see the reality of their situation. MI philosophy states that this is unnecessary to enact the change process and that the goal is to lower patient resistance through nondirective strategies, and it identifies patient's ambivalence about making changes. Once the ambivalence, or the conflict, about making change is identified, the counselor uses any number of techniques to help the patient resolve the ambivalence and move toward making important and necessary changes. One method used in MI is the provision of objective feedback from various psychosocial measures. MI authors have developed an explicit and concrete conceptual framework for providing feedback in a patient-centered manner. These principles are highly consistent with previous authors' ideas of ways to use psychological test feedback. This section will provide a brief overview of MI principles including methods for providing objective feedback. This will include a brief literature review of the evidence of efficacy for the

provision of feedback in an MI style. Most of the information will be based on the groundbreaking work of Dr. William Miller and Dr. Stephen Rollnick (Miller & Rollnick, 1991, 2002).

MI is a brief intervention designed to enhance treatment adherence in patients with various health or mental health problems. MI was developed to enhance treatment adherence in patients with alcoholism but over the last 15 years has shown to be effective in enhancing patients' motivation to change drug use, health behaviors such as following diabetic regimens, improving medication compliance, and others (Miller & Rollnick, 1991, 2002; Hettema, Steele, & Miller, 2005; Resnicow et al., 2002).

MI is more a method of dialogue than a theory, and the mechanisms of action are not well understood; however, it is based on well-established theoretical principles (Hettema et al., 2005). MI is heavily based on Carl Rogers' necessary and sufficient conditions for establishing a therapeutic relationship; empathy, congruence, and respect (Rogers, 1951). Empathy and reflective listening are the heart of MI, where the goal is to understand the patient's point of view regarding a problematic behavior they are trying to change. Empathy and respect by the clinician are hypothesized to lower a patient's resistance to making changes and allows for the exploration of ambivalence (Miller & Rollnick, 1991, 2002; Moyers & Rollnick, 2002). MI principles suggest that most patients are ambivalent about making changes in their behavior, as opposed to being completely resistant or completely ready to make changes. Exploring and resolving ambivalence is a key goal in MI. The exploration and resolving of ambivalence has roots in Festinger's Cognitive Dissonance Theory and Bem's Self-Perception Theory (Bem, 1967; Festinger, 1957). One of the MI principles is to develop a discrepancy between a patient's behavior and their personal goals or values. The patient will then become uncomfortable and begin to take steps toward resolving the discrepancy, which is hypothesized to move in the direction of growth and change. Finally, MI is associated with the "stages of change" conceptual framework, which posits that patients change problematic behavior through a sequence of stages. These stages are precontemplation (change is not considered), contemplation (change is considered), preparation (a commitment to change is made), action (change is enacted), maintenance, and relapse prevention where ongoing change is fostered (Miller & Rollnick, 1991, 2002; Prochaska, DiClemente, & Norcross, 1992).

MI's conceptual basis can be summarized in four principles: (1) a counselor expresses *empathy* for a patient, which creates an atmosphere of safety and promotes self-focus and disclosure; (2) a counselor *develops discrepancy* between the patient's behavior and important goals or values; (3) a counselor avoids argumentation and *rolls with resistance* versus imposing change strategies; and (4) a counselor supports a patient's *self-efficacy* to resolve problems (Miller & Rollnick, 1991, 2002). MI is a humanistic/phenomenological

intervention because the clinician works to enter the patient's individual world before making any attempts to enact change strategies.

MI shares methods identified as effective in other brief therapies. These methods are captured in the acronym FRAMES. Patient's receive personalized *F*eedback from objective measures in order to gain insight and awareness; clinicians emphasize a patient's personal *R*esponsibility in making changes in their lives; clinicians may offer *A*dvice on ways patients can begin to make changes; advice may be given as a *M*enu of alternatives for making behavioral changes; a clinician is always *E*mpathizing with a patient's perspective; and finally, clinicians seek to enhance a patients *S*elf-efficacy in their ability to make changes(Miller & Rollnick, 1991/2002).

The Feedback Process in MI

The provision of objective feedback is one method used in MI to enhance problem recognition. The most common use of feedback is the personalized feedback report. The feedback report gives patients information about their severity of substance use, general functional abilities, DSM-IV diagnoses, frequency of drinking and other drug use compared to national norms, and occasionally, the results from very brief neuropsychological tests (Miller et al., 1992). In MI, feedback is given in an objective, nonjudgmental manner that is designed to enhance the therapeutic dialogue. The conceptual framework for providing feedback, information, and advice is termed, "Elicit–Provide–Elicit." A clinician *elicits* a patient's commitment to engage in the feedback process and asks permission to provide the patient information that may be useful to them. Upon receiving the patient's agreement, the clinician *provides* information that is related to the patient's concerns and is designed to facilitate the change process. This information may include results from objective feedback reports and assessment results. After providing the information, the clinician *elicits* a patient's reaction to hearing the information. The clinician then responds to the patient's reactions with reflective listening, affirmations, summarizations of the patient's statements, and open-ended questions to encourage elaborations. If patients disagree with the results, become angry, or question the feedback validity, the clinician does not become defensive or try to justify the results. In MI, clinicians "role with resistance," which means they meet resistance with understanding, empathy and open-ended and evocative questions designed to clarify the nature of the resistance. The belief is that by lowering resistance through nondirective methods, patients become more open to exploration of ambivalence and begin to experience a discrepancy between their behavior and their goals and values. The clinician's goal is then to help patients work through and resolve ambivalence and move through the stages of change to enhance motivation to change a problematic behavior (Miller & Rollnick, 1991, 2002).

Evidence for the Effectiveness of Brief Feedback

There is evidence that brief feedback is effective in enhancing outcomes. A review of 13 studies examining the use of feedback as an alcohol intervention for college students concluded that feedback has modest support in the literature for changing drinking behavior (Walters & Neighbors, 2005). Feedback was hypothesized to be effective because college students learned how their behavior compared to similar norm groups. The most common feedback mechanism is the drinker's checkup, where patients are given objective feedback about their risk of developing alcohol-related problems (Hester, Squires, & Delaney, 2005; Miller, Sovereign, & Krege, 1988). Most studies using objective feedback delivered in the style of MI have shown good outcomes for reducing alcohol-related risk factors, improving treatment compliance, and making changes in health habits (Barrowclough et al., 2001; Bien, Miller, & Boroughs, 1993; Carroll, Libby, Sheehan, & Hyland, 2001; Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998; Martino, Carroll, O'Malley, & Rounsaville, 2000; Miller, Benefield, & Tonigan, 1993; Stotts, Schmitz, Rhoades, & Grabowski, 2001; Swanson, Pantalon, & Cohen, 1999). A limitation of these studies is that it is difficult to discern whether the effect is from the feedback or from the MI style of delivery. A common practice is to adapt the personalized feedback report in order to meet the needs of the patient population being studied. Variables incorporated into feedback reports may include information about substance use frequencies, motivation, psychiatric symptoms, medical factors, and others (Martino et al., 2000; Miller et al., 1993; Stotts et al., 2001). In studies conducted in Addiction Medicine Services at Western Psychiatric Institute and Clinic, feedback forms were adapted for dual-disorder patients based on diagnostic symptoms; scores from a measure of functional behavior called the Addiction Severity Index; scores from the Drinker Inventory of Consequences (DRINC), which measures various psychosocial and interpersonal consequences from substance use; and comparisons of drinking frequencies to national norms. Occasionally, psychological measures of personality or cognitive functioning may be used, but these are not primary feedback tools in MI.

In summary, MI principles for the provision of patient-centered, objective feedback share many concepts with other author's previous ideas on ways to provide information from the results of psychological and neuropsychological tests. Miller and Rollnick have elucidated a process for providing patient-centered feedback with a clear and concrete method. The strength of this approach is that different types of information can be nested within the feedback method. A personalized feedback report can be modified to meet the needs of the examiner or the patient.

These three primary components comprise the conceptual basis for the CTNA feedback session. The most important notion is that the clinician and patient are working together to understand the patient's functioning from a holistic perspective. Rather than just relaying test scores and performance, the

clinician's task is to help patients make sense of their difficulties by offering them a "snapshot" of their cognitive and behavioral functioning. Conversely, the patient's job is to help the clinician make sense of the test scores in the context of the patient's real world.

The Format of a CTNA Feedback Session

Step 1: Setting the Agenda and Introducing the Feedback Report

The first step in the CTNA feedback session is to outline the goals and structure of the feedback session to set the agenda or develop the contract with the patient. Developing the contract is important so that the session is a democratic process that does not flounder and become unstructured. A democratic process is one where there is circumscribed freedom of therapeutic dialogue. This means that the overarching framework is one where the patient will receive information from the results of the tests, but within that framework, the patient is free to comment on, question, and agree or disagree with results. In addition, the patient is free to comment on how they see the results applying to their life and functioning and to develop their own ideas as to how they would like to use the test results. In order to develop the "spirit" of this framework, the CTNA clinician may want to open the session with the following statement:

"I want to thank you for your willingness to attend this session and with your permission I'd like to begin by giving you an idea how the session will progress, would that be all right with you? [*Patient gives permission*]. I will give you the results from the tests you took previously. However, this session will not just be me giving you information; I hope it will be a dialogue between the two of us. I will be going over what is called a personal feedback report. This report includes your scores on each of the tests that you took and whether the skill that test assesses is a strength or weakness for you. I will review each test with you and make sure that you understand what the results mean. I want you to feel free to ask questions, make comments, agree or disagree with results. But what is most important is that we work together to find out how these results apply to your life and to any problems you might be experiencing related to the issues you presented with. In doing so I hope we can use these results to develop plans and goals for helping you improve life areas that you are concerned about. How does all that sound to you?"

The clinician should then invite the patient to ask any questions or make any comments. The clinician should answer any questions directly and clarify any misconceptions about what the test results will show or how the session will progress. Experience suggests that many patients find neuropsychological assessments interesting and challenging and are highly inquisitive about their performance. However, there may be performance anxieties as patients are often concerned about their cognitive abilities. They may have noticed difficulties with memory, attention, concentration, or other skills. Thus, it is a good

idea to spend a few minutes providing empathy and support and clarifying any misconceptions or concerns patients have about receiving personal feedback about their cognitive abilities.

Check-In

Before beginning the actual feedback process, it is often helpful to provide a check-in to assess how the patient's life has been since the initial assessment. It is important to note any changes, new developments, setbacks, or successes. In addition to developing rapport, this helps to gain information that may lead to modifications of the test interpretations.

As part of the check-in, it may be helpful to remind the patient of the CCEC as a means of organizing the information to be discussed. An example of a reminding statement may be as follows:

Clinician: "Now as I understood during our previous meeting(s), it seems that the main reason you came for this evaluation was because you want to go back to college (W), but feel as though there has always been a reason that completing work on time has been so difficult (CR). This difficulty has been really frustrating for you over the years and has even left you feeling down on yourself (ER). You hope that this evaluation could help you answer some questions about yourself such as whether or not you have a learning disability, ADHD, or some other problem that causes you to feel as though you work slowly compared to others. Is all that about right?"

Following a process of patient reactions, the clinician will provide the patient a copy of the feedback report and orient the patient to the paperwork.

A discussion of patient questions or concerns about the feedback process easily flows into an explanation of the purpose for providing neuropsychological test feedback. Patients often have misconceptions about what it means to receive cognitive test feedback. Examples of patient misconceptions include the following:

- "You're going to tell me if I have brain damage."
- "You're going to tell me if I have Alzheimer's."
- "You're going to tell me if I'm crazy."
- "You're going to tell me how to solve Brian's problems."

The clinician will clarify for the patient that the purpose of the report is to provide the following: (1) an assessment of cognitive strengths and weaknesses; (2) the relationship between the tests results, the skills assessed, daily life problems, and behaviors that are of concern; and (3) ways to use the test results to develop more applicable and realistic treatment goals that address life areas of concern to the patient.

Next, the clinician will ask the patient about their recollection of taking the neuropsychological assessment and what general reactions they had. Neuropsychological testing is likely to be new for patients, and experience suggests

that they may have reactions to the testing itself. This is because the skills required to complete these tests may relate to patients' functional performance in life areas of concern. As a result, patients may have thoughts and feelings triggered from the test stimulus, and the clinician should provide an opportunity to discuss these reactions. This process is important because patients will-begin to see the feedback session as a collaborative endeavor where the patient and clinician work together to explore what the test results mean for the individual. For example, a patient may initially state that the test results stimulated concerns about their memory. However, through further exploration, it may be that memory concerns are part of a larger concern, which the patient is beginning to notice a significant change between who they used to be and who they are now. This may trigger feelings of sadness and loss. The following scenario demonstrates this.

Clinician: Ok, this part of the report talks about what neuropsychological assessment is. So let me ask you this, you took these yesterday, do you remember taking them yesterday? [Providing information and closed-ended question assessing patient's recollection]

Patient: Yes

Clinician: Tell me, what was it like for you taking all those tests? [Open-ended question]

Patient: It made me see where my thinking is at. It made me think about my memory and some things my memory is good on and some things my memory is not.... I think I have a blockage or something.... 'cause I will go upstairs and I know what I want ... before I get upstairs and I know what I'm going up there to get but when I get there I can't remember.

Clinician: Ok, sounds like you notice you forget things but then you will remember them at some point and it's like they've blocked out of your mind for awhile, or like something keeps them from getting past a certain point .... [Reflective summary]

Patient: Right! Right! Exactly! That's scary.

The patient continued along this discussion by remembering times when they had severe memory lapses that often led to scary and dangerous consequences. The patient became visibly concerned during the session and, as it progressed, became sad because prior to the problematic event, the patient was a competent and mentally sharp professional. The change they saw created a psychological discrepancy in regard to how they would like to be versus how they are. This particular patient was very pleased to be a part of the feedback because they had been concerned about their memory for some time.

At this time, it is important for the clinician to interact with the patient in an MI-consistent manner using *OARS* based on MI principles. This helps the patient feel understood in their perceptions and gently leads them to begin exploring life areas of concern that may provide material for the next section of the feedback form, life implications.

Summary Points for Setting the Agenda and Introducing the Feedback Report

- Develop a "democratic" contract that includes providing cognitive information while creating an atmosphere of openness, acceptance, trust, and warmth in order to facilitate patient self-disclosure. Questions, comments, and inquiries about the tests and results are welcomed and encouraged.
- Discuss and clarify any patient questions or concerns about the feedback process in general.
- Provide a copy of a feedback report.
- Discuss the purpose of the feedback process as providing information about cognitive strengths and weaknesses, relating these areas to important life areas, and developing applicable and realistic treatment goals. Remind the patient of the CCEC as a means for organizing and structuring the feedback process.
- Discuss the patient's recollection of the testing process as a way to personalize the experience and enhance collaboration.
- Always interact with the patient in a person-centered manner using the MI strategies reflected in the acronym OARS.

Summary of the MI Verbal Skills "OARS" (Miller & Rollnick, 1991, 2002)

Open-ended question: Any question that requires elaboration versus one that can be answered with "yes" or "no."

Example: "Tell me about your medical history." *versus* "Do you have any medical problems?"

Affirmation: Affirming a patient's efforts at changing or understanding the need for change.

Example: "I really appreciate how you're struggling to understand this with me."

Reflection: An expression of empathy for something the patient said.

Example: "You're feeling angry because of the loss of your cognitive abilities."

Summary: A clinician's summarization of main points discussed in a session.

Example: "So what I've heard so far is that you've noticed a change in your ability to remember things; this has created quite a bit of distress for you and your family and as a result you're feeling like your role has changed completely, and this frightens you."

Step 2: Develop Life Implications Questions

In order to make the feedback report as useful as possible, patients provide specific questions they hope the test results will answer for them. Initial questions patients have are likely to be rather vague and nonspecific. Therefore, it helps the clinician to use MI skills in order to reflect, question, and elaborate on patient concerns so that the true nature of the question is brought about. An example of a vague concern a patient had was the following:

"Why do I keep relapsing into drug use?"

Through guidance and exploration, asking open-ended questions, and reflecting important themes and feelings, the clinician was able to develop a more specific question that the test results may be able to answer.

"Why am I not able to stay focused and organize my thoughts, which have led me to begin slipping in my recovery plan and eventually lead to relapse?"

Experience suggests that it is best to limit the life implications section to two or three well-developed questions. Too many questions are unlikely to be addressed in a 1-hour feedback report. It is also important to remind patients that test results are not guaranteed to answer all their questions. It may be that different types of tests, such as personality assessments, are more appropriate for some of their questions. However, experience suggests that the neuropsychological tests can provide guidance and direction to many questions patients have and in many cases provide concrete answers to specific concerns. For example, a patient in her mid-40s had concerns that she may have brain damage or early Alzheimer's disease as a result of her drug and alcohol usage. She had been abstinent for many months, but her memory did not seem to be improving. In a review of her test results, she scored in the high average and in some cases superior range on most tests of memory, but was in the low-average range on many tests of attention, concentration, and working memory. When the patient was given this feedback, and asked how it may have applied to her daily life, she began disclosing her frustrations with getting her life back together in early recovery. Although she felt better being clean and sober, she admitted that many areas of her life needed attention, including family, work, daily household tasks, in addition to debt she had accrued. She tried to go about life like everything was in order, but in reality, her mind was constantly racing with all these responsibilities, and she felt overwhelmed, disorganized, and unfocused. She had been afraid to tell anyone of her struggles because she was afraid they would just tell her to be patient and take one day at a time or that they might think she was on the verge of relapse if she told them how overwhelmed and depressed she felt.

After spending time listening to her thoughts and concerns and providing empathic support, the clinician asked permission to offer the patient some thoughts. The patient emphatically said "yes" and that any suggestions would be appreciated. The clinician suggested that, in fact, her memory is quite good but that her ability to attend to, organize, and carry out all the multiple, competing tasks has become overwhelming for her. As a result, she feels depressed, stressed, and inadequate, which further compromises her ability to attend to and organize all the many difficult and competing demands in her life. Although her drug use may have compromised some of these skills, it appears as though her depression and stress are more pronounced and have a greater affect on her.

The patient agreed with this and began to say how she has tried to ignore her depression and stress because she thought it meant she was weak and not following a good recovery program. After further discussion and exploration, the clinician and patient agreed on a change plan that consisted of (1) using cognitive–behavioral strategies to organize and prioritize her multiple competing demands while challenging negative thoughts about her competency and

self-worth; (2) working on reducing her stress and depression by taking time for herself; (3) considering a medication regimen; and (4) working more closely with her primary clinician on these particular issues and reducing the shame associated with them.

This is an example of how neuropsychological tests and feedback can provide a bridge between cognitive and emotional issues while potentially answering salient life concerns.

The introduction to the feedback report is not merely a quick description of the feedback in order to lead in to the rest of the report. The introduction phase begins the development of a collaborative relationship where the clinician and the patient are working together to discover what the neuropsychological test results mean to the individual. By the end of the introductory session, the clinician will have elicited from the patient what life areas are of most concern for them and how the cognitive test results can potentially answer important questions that patients have about their lives and their ability to function.

Summary Points for Developing Life Implications Questions

- Use clinical skills to develop questions into well-developed and specific questions that provide guidance for the CTNA feedback session.
- Limit the number of questions to two or three. Too few questions are likely to leave the patient feeling unfinished. Too many questions are unlikely to be addressed and also may leave the patient feeling unfinished.
- Acknowledge the strengths and limitations of testing by helping patients understand that not all questions can be answered by neuropsychological tests.
- Consistently interact with the patient in a person-centered manner, using OARS to reflect and clarify the nature of patient questions and concerns.

Step 3: Determining a Personal Skill Profile

In the next phase of a feedback session, a clinician provides information on how a skill is rated as a personal strength or weakness. Our experience is that it is best to keep such an analysis simple and straightforward. Therefore, we have three categories: above average, average, and below average. To determine where an individual's score falls, we convert the raw score into a percentile.

A percentile is a standard measure of how an individual's raw test score is compared to other individuals who have taken the same test. For example, if an individual's score falls in the 25th percentile, this means that this individual scored better than 24% of those who have taken the test and worse than 74% of those who have taken the test. On the contrary, if an individual's score falls in the 80th percentile, it means that this person scored better than 79% of people who have taken the same test and worse than 19% of people who have taken the same test.

An individual's test is considered in the below-average range when their score falls in the 24th percentile or less. An individual's score is considered to

be in the average range if their score falls between the 25th and 75th percentiles. A score is in the above-average range if it falls in the 76th percentile or greater.

It is important that the clinicians use whatever measurement that best suits them. The scale of measurement identified above was used in the NAFI study because it was felt that this would be most understandable to the patient group. It is important that the scale of measurement is understandable to the patient and that they understand how this scale was developed. This requires an open conversation about norm-based scoring, how scores are derived, and the strengths and limitations of this type of scoring. A second important factor is that patients should understand that norm-based scoring is a method for describing their cognitive functioning in relation to peers who are similar to them. However, the scoring does not presume to describe *who the patient is as a person*. Norm-based scores are tools that serve to describe one piece of a patients' world, not the patient as a whole person.

Summarizing How a Personal Skill Profile Is Determined

- Explain that a skill is rated in one of three ways: average, above average, or below average.
- Average scores are scores that fall between the 25th and 75th percentiles, above-average scores are above the 75th percentile, and below-average scores are lower than the 25th percentile.
- Use a graphic illustration to explain the concept to patients (see example below).

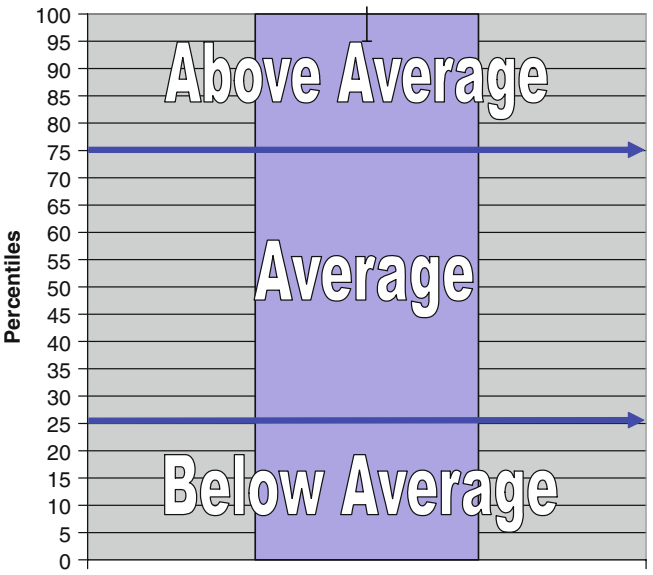

Figure 5.1 Example graph from the NAFI Personal Feedback Report from the study Effects of Cognitive Test Feedback on Patient Adherence

Step 4: Individual Test Results: Feedback About Personal Strengths and Weaknesses

The following section will describe the procedures for providing feedback from individual test results. The general conceptual framework for providing feedback will be described in addition to case examples.

The section has three main purposes: (1) to provide patients information about functional strengths that they have based on neuropsychological test results, (2) to identify the relationship between cognitive strengths and daily life concerns, and (3) to identify ways patients' personal strengths can be used to aid in resolving life problems.

Introducing the test and the skills examined

The first step of the feedback process is for the clinician to (a) briefly describe the nature of the test being discussed and elicit from the patient (b) what memories they have about taking the test and (c) what skills *they* saw the test as examining. This is important so that the patient is an active participant in the feedback process and is able to express what the experience meant to them. An example of an introductory statement includes the following:

"This test is called the Wisconsin Card Sorting Test. This is the test you took on the computer where you had to match cards to a series of key cards and were given feedback as to whether you were right or wrong. Do you remember taking this test?"

Examples of probing open-ended questions are as follows

- Can you tell me what it was like for you to take this test?
- What skills did you seem yourself as having to use in order to effectively complete this test?
- In what way(s) do you use these skills in your daily life?
- How do you think these skills are working for you in your daily life?
- In what way(s) do these skills have an impact on your [injury or illness]?

Mental skills are addressed in this way so that the patient can put the cognitive abilities in their own words and then relate these skills to their daily life, problems, and concerns. Even if the patient does not precisely state what skills the tests measure, it is more important to have the patient think about the nature of the tests and the meaning(s) derived from them. In this way, the testing experience becomes more personal and applicable to the patient's life.

When working with children and adolescents, feedback is often provided primarily to parents or other caregivers. In these situations, it is often helpful to describe a test by showing parents the testing materials so that they might fully understand the nature of their child's performance. For example, many parents can quickly surmise the challenges in copying the Rey figure and completing

block design or matrix reasoning. It can be helpful to have parents respond to a few example questions when introducing tests such as vocabulary, information, or similarities.

"Elicit–Provide–Elicit" and OARS

When providing information about cognitive tests, CTNA follows the framework of "Elicit–Provide–Elicit" from MI. When beginning the process of providing information, the clinician first *elicits* reactions from the patient about the test itself and their perceptions of what skills they saw themselves as using and how they think they performed. This serves to personalize the test results for the patient and enhance the collaborative nature of the feedback process. Second, the clinician asks permission to *provide* information about the nature of the tests, the skills they assess, and ways these skills are used in daily life. Asking permission is a key concept in the provision of information in MI. The clinician asks permission because the goal is to empower the patient to accept or reject the information as applying to them. This also avoids the "expert trap" where information is imparted in a top-down manner, with the patient being a passive recipient of the clinician's "expertise". When addressed in this manner, the majority of patients will give permission to the clinician to provide information. Once the clinician provides information, the next step is to *elicit* patient reactions to the information. This allows the patient to comment on the applicability and usefulness of the information to their daily lives and concerns.

Throughout the introduction and eliciting of patient reactions, it is important for the clinician to go back to using OARS. The goal is to clarify patient reactions to the testing experience and what the experience meant to the patient in terms of stimulating ideas about how they see themselves functioning and finally to enhance the patient's ability to apply the tests and what they measure to their daily life. Patients may be able to express vague knowledge of the connection between test results and their daily lives. However, skillful reflective listening and evocative, open-ended questions can further develop the applicability of the test results to patient life problems and concerns. The following sections will illustrate this process more in depth.

Providing Information from the Test Results

Once the clinician has elicited information from the patient and used OARS to clarify the patient's perceptions, the clinician may then provide information to the patient about the skills an individual test assesses. The important task here is not to use fancy words or jargon in describing the cognitive skills. The feedback report provides bulleted descriptions of each cognitive skill in simple layman's terms. Table 5.1 provides the cognitive terms along with more simplistic, layman definitions.

Table 5.1

Neuropsychological term	Layman definition
Executive functioning	Analyze and solve problems, identify patterns, make correct decisions, hold ideas in your head, organize and sequence plans, be flexible in your thinking, solve a problem logically, focus without getting distracted
Attention and concentration	Pay attention and remember things, hold ideas in your head and reverse them, focus, concentrate
Learning and memory	Remember words or stories that are read to you, recover memories from things told to you a long time ago,
Motor skills	Work quickly with your hands and fingers
Visuospatial ability	Accurately copy things you see

Elicit Patient Reactions to the Information

Once the clinician has provided the patient information about the cognitive skills, the next step is to again *elicit* from the patient their reactions to hearing the cognitive skills as a strength and in what areas of their life they see the skill operating. The clinician then uses *OARS* in order to reflect and clarify the patient's perception of how they see this skill operating in their life and what it means to them. Some important questions a clinician might pose to the patient include the following:

- "How do you see yourself using these skills in your daily life?"
- "How does these skills relate to some of the questions you posed at the beginning of the session?"
- "Can you see how this skill might be a problem for your daughter?"
- "What relationship do you see to these skills and issues related to your [presenting problem]?"

The purpose of such questions is to facilitate patient self-disclosure and open a dialogue as to how the test results apply to patient real-world problems and concerns.

Example #1 The following example provides a segment of a session where the patient is given information about a cognitive skill determined to be a personal strength:

A patient receiving feedback had performed within the average range on the Wisconsin Card Sorting Test. A graphical illustration (Fig. 5.2) of the results appears as follows:

The results indicated that the patient performed within the average range in regard to the number of categories achieved (6/6), number of errors (48th percentile), and perseverative errors made (38th percentile). Based on these results the following conversation ensued:

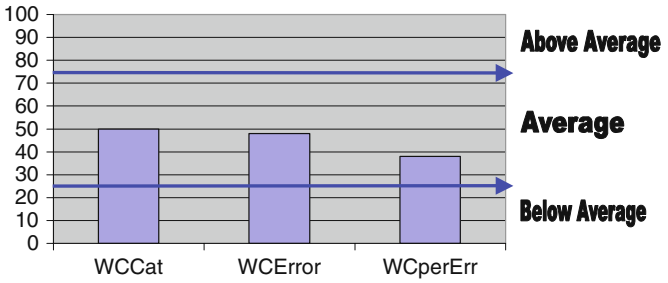

Figure 5.2 Graphical illustration of a patient's performance on the Wisconsin Card Sorting Test

Clinician: Ok, let's go over this test here called the Wisconsin Card Sorting Test. That's the test you did on the computer where you had to match different cards to four key cards on the top of the screen. [Providing information]

Do you remember having taken this test? [Closed question]

Patient: Yes.

Clinician: What do you remember about that test? [Elicits patient reactions to the test with an open-ended question]

Patient: It was really challenging. (laughs) I remember looking at it, trying to see what way it was supposed to go, and then once I thought I got it, it would be wrong so I had to figure out another way.

Clinician: It was a curious and confusing test because it shifted on you. [Amplified reflection]

Patient: Yeah, first it would be blue circles, then red triangles, then red circles, and it just kept changing and changing.

Clinician: So you really had to be on your toes. [Simple reflection]

What was it like for you to have to do that? [Open-ended question]

Patient: I liked that! I could play that every day!

Clinician: So you really enjoyed that. [Simple reflection]

What was it that was most enjoyable for you? [Open-ended question]

Patient: Just the challenge, analyzing things, having to figure it out. I've always liked those kinds of things because that's what I did when I used to work. I had to analyze problems and find solutions to things.

Clinician: So this test really tapped into something you like to do and in fact are enthusiastic about. [Amplified reflection]

Would you like to know what this tests measures and how you did? [Closed-ended question asking permission to give information]

Patient: Yeah, absolutely.

Clinician: This test assesses a lot of what you just mentioned, your ability to analyze and solve problems, to figure out patterns to things, and to benefit from feedback about your performance so you can change something that might not be going well. [Providing information]

According to the results, you performed in the average range on this test, which means you did as well as anyone else who has taken this. [Providing information]

What are your thoughts about how that fits for you and your life? [Elicits patient reaction to the information with an open-ended question]

Patient: (Pauses) I think that's how I've survived all these years.

Clinician: Really? Tell me about that. [Open-ended question]

Patient: That's how I survived. I've been through a lot and there are times I wasn't sure I was going to make it. There are other times when I look back and I think that I should be dead. But somehow, I've been able to look at where I am and once I realize what it is I need to do, I try to set things in motion so that I'm around positive people and positive things. It isn't always easy but as many times as I've fallen down, I've picked myself back up.

Clinician: You're a survivor. [Amplified reflection]

Patient: (Pauses, smiles) I guess I am. Yeah, you're right, I am.

The above scenario demonstrates how the test results are used to create a bridge between the patient's cognitive abilities and important life issues. The patient's performance on the Wisconsin Card Sorting Test is an illustration of how they have used their analytical skills to survive in very difficult times. This information can be used later when the clinician and the patient work together to develop strategies for resolving important life issues the patient is struggling with. Furthermore, the clinician and patient collaborate to discover the patient's personal resources for resolving problems in their life. This will be important when discussing ways to adapt or cope with weaknesses.

Example #2 In this scenario, a clinician is providing feedback to the mother of an 8-year-old boy who is having behavior problems in school. He was referred for the evaluation of a learning disability versus attention-deficit/hyperactivity disorder. The test results indicate that his behavior problems are likely the result of undiagnosed dyslexia and that he displays no cognitive markers of attention problems. The following is an example of the dialogue between the parent and the clinician.

Clinician: The first test I want to talk about is called the Continuous Performance Test. Jason took this test on a computer in my office. [Providing information]

Did he tell you about it? [Closed-ended question]

Parent: I don't think so.

Clinician: Ok, on this test, he had to look at the computer screen while different random letters are flashed on the screen, one at a time. Sometimes they go fast, other times they go more slowly. Each time that he saw a letter, he had to press the space bar – except when he saw the letter *X*. When he saw the letter *X*, he had to try not to hit the space bar. One trick here is that the test takes sort of a long time – around 12 or 15 minutes. [Providing information]

What do you think this test was getting at? [Open-ended question]

Parent: Well, it seems really boring. I'm guessing that he'd need to pay attention to this boring game for a long period of time. And he'd have to try real hard to not react when he's not supposed to.

Clinician: Exactly right! The test is a great measure of one type of attention and ability to not be impulsive. [Providing information]

Can you think of how this skill might be useful in Jason's life? [Open-ended question]

Parent: Well, it's a lot like school. He's gotta sit there all day and pay attention to things that maybe aren't as interesting as his video games.

Clinician: Bingo! In order for him to be successful in school, he needs to be able to sit there and filter out the junk and focus on the important stuff. [Amplified reflection]

So, how do you think he did? [Elicit]

Parent: Oh, I'm afraid that he probably bombed it. I imagine that he hit that space bar for nearly everything, but eventually, he just quit or got frustrated.

Clinician: Well, would you like for me to tell you about his scores? [Closed-ended question asking permission to give information]

Parent: Yeah, although I'm not sure I want to know (laughs).

Clinician: Jason performed in the high average range on this test. His score showed no impulsivity or distractibility throughout the entire process. It's exactly what we would expect, or better, from other eight year-old boys. [Providing information]

What do you think about that? [Elicits parent reaction to the information with an open-ended question]

Parent: I'm totally surprised. Are you sure you scored that correctly (laughs)? So, this test of attention didn't show that Jason has trouble?

Clinician: No. In fact, he did rather well. You look a little stunned. [Reflection]

Parent: Yeah, it's just so different from what I would expect.

From this point, the clinician and parent went on to discuss the weaknesses noted on measures of lexical processing and phonemic decoding that underlie Jason's learning disability. Like all neuropsychological assessment, CTNA assessment can help patients and their families revisit personal

narratives and ways of understanding problematic behavior. However, CTNA offers patients and families a voice in the process so that the new narrative is their own.

Summarizing the Provision of Individual Test Results: Strengths

- Introduce each test by first eliciting memories from the patient about the test itself and what skills they saw themselves as using to complete the test.
- Ask the patient for permission to provide information about the skills individual tests assess.
- Use the Elicit–Provide–Elicit framework from MI when providing neuropsychological test information:
  - Elicit patient reactions and memories about the tests.
  - Provide information about the tests and the skills they assess.
  - Elicit patient reactions to the information provided.
- When providing neuropsychological test information, avoid jargon and discuss the cognitive skills in simple, layman's terms using examples where appropriate.
- When eliciting patient reactions, use OARS to reflect and clarify patient thoughts and perceptions.

Feedback About Difficulties or Weaknesses

Providing feedback about cognitive difficulties or weaknesses follows the same basic format as for personal strengths with similar goals: (1) to provide patients information about functional weaknesses based on neuropsychological test results, (2) to identify the relationship between cognitive weaknesses and daily life concerns, and (3) to identify ways cognitive weaknesses may be contributing to life problems and ways to adapt, cope with, or possibly remediate these weaknesses.

Introducing the Test and the Skills Examined

Providing patients information about cognitive weaknesses follows the same format as those for personal strengths. The clinician first *elicits* memories that patients have about taking the test and then uses *OARS* to reflect, clarify, and understand the patient's perception of what skills they used and how they see these skills applying to their daily life.

Providing Information About Cognitive Weaknesses

The clinician now may *provide* information to the patient about the cognitive weaknesses and what skills the test assesses. Providing this information requires sensitivity on the part of the clinician to pay attention to patient reactions.

Experience suggests that most patients are able to deal well with hearing that they have cognitive weaknesses, although there are times when patients may jump to conclusions and think that a cognitive weakness has some catastrophic meaning. There is also the possibility that a patient's cognitive profile may suggest more serious problems. Such issues will be discussed in the section on special issues.

Elicit Patient Reactions to the Information

The clinician will now *elicit* patient reactions to hearing information about cognitive weaknesses and what areas of their life they see the skill operating. The clinician then uses OARS in order to reflect and clarify the patient's perception of how they see these skills operating in their life and what it means to them. It is during this process that patients may express some form of resistance to the test results, and it is important that the clinician respond to patient resistance in a manner consistent with the person-centered principles of MI.

The following example demonstrates providing information about cognitive weaknesses.

Clinician: Janet we're going to shift now and discuss test results that you struggled with or are what we call weaknesses. [Providing information] Are you ready to discuss these? [Closed-ended question assessing Janet's readiness to review these areas]

Patient: Yeah, I think so.

Clinician: Ok, let's look at this first test called Letter Number Sequencing. This was the test where I read to you a series of numbers and letters and you had to put them all in the right order, numbers first and then the letters. [Providing information] Do you remember this test? [Closed-ended question]

Patient: Oh, yeah, that was hard.

Clinician: Tell me what it was like for you while taking that test. [Open-ended question]

Patient: I remember that one being really confusing. The first two were ok but after that there were just too many numbers and letters and I just got lost.

Clinician: So it became a bit overwhelming for you. [Simple reflection] What kind of things did you have to do in order to complete this test? [Open-ended question]

Patient: Well, I had to pay real close attention to what you were saying and try to remember what you said when you read another set of numbers or letters. That's what became frustrating, is when I thought you were done reading some numbers you started with another set of letters and I couldn't remember what you previously said.

Clinician: It sounds like you really tried to hold on to what was told to you but it became too much and the old information gave way to the new. [Amplified reflection]

Patient: Yeah, something like that, I could only remember so much.

Clinician: Ok, well can I tell you what we know this test to assess. [Closed - ended question asking permission]

Patient: Yes, mmm hmm.

Clinician: You're pretty much on the mark with what you noticed this test to assess. This test measures what we call "working memory". This is your ability to hold pieces of information in your head for a period of time and then do something with that information. [Providing information]

Patient: Kind of like adding numbers in your head?

Clinician: Yes very much like that. You have to hold different thoughts in your mind and then use that information in some way. It's kind of like if your clinician tells you to go to a 12-step meeting, get a sponsor, take some literature, get a signature from the chairman, and meet at least three people. You use your working memory to hold all those different ideas in your head and then figure out how you're going to do all that. Does that make sense? [Providing information/closed-ended question assessing comprehension]

Patient: Oh, yeah. I have a big problem with that. Whenever I set out to do something that is kind of complicated, I almost always forget some part of it.

Clinician: Ok, well in fact the test shows that you do struggle with this. Your score fell in the low average range, or 16^{th} percentile. It sounds like you recognize this is a problem can you tell me more about that? [Providing information/elicit patient reactions with an open-ended question]

Patient: Just like in group. I can't remember everything they talk about. I hear what's being said and I'm trying to pay attention to it, but then they keep going on and I'm still stuck on the previous topic and I completely miss what's being said.

Clinician: Do you think it matters what the topic of conversation is? [Closed-ended question]

Patient: No, I don't think so. Because it happens all the time. I go out to smoke break and everyone is talking about the group and I don't remember at least half of what was talked about. So eventually I just say to hell with it.

Clinician: It sounds like you're worried you might be missing some important things. [Amplified reflection]

Patient: I know I am. People think I just don't care or I'm not paying attention. I'm trying but I just can't focus on all that stuff at one time.

In the above example, the patient has been experiencing difficulties with working memory that were interpreted as lack of motivation. Providing concrete feedback in an understandable way created insight that was useful to the patient and explained something they had been struggling with.

Summarizing the Provision of Individual Test Results: Weaknesses

- Introduce each test by first eliciting memories from the patient about the test itself and what skills they saw themselves as using to complete the test.
- Ask the patient for permission to provide information about the skills individual tests assess.
- Use the Elicit–Provide–Elicit framework from MI when providing neuropsychological test information:
  - Elicit patient reactions and memories about the tests.
  - Provide information about the tests and the skills they assess.
  - Elicit patient reactions to the information provided.
- When providing neuropsychological test information, avoid jargon and discuss the cognitive skills in simple, layman's terms using examples where appropriate.
- When eliciting patient reactions, use OARS to reflect and clarify patient thoughts and perceptions.

Responding to Resistance

It is possible that, when presenting cognitive weaknesses, patients may be resistant to hearing such information due to shock or fear or because the results seem discrepant from their own experience. If this happens, it is important that clinicians follow the MI principle of "rolling with resistance." In MI, resistance is not challenged directly but met with understanding, empathy, and openness by the clinician to empathize with the patient's perception of the situation.

In MI, there are two sets of strategies for responding to patient resistance reflective and strategic approaches. Reflective approaches are statements made by the clinician that empathizes with a patient's perception of a situation. Reflective statements are simple yet are often effective means of disarming resistant dialogue and guiding the conversation to a more therapeutic topic. Miller and Rollnick (1991, 2002) identify five different types of reflective statements.

1. *Simple reflection*: The clinician says back to the patient what they just said, staying close to his or her words.

Patient: Are you sure these tests are right? I've never noticed this kind of problem before.
Clinician: You're wondering of the tests are accurate.

2. *Reflection of feeling*: The clinician reflects back to the patient the underlying affect expressed in their statement.

Patient: (Eyes wide open, wringing their hands) I can't believe I performed so poorly on this test!
Clinician: You're rather shocked by this and feeling very nervous about what this might mean.

3. *Reflection of meaning*: The clinician reflects the implied cognitive content of what the patient says.

Patient: I'm a little nervous about hearing the results given that my father had dementia when he was near my age.
Clinician: Your worried what these results might mean for your future and what could happen to you.

4. *Double-sided reflection*: The clinician reflects both sides of a conflict the patient may express.

Patient: Yes, my wife has told me I don't seem as sharp as I used to be but I think she may just be over-reacting.
Clinician: You're not really worried about your faculties but other people have expressed concern.

5. **Amplified reflection**: It is used when the patient has expressed only the negative side of a conflict: The clinician intensifies what the patient has said, which usually leads the patient to correct the distortion. For example:

Patient: Yes I forget things now and then but doesn't everyone my age?
Clinician: It seems like your memory is just as good as everyone else you know and there appears to be no reason for concern.

Often clinicians may use strategic approaches to handle resistant statements. Examples of strategic approaches include shifting focus to another topic with the hopes of coming back to the more emotionally charged topic, reframing a statement, emphasizing patients' personal choice and control, and paradoxical interventions (Miller and Rollnick, 1991, 2002). Examples of these strategies are as follows:

1. *Shifting focus*: This refers to the clinician shifting away from an emotionally charged topic to one that engenders less resistance with the hopes of coming back at a later time.

Patient: I think the test is wrong! There is no way my concentration could be that poor!
Clinician: So you see you're ability to focus and concentrate as pretty good. What kind of things have you noticed that tells you that?

2. *Reframe*: This refers to presenting what the patient has said from a different perspective.

Patient: I don't see why my mother should take this medication if it's not going to stop her from becoming demented.
Clinician: You really only want something if you think it's going to cure her.

3. *Emphasizing personal choice and control*: This assures the patient that whether they take any action or not is completely in their hands.

Patient: I've already been to speech, occupational and physical therapy, I don't want to go to something else, I'm tired of all this therapy and I still can't think through things the way I used to.
Clinician: Although I believe that this rehabilitation program could help you, you are right that it is totally your choice and I understand that this has been a long hard road.

4. *Paradoxical intervention*: This is a last resort intervention. It refers to the clinician "coming alongside" the patient's perception and agreeing with them as a way to disarm the resistance and bring the patient to a more balanced view. This must be done with sincerity and sensitivity so as not to seem sarcastic.

Patient: My doctor told me that I have severe damage to my brain, so if that's the case then nothing can be done and I'm not going to any more programs just to spin my wheels.
Clinician: I can see that you think nothing else can be done and you sound pretty set that you're not interested in doing any more therapy. Perhaps you're right that this isn't the right time to think about any further treatment. Would it be all right if I just shared a few thoughts with you anyway?

In providing neuropsychological results, a clinician deals with resistance by (1) rolling with it as is consistent with MI principles, (2) acknowledging the strengths and weaknesses of neuropsychological tests, and (3) ensuring that the relationship between test skills and actual real-life functional behavior has been adequately illustrated.

1. Rolling with resistance: The first step in rolling with resistance is to recognize that resistance is occurring. Resistance usually takes the form of four types of behaviors: when a patient openly argues with the clinician about test results, interrupts the clinician during an explanation, negates information the clinician provides, or outright ignores the clinician (Miller & Rollnick, 1991, 2002). In providing neuropsychological information, such behaviors are likely to occur if the information provided is discrepant from the patient's own viewpoint or if the information upsets the patient for any number of reasons. Should this occur, clinician's responses to the patient that are not helpful include the following: arguing that the test results are correct, assuming an expert role, criticizing or belittling the patient in some way, labeling the patient as being in denial or resistant,

or stating that the test results hold some preeminence over the patient's viewpoint. The following scenario demonstrates a poor way to handle resistance in the CTNA.

Clinician: James, the results of the test you took called the Logical Memory Test indicates that you have some problems with your memory.
Patient: Really? I thought I did well on that?
Clinician: No, actually you scored in the 5th percentile, which is considered in the borderline range.
Patient: What does that mean?
Clinician: It means you're almost in the impaired range but not quite.
Patient: I just don't see how that can be, I thought my memory was pretty good.
Clinician: No it's quite low. Perhaps your alcohol use has caused some memory problems. Research suggests that even social drinkers can have some problems with memory but your level of drinking places you in a more severe category. Therefore it would be expected that your memory would be more impaired.
Patient: Wait, wait, slow down. I don't see my memory as impaired. I think I remember stuff pretty good, I'm not sure where you're getting this stuff.
Clinician: These tests are highly reliable estimations of cognition. The Logical Memory test has shown to have a reliability estimate of between 0.7 and 0.9, which means that it's very good at picking up memory problems. I really think you need to consider this.
Patient: Well I don't care what or who it relies on. I'm saying it's wrong, I've never noticed a problem with my memory.
Clinician: What has your wife said?
Patient: About what? What's she got to do with this?!
Clinician: I can see this has upset you but the fact of the matter is you're showing memory problems and we need to talk about what can be done about that. Shall we move on?
Patient: Yeah, right.

The following is the same scenario with the clinician responding to the patient in a more MI consistent fashion.

Clinician: James, do you remember the test where stories were read to you and you had to remember them? What was that like for you? [Open-ended question assessing comprehension and memory of the test]
Patient: That was fine, I think I did pretty well on that.
Clinician: Ok, so trying to remember those stories was not a problem. [Simple reflection] How does that apply to your ability to remember things on a day to day basis? [Open-ended question]
Patient: It's ok as far as I can tell. I've never had a problem with it.
Clinician: Ok, well would you like to see how the test results turned out? [Closed-ended question asking permission to provide information]

Patient: Yeah.
Clinician: According to the results, your score on the first logical memory test, which is a test of short term memory or your ability to remember the story after a short period of time, your score fell in the 5th percentile. [Providing information] What thoughts do you have about that? [Open-ended question]
Patient: What does that mean?
Clinician: That means that you scored higher than about 4% of people who have taken this test and lower than 94% of people who have taken this test. We would say that score falls in the borderline range, which is not impaired, but lower than below average. [Providing information] How does that fit for you and how you saw your performance? [Open-ended question]
Patient: That can't be right!
Clinician: You're surprised by this? [Simple reflection of affect]
Patient: Yeah, I thought I did good. I can't believe you're saying my memory is that bad.
Clinician: So this is really concerning to you and doesn't fit with the way you see yourself remembering things on a daily basis. [Amplified reflection]
Patient: Well, yeah, I mean. . .I just don't see my memory as that bad.
Clinician: This seems upsetting to you. [Simple reflection]
Patient: Yeah, I mean, I don't see it as *this* bad anyway.
Clinician: So it doesn't seem like it should be as bad as this but now that you think of it there might be some things you've noticed that concern you. [Double-sided reflection]
Patient: Well, I mean there are times when my wife has said that she told me something and I insist she didn't.
Clinician: What kind of situations has that created? [Open-ended question]
Patient: Well that's one of the things we fight about.

This scenario provides an example of rolling with patient resistance. In this case the patient questioned the validity of the test. Instead of becoming defensive and justifying, the clinician empathized and asked a few nonthreatening yet evocative open-ended questions, which lowered the patient's resistance enough to where he admitted that there may have been some discrepancy between how he sees himself versus how he really is. This leads into the next principle for dealing with resistance.

2. Acknowledging the strengths and weaknesses of neuropsychological tests. There is ample evidence to suggest that neuropsychological tests are valid estimations of functional behavior. However, as with all tests, neuropsychological tests have their limitations. For example, the conditions of the testing situation may affect performance. Conditions such as room temperature, lighting, rapport with the examiner, stress of the task, and patient variables such as how much sleep they had, if they had a meal, level of fatigue, and

others all may affect how valid a test is in measuring a specific skill. Another example relates to the nature of specific tests. Neuropsychological tests are designed to measure specific cognitive skills; however, many tests actually measure a variety of different skills, and it may be difficult to discern which skill contributes to a poor score. The important concept is that neuropsychological tests are potentially valid and powerful measures of functional skill, but they are not perfect. Thus, one way to diffuse resistance and begin a dialogue to determine if a test score is valid is to simply acknowledge the strengths and weaknesses of cognitive tests.

Clinician: Ok, let's go onto the next test. Do you remember the test where you had to put pegs in holes as quickly as you can? [Closed-ended question] What was that like for you? [Open-ended question]
Patient: I really hated that one. My dexterity has never been good.
Clinician: Ok, so that really wasn't a good test for you and it sounds like it tested a skill you know yourself to struggle with. [Simple reflection]
Patient: Yeah I never was good with my hands.
Clinician: Ok, well would you like to know how you did? [Closed-ended question]
Patient: I can see here that I look pretty low but that doesn't surprise me.
Clinician: So this is not news for you, what have you noticed about your abilities in this area? [Open-ended question]
Patient: Well I've never had good eye-hand coordination, that's why I've never been good at things that I have to use my hands. So I think that's really all its testing.
Clinician: Ok, so this is something that's been around for a while. [Simple reflection] And in fact, you're right, this test does not really give information about whether your score is related to an actual problem due to substance use or whether this is just the way you are. [Providing information that affirms the patient] However, I would like to make one observation if you're willing to hear it? [Closed-ended question asking patients' permission to provide information]
Patient: Sure.
Clinician: Your score fell in what we would call the impaired range, meaning that more than 99% of people who took this test scored higher than you. This reminds me of the fact that you have been concerned about tingling in your arms and feet. [Providing information] What concerns do you have about that? [Open-ended question]

In this scenario, the clinician acknowledges the limitations of the test but then asks an open-ended and evocative question that lays the groundwork for placing doubt in the patient's mind that there really is no problem. The patient represented in this scenario did, in fact, have peripheral neuropathy possibly related to alcohol use.

3. Illuminating the relationship between test skills and functional behavior. Ideally, this concept should have already been made clear but may need to be revisited if the patient does not comprehend the connection. The clinician needs to make sure they have adequately elicited from the patient what skills they saw themselves using to complete a test and then express how they see those skills operating in their daily life. Second, cognitive skills should be described in simple, layman's terms with examples provided. Consider the following example of a patient who does not understand why they scored in the low-average range on the Wisconsin Card Sorting Test.

Patient: I couldn't understand that test; I don't think it was fair; I'm a good problem solver.

Clinician: So this doesn't fit with how you see yourself? [Reflection of meaning]

Patient: No, not at all. I'm good at puzzles and things and I play cards all the time so I can't understand it!

Clinician: Ok, I can see this is frustrating for you. [Simple reflection] Can we talk a bit about what specific things you had to do for this test? [Closed-ended question asking permission to provide information]

Patient: Yeah, ok.

Clinician: It seemed like early on in the test you had a hard time figuring out what you were being asked to do. You would figure out a pattern, get a few cards right and then suddenly switch. One of the things you have to do to complete this test is to focus and concentrate for an extended period of time and then wait for the test to tell you whether a move you made was right or wrong, and then use that feedback to figure out another pattern. It seemed though like you were trying to get ahead of the game. [Summary of clinician observations] How do you see that working in your regular life? [Open-ended question]

Patient: (Silent, thinking). You know what; I have been told that I'm impulsive.

Clinician: Really? Can you tell me more about that? [Open-ended question]

Patient: Yeah, y'know, sometimes I just go with things. I don't sit and think I just run with it and next thing y'know I'm in trouble.

Clinician: Do you think that might have been happening while taking this test? [Closed-ended question]

Patient: (Laughs) Yeah I think it was.

This example demonstrates how the patient was able to come to their own insight that inattentiveness and impulsiveness may be affecting their problem-solving and decision-making skills. What was needed was further clarification by the clinician as to what specific skills are assessed with the test and encouraging the patient to think of these skills in real-world terms.

Summary of Providing Skill Profiles

The important things to consider in providing information from neuropsychological tests in CTNA is that the clinician must first elicit answers from the patient in regard to how they saw their performance, what skills they see the test measuring, and how the skills related to the patient's daily life. At the same time, the clinician should be interacting with the patient in an MI-consistent manner using reflections and open-ended and evocative questions, affirming the patient, and summarizing thoughts. The clinician must emanate a spirit of collaboration with the patient or family, respect their autonomy as an individual, and continually evoke thoughts and reactions from the patient versus falling into a question-and-answer trap where the patient is merely a passive recipient. When the clinician offers information from the test results, s/he does so in a nonjudgmental and objective manner, always making sure the patient is ready to hear this information. Throughout the information provision, the clinician maintains an attitude of respect and unconditional regard and avoids labels or complicated cognitive jargon. Questions are answered directly and objectively, and patient reactions to the information is elicited and further empathized with and clarified. As such, the provision of feedback is not a one-sided, top-down endeavor where the clinician passively imparts information to the patient. The interaction is one of collaboration and equality where the clinician maintains the stance that they have some knowledge and expertise, which may be useful for the patient, but the patient is the ultimate author and director of their lives who can use the information as they see fit.

Summary of Ways to Respond to Resistance in CTNA

- Do not become defensive or justify the test results.
- "Roll with resistance" as is consistent with MI principles, where resistance is not met with confrontation but is understood from the patient's perspective.
- Acknowledge the strengths and weaknesses of neuropsychological tests.
- Be sure that the relationship between test results and the patient's daily functioning has been adequately illuminated.

Step 5: Summarizing the Relationship Between Tests Results, Life Areas, and Patient Questions

This is the part of the session where the clinician and patient work together to find the best way to use the test results to help make changes in important life areas and to answer questions the patient posed early on. This is highly individualized and depends a great deal on the direction in which the session has progressed. For example, some patients begin talking about the relationship between their cognition and life problems well into the session, so making the connection in the summary is merely a reminder. For others, they may be unable

to see the connection until the clinician summarizes the different points discussed. This segment of the session is comprised of three areas, offering a grand summary, asking the patient how they would like to use the results, and answering questions and making recommendations.

1. The Grand Summary

In MI, the grand summary consists of the clinician providing a concise and relatively brief account of the major themes discussed in a session. This is the same for the CTNA feedback session; however, the grand summary can be more complicated because the clinician must summarize important points about cognition and personal themes the feedback has elicited from the patient. The CTNA feedback form contains a large quantity of information, and the discussion may cover many points. It may be helpful for the clinician to write down the main points as the session progresses. It is important to note that the grand summary does not require the clinician to simply regurgitate every little detail but instead to provide a concise summarization of the important themes that were discussed. A summary may be interactive and does not simply have to be a long dialogue by the clinician. Consider the following summary.

Clinician: I'd like to pull together everything we've been talking about, would that be ok with you?

Patient: Yes, sure. Good luck.

Clinician: It sounds like that as we've talked you are really seeing how this information applies to your life. Your strengths are that you're a good problem solver because you figure things out really well, you can think on your feet, and can really focus and pay attention when you need to and stay on the task at hand. What seems to get in your way of meeting your goals is that you do become distracted and feel lost at times, especially when you're stressed out, and this leads your mind to race and become disorganized so you forget things, lose track of where you're at, and ultimately your goals and plans fall apart. Does that sound about right so far?

Patient: I mean, it hits the nail on the head. I can't stay focused I end up all over the place, and the next thing you know, boom, relapse; I'm out using that drug again.

Clinician: And another thing we talked about is that this really seems to happen when you don't have any support or structure. It's like when you do have structure, it gives you the safety and security of something that it's hard to do in your mind, structure and organize yourself.

Patient: That's it, that's what I need to do, find that structure and keep it otherwise I'm gonna be right back were I started.

The above scenario demonstrates how a grand summary is used to provide concise information that the patient can use and think about. In this case, the

patient was able to use the summary to develop their own ideas about how they can begin to use this information. The situation illustrated in this example is not uncommon with many drug-addicted patients. Many of them have trouble with executive functioning abilities of planning, organizing, and staying focused. When they are in structured environments, they tend to do well because the structure is provided for them. However, when they are on their own, they do not have the internal resources provided with intact executive abilities. As a result, they become lost, disorganized, and hopeless. Most of them think that the reason is that they are crazy, deficient, or have some other negative label. CTNA makes no judgments or labels but simply provides objective information about strengths and weaknesses, so patients can visually see what areas they need to improve. This approach seems to allow for greater internalization of these issues, which creates insight and hope that these problems can be solved.

2. Providing Information and Advice

The grand summary is the time in the session where the clinician may offer diagnostic impressions based on the test results. These results are highly individualized and depend on the test profile, clinical history, and impressions by the consulting psychologist.

Regardless of the association, the method for providing such information is the same and is conducted in an MI-consistent manner. The clinician first asks permission to provide the patient information that may be useful to them. Once the patient agrees, the second step is to provide the information in an objective nonjudgmental manner. In CTNA, it is important to provide the information in simple terms without using complicated jargon. It is also important to tell the patient that although the information is viable, it is not "set in stone," leaving the opening for other possibilities. Finally, it is important to elicit patient reactions after providing the information to process any feelings or reactions and maintain a collaborative relationship. The following scenarios provide examples of providing information. The first example is not consistent with MI.

Clinician: James after reviewing your profile, your cognitive impairments are likely due to your 20 years history of alcohol and 10 year history of using alcohol and cocaine together. Based on the research, individuals who use alcohol and cocaine together perform worse on various cognitive measures than those who use alcohol or cocaine separately. When taken together, alcohol and cocaine combine to form a compound called cocaethylene. Cocaethylene tends to impair dopamine transmission in the frontal areas of the brain, which is most likely the cause for your executive impairments. Abstinence would be the best measure for remediating these problems.

The problem with this summary is that it (1) is filled with too much jargon, (2) is too long, and (3) does not encourage an open dialogue, and (4) the spirit of the summary is more reflective of an authoritarian clinician imparting information to a passive patient.

The following is a more MI-consistent way to provide information in the same scenario.

Clinician: James we've talked about what the results of the tests mean for you. Would you be interested in hearing some thoughts I have about some of these results? [Closed-ended question asking permission to give information]

Patient: Yes, sure.

Clinician: I'm thinking that your cocaine and alcohol use may have contributed to some of the weaknesses we were looking at earlier. You mentioned that you have noticed a difference than before you started using drugs and it sounds like you saw yourself as pretty sharp, focused, and really "with it" in many different areas. [Providing information]

Patient: Yeah, I was really good at doing a lot of different things at once, it seems now I can barely complete one thing.

Clinician: Well there is information that cocaine and alcohol, especially when using it over a period of time, can really affect these skills that we've been talking about. Based on your history, there doesn't seem to be any other real good reason why your thinking would be this way so I have to assume that the cocaine and alcohol had the biggest effect. [Providing information in simple terms] What are your thoughts about that? [Open-ended question assessing patients' reactions to the information]

Patient: Yeah, it makes sense. I mean I've really noticed it about the last five years or so, that I really can't do things the way I used to. Does this get better?

This summary is more consistent with a collaborative approach because it (1) more openly enlists the patient's cooperation by asking permission, (2) is given in workable chunks versus a long drawn-out statement, (3) is stated in understandable terms, and (4) enlists the patient's thoughts and opinions about the information.

The above example shows how information provision is much more of a dialogue where the patient is an active collaborator versus a passive recipient. This is more effective in accepting the feedback, clarifying misconceptions, or modifying the information if so appropriate.

3. Using the Test Results

This is the next step in moving toward making recommendations. In CTNA, it is important to not jump right into making direct recommendations without first eliciting the patient's own ideas about how they would like to use this information. It is easy to fall into the expert trap and think that professional ideas or consultation will serve as an eye opener for patients. In reality, it places the patient in a passive and powerless recipient role without respecting that they may have ideas for how they want to use the information. Therefore, the first step would be to ask the patient how they would like to use the information and then use OARS to clarify their thoughts and perceptions. From there, the second step

may be to gradually move into a change plan by specifying specific steps a patient will take to accomplish their goals. Consider the following example:

Clinician: So how can this information be used to help you, what have you gotten out of it and where do you want to go with it? [Open-ended questions]
Patient: The next step for me is that I have to learn to make decisions on my own.
Clinician: Ok, how are you going to do that? [Open-ended question]
Patient: I'm going to take my time, sit down and try not to let my thoughts go awry. I let my feelings override my thoughts and I get confused. It might sound crazy but that's what I need to do. I also need to find a balance between needing other people and standing on my own two feet.
Clinician: You need people but you also need independence. [Reflection of meaning]
Patient: Right, I need to be responsible. I have to sit back and analyze these things. I'm not lazy! Not at all! I want to be responsible and normal, whatever that is! That's what I learned here today, I want these things!
Clinician: The other thing is to focus, slow down and focus and use those problem solving skills that you have. [Simple reflection]
Patient: The focus is first. I've got to be focused.

The clinician can never be sure what information a patient will take as valuable to them, so it is important to roll with the patient's perception and not challenge it as invalid in some way. It would be easy, if what the patient learned is contrary to what the clinician thinks they should have learned, to fall into the trap where the clinician opinion is preeminent and that will likely shut the patient off from further dialogue. The best strategy is to elicit the patient's perception as to what they think they need to change, and then once that has been adequately addressed, offer information and recommendations as to what may be clinically helpful. Experience suggests that when patients' concerns are addressed in this manner, they are much more open to hearing clinician advice and suggestions and are more likely to consider them as viable options.

Patient: The thing is that I want this all right now! I want to feel better now! I know I can't think that way but I just get anxious. I think about everything that's happened and I don't want it to be that way, I want to fix it yesterday.
Clinician: When you think of all the consequences that have piled up from your accident it seems overwhelming and you'd like to make it just disappear. [Reflection of meaning]
Patient: Yes disappear, exactly, man I wish it could all just go away!
Clinician: And what happens when you think like that. [Open-ended question]

Patient: We'll I get really energized but somehow everything ends up going to hell and I end up saying to hell with it.

Clinician: And there were some things that came out of the test results that might be helpful in understand and working with this, would you be willing to hear them? [Providing information/closed-ended question asking permission to provide further information]

Patient: Oh yeah, yes.

Clinician: Remember we talked about what good problem solving skills you have but one thing that throws you off is when you don't have any structure? One thing I think that might help you is if you begin to think about what a structured rehabilitation program might look like for you and then take very small steps in working with that program. Saying that you have to keep all of your rehab meetings and do the recommended exercises is fine, but if you don't have a plan for meeting these goals, I'm thinking you'll become overwhelmed and frustrated again because you didn't think the whole process out. [Providing information]

Patient: That's usually what happens. I have good intentions and I really want to do this, but somehow I miss something from point A to point D or whatever.

Clinician: You don't think about points B or C. Or maybe even subpoint A1, A2, A3 [Reflection of meaning]

Patient: Or B1 or B2 (Joint laughter).

Clinician: Right, so what steps do you think you need to take in order to begin to meet some of these goals? [Open-ended question]

In this example, the clinician relates conflicts expressed by the patient to results from the neuropsychological tests. This creates a bridge of understanding between the assessment and the patient's real life. From that point, the clinician uses the test results as an avenue toward offering a suggestion for change. The patient is then more amenable toward hearing the clinician's ideas about change because (1) the clinician addressed the patient in an open and respectful manner, and (2) a bridge of understanding between the assessment results and the patient's real life was created.

This phase of the session is the beginning of a change plan, where the clinician and the patient work together to identify the steps to begin resolving life problems.

Summarizing the Relationship Between Test Results, Life Areas, and Patient Questions

- Provide a concise grand summary of the main points discussed in the feedback session. The grand summary is used to elicit thoughts from the patient regarding how they perceive the information and how they would like to use it to benefit their lives.

- Provide information and advice to the patient in an MI-consistent fashion.
- Use the test results to create a bridge between the assessment and the patient's real-world problems and concerns. This is done by first asking the patient how they would like to use the information and then providing any information and recommendations that are individually tailored to the patient's concerns.

Developing a Change Plan and Providing Recommendations

By the end of the grand summary, the patient and the clinician are likely to have some idea about what changes a patient wants to make. The stage is set to write down specific change plans and for the clinician to offer recommendations. These change plans can be written down on the last page of the CTNA feedback form. An important component of this phase is to encourage the development of a change plan but to watch out for traps that may hinder goal-setting efforts. Such traps include *underestimating ambivalence*, where the patient may still express uncertainty about goals they want to set or their commitment to implementing those goals. Evidence and experience suggests that patients who are pushed into change plans at the end of a session may actually show a decrease in their motivation to make changes (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). Therefore, it is important to encourage but not push a change plan if the patient is not ready. In these cases, it is best to simply offer some recommendations while reinforcing that it is the patient's choice and responsibility to carry out the change plans. Two components of developing a change plan are eliciting ideas from the patient regarding what they would like to change and then providing recommendations in an MI-consistent manner.

1. Eliciting Patient Change Plans

The first step in developing a change plan is to elicit the patient's ideas about how they would like to use the information discussed in the feedback form. To initiate this conversation, the clinician begins with a "key question" (Miller & Rollnick, 1991, 2002). The key question is an open-ended question that asks the patient how they would like to use the information given and what kind of change plan they want to develop. The key question also provides valuable information to the clinician in regard to the patient's thought processes at this stage in the session and what kind of changes they are ready to make. Important knowledge to be gained from the patient following the key question includes the following: (a) what behaviors is the patient willing to change, (b) how ready are they to make these changes, and (c) what steps are they prepared to take that can be included in the change plan?

2. Behaviors for Change

The key question is designed to identify what behaviors a patient is ready to think about changing. Even if the CTNA session has progressed smoothly with little resistance, this does not necessarily mean a patient is ready for life-altering

change plans. Therefore, it is important that the clinician relies on active listening skills and open-ended questions in order to clarify the patient's thoughts about change. Consider the following example with a patient who learned through the testing that she becomes highly anxious and dependent on others to make decisions for her: The result is that her anxiety causes her thoughts to race, she becomes unfocused and disorganized, and she is unable to make good decisions for herself.

Clinician: So how can we use this information to help you? What's the next step for you? [Open-ended key question]
Patient: The next step for me is that I have to learn to make decisions on my own.
Clinician: Ok, how are you going to do that? [Open-ended question]
Patient: I need to sit down and take my time and not let my thoughts go awry. I let my thoughts and feelings get the best of me and I get confused. Those are the kind of things that make me think of suicide. I know that sounds crazy. . ..
Clinician: So you need to be able to contain your own thoughts so as to not rely on others so much to keep you together. [Amplified reflection]
Patient: Right, right.
Clinician: So finding a balance between including important people in your life yet standing on your own two feet when you need to. [Reflection of meaning]
Patient: Right and I think my depression is a big part of that. I want to find out more about what that's about. Because I didn't have this when I was really young it was when I hit my young adult years that I really noticed that and that's when everything started to fall apart.
Clinician: So it sounds like one thing you'd like to do is find out more about this depression you've experienced for a long time and gain some understanding about it and what might be causing it. [Reflective summary]

In this example, the scenario is that one part of the change plan was for the patient to receive more knowledge and education about depression, how it fits in their life, and what can be done about it.

3. Assessing Readiness

The next part of developing a change plan is to assess the patient's readiness to carry out the plan. This can be done by assessing the stage of change a patient is in regarding a particular behavior. One of the key insights developed through research on MI is that a patient's expression of a desire to change is not necessarily related to the likelihood that they will change. What does seem to be related to an increased likelihood of change is the *strength* of the patient's commitment to change. In MI, clinicians look for commitment language, which is reflected in the acronym DARN (desire, ability, reasons, need). However, commitment language itself has not been found to predict change.

It is rather the intensity of the commitment language that has predicted the likelihood of change in behavior (Amrhein et al., 2003). Therefore, it is important for the clinician conducting CTNA to listen closely to the intensity of a patient's commitment to a change plan. Otherwise, it may be erroneously assumed that a patient is ready for change when, in fact, this may not be the case. Consider the following scenarios.

Clinician: So, how would you like to use these test results to help your situation?
Patient: Well, I guess I should think about my long-term plans.
Clinician: So you're thinking about how to plan for your future?
Patient: Yeah, I suppose I am.
Clinician: Ok, are you open to some suggestions on how you might do this?
Patient: Sure.

In this scenario, although the clinician is not pushing or coercing the patient into a change plan, it is clear that the clinician has missed some underlying ambivalence that may be present. Words such as "I suppose" or "I guess" are more reflective of ambivalence and indecision than a true, solid commitment to change. Instead of glossing over the ambivalence and increasing the likelihood that the plan will not be followed, it would be advisable to address the ambivalence directly and develop a more realistic plan.

Clinician: How would you like to use these results to help your situation? [Open-ended question]
Patient: Well I guess I should think about my long-term plans.
Clinician: You're thinking it would be a good idea but you're not too sure? [Double-sided reflection illuminating ambivalence]
Patient: I mean. . .I don't know, I suppose I should.
Clinician: You seem uncertain [Simple reflection] Can you share your thoughts? [Closed-ended question]
Patient: I mean I know I need to think about a different future given my accident, and I know that these results are right, and I'm sure that my memory is pretty bad . . . but I just don't know if it really makes that big of a difference.
Clinician: There are a lot of changes and it's hard to really know how things are going to be different now. [Reflection of meaning]
Patient: Right, how am I going to deal with things? I mean this is so different from the *me* I've lived with for 53 years.
Clinician: So the question is how you can adapt to the new you and plan for a realistic future for you and your family. It must be hard to think about that. [Reflection of meaning]
Patient: Yes, it just feels like giving up a little hope.
Clinician: Tell me about hope [Probing statement]

In this situation, the clinician identifies the ambivalence, reflects it back to the patient, and then offers a challenging question to encourage the patient to think of other possibilities. It would be easy for the clinician to say something like, "Yeah, but if you don't start making realistic plans, you and your family will face some bad times." Such a response uses the CTNA information almost as a threat. The clinician would essentially be trying to appeal to the patient's fear by saying, "If you don't change, then your family will suffer." This is *not* what the CTNA is intended to accomplish. The CTNA is not a fear tool. It is designed to provide objective information to the patient so that the patient can use that information in any way they see fit. The clinician acts as a guide to help the patient understand the information and what it means for their life. Certainly, there are situations where a clinician will tell a patient about possible consequences of their behavior. However, the clinician must not take the approach of using the information to scare or *make* the patient change. Instead, the clinician uses the information and the patient-centered style to *create an atmosphere where change is likely to occur*.

4. Providing Recommendations

The next step is to provide recommendations to the patient for treatment planning. These recommendations are highly individualized and are based on information acquired during the course of the feedback session and the results of the tests.

Recommendations are developed based on important themes elicited from the feedback session, information from the patient's cognitive profile, and life areas the patient is concerned about. The format for providing recommendations uses the framework "Elicit–Provide–Elicit." First, the clinician elicits ideas from the patient on what things they would like to put on a treatment plan; second, the clinician provides recommendations with permission; third, the clinician elicits patient reactions to the recommendations. Consider the following example of a patient who was concerned about their memory. In this situation, the patient's memory was actually quite strong, but she had problems with attention and working memory. Her attention and working memory problems were likely related to a history of drug use but also anxiety and depression she had been experiencing as a result of feeling overwhelmed in recovery.

Clinician: Lori, have you given any thought as to how you would like to use this information we discussed today? [Eliciting patient ideas]

Patient: Well, I'm relieved that my memory is ok, but I'm not sure what to do about my attention span.

Clinician: Ok, well can I offer you some ideas? [Asking permission to provide information and recommendations]

Patient: Yes please.

Clinician: I do think that your drug and alcohol use has affected some of the abilities we've talked about today. [Provides information based on clinical experience] However, I'm also struck by how overwhelmed you told me you've been feeling. You mentioned that raising your children, staying clean and generally trying to get your life together has been trying and at times you feel like you just want to sleep? [Summarizes what the patient said as a bridge to recommendations]

Patient: Yes that's right.

Clinician: Depression and anxiety can also affect some of the abilities we've been discussing [Providing information] What are your thoughts about that? [Elicits reactions to the information]

Patient: (Sighing in relief) I have been depressed and I've just been trying to ignore it. I just don't feel like I'm doing anything (beginning to cry). I mean I'm trying but I can't seem to get it together. Do you think my drug use has made me like this?

Clinician: Drug use certainly affects these things but you've been clean for a couple months, I think your depression and stress may be affecting this even more now. [Providing information] When you're depressed it's hard to focus and pay attention and it's easy to get overwhelmed. [Providing information] Does that fit for you? [Open-ended question]

Patient: Yes, very much so. I can't keep things straight in my head. A lot of it has to do with that I thought things would get better after getting clean but it seems to be getting harder.

Clinician: A lot of patients feel the same way. They get clean but then become overwhelmed with putting the pieces of their life together. Often they think their failing but really it's that their stressed, anxious, and depressed and that if they begin to address those things they begin to notice life smoothing out a bit. [Providing information based on personal clinical experience] Is that something you'd be interested in talking further about? [Open-ended question eliciting a commitment]

Patient: Yes definitely, I need to do something or I'm going to shut down.

Clinician: Are you open to some ideas from me? [Open-ended question]

Patient: Absolutely.

Clinician: Because you're already taking medication and that seems to be working for the most part, I would just encourage you to continue that. [Providing information]

Patient: Ok.

Clinician: The other part is therapy. What you might consider is focusing now on your daily tasks and routines and the way you feel. There are strategies called cognitive–behavioral strategies. They can help you learn self-management strategies. These are tools to help you organize and prioritize your daily routines in a way that seems workable

and doesn't overwhelm you. In that way you're not just relying on your attention and memory to do these things, you have a concrete, visible plan for structuring your day that makes sense and doesn't leave you feeling overwhelmed and hopeless. [Providing information] Does that sound like something that would work for you? [Open-ended question eliciting patient thoughts]

Patient: Yes! That's what I need to do. I just try to figure things out in my head and it doesn't work. I have too much going on. How would this therapy work?

In this example, the clinician makes recommendations based on the test results, the patients' disclosures, and observations during the early parts of the session. Thus, the recommendations are tailor made for the patient and their needs versus being esoteric advice that may or may not fit the patient's life and needs. In addition, patient reactions to the clinician's observations and recommendations are elicited throughout the session. In this way, the clinician can make sure the recommendations fit the patient and that the observations are correct.

The main points for developing a change plan and providing recommendations are as follows:

- Ask a "key question" in order to elicit from the patient what changes they want to make.
- Assess the patient's readiness to make changes by assessing the stage of change and the strength of their commitment language.
- Provide recommendations based on themes from the feedback session, the patient's cognitive profile, and life areas the patient has expressed concern about.
- Provide recommendations using the format "Elicit–Provide–Elicit," always enlisting the patient as an active collaborator in the treatment plan recommendations.