Advisory report

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Foreword

We needed to write a thesis to complete our physiotherapy degree at the hogeschool van Amsterdam. This advisory report is the first part of that thesis; the second is an article. Our article is a research project regarding the knowledge of sport theory and active participation in sports in terms of the effects on the limitations of chronic lower back pain (CLBP). The article describes our methods and conclusions and the statistical validity of the above relationships. This report contains the conclusions of that article and gives an insight into the statistics compiled in our research.

We want to thank the management, especially Dr. Joachim Mallwitz and Dr. Gerd Müller of the Rückenzentrum am Michel (RZAM) for giving us the chance to investigate the Michel-2 programme and for their time and advice. In this connection, our thanks also goes out to the RZAM team for giving us feedback, information and ideas to work with. We would also like to thank Michael Richter for his enthusiastic and professional insights and for finding time for us in addition to all his other responsibilities. Especially the brainstorming sessions were important. Thank you.

Our thanks go out to Sarina Keller and Hannah Böhm for their tips, ideas and translation work. We would also like to thank Liena van Oijen for her editing of the English texts.

We want to thank Mark Scheper for the statistical section.

Last but not least, we want to thank Edwin Bogaard, who guided us from beginning to end with amicable straightforwardness and professionalism and who always found the time to confer with us.

We hope you enjoy reading the report.

Remy Hakvoort and Jascha Kelters
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Advisory report RZAM  
Remy Hakvoort and Jascha Kelters
Introduction

The Rückenzentrum am Michel (RZAM) conducts a large amount of academic research and its programme is built on a firm scientific basis. Scientific-based work is an ongoing process.

For this reason, the RZAM wanted more scientific evidence for some aspects of the Michel-2 programme. Two important aspects of the programme are: staying physically active after the programme and a basic knowledge of sport theory.

As stated, this advisory report is the first part of the thesis; the second is an article describing the methods, results, conclusions and discussion. Some of the article’s conclusions are set out in this advisory report.

The outcomes of the article are only a fraction of the this report’s contents because of the stringent rules for scientific-based work. The information in this advisory report was not acquired scientifically but can nonetheless be of great value to the RZAM.

The goal of the advisory report is to provide the RZAM and its policy makers with an overview of some aspects of the Michel-2 programme and its effects. This report does not set out to require policy makers to make changes, but merely gives an insight and can be used as a form of feedback.

Chapter 1 contains conclusions from the article
Chapter 2 consists of advice regarding the Michel-2 programme
Chapter 3 sets out the statistics compiled for the thesis
Chapter 1: The conclusions of the article

- The subjects have significantly improved on the FABQ and SF-36 on the subscales for general health and the role of (physical) limitations compared with the past scores of the above questionnaires.
- Subjects who are presently active score significantly higher on the SF-36 on the subscales for general health and the role of (physical) limitations than subjects who do not participate in some kind of sport.
- Subjects who are presently active do not have a job significantly more often than subjects who are not active in some kind of sport.
- A weak positive relationship was found between the knowledge of sport theory and the score on the current SF-36 subscale for general health.
- Only 16 of the 46 subjects scored 6 or more points (total points = 11) and therefore have sufficient knowledge of sport theory.
- 60.9% of the subjects are currently still active in some type of sport.

Since the validity of the article is very low, the above conclusions should be interpreted with caution!
Chapter 2: Recommendations regarding the Michel-2 programme

Questionnaires
The RZAM uses four questionnaires: the FFbH-R, the HADS, the SF-36 and the FABQ. The patients complete these when they are admitted to the programme, but the authors discovered that these were not always completed at the end of the programme. Because the participants are easy to reach as long as they are in the RZAM, they can therefore be requested to completed questionnaires as yet. There are two reasons for doing this: 1) it provides direct feedback on the effects of the programme; and 2) future research will have access to more data.

Recommendation: Make the completion of questionnaires at the end of the treatment programme a standard procedure.

Inclusion criteria
There are inclusion and exclusion criteria for the Michel-2 programme. After several interviews, the authors discovered that these criteria are not always adhered to. This could affect the treatment programme and therefore the effectivity of the treatment.

Recommendation: review the inclusion and exclusion criteria for the actual treatment programme.

Criteria for successfully completing the programme
The authors do not know which precise criteria are used to decide whether patients had successfully completed the Michel-2 programme. When this has been established, it will be much easier to calculate the programme’s success rate.

Recommendation: use criteria which can be measured. For instance, do not use criteria such as “people are able to resume work after the programme” but “80% of people who completed the Michel-2 programme are able to resume work and to cope with the demands imposed by their work environment”.

The SF-36 version 1.0 vs. version 2.0
Morfeld et al. published an article which evaluated the amended the German SF-36 (version 2.0) in terms of psychometric properties (Morfeld et al. 2005). The RZAM uses version 1.0. Due to changes in version 2.0, the psychometric properties have improved. Morfeld et al. furthermore states that the licence for version 2.0 is in the hands of the US licensing authority whereas the user rights of the version 1.0 are available in Germany.

Recommendation: If the license can be obtained, version 2.0 of the SF-36 should be used. This is preferable because of the improved psychometric properties.
Record changes to the programme
Every treatment programme is liable to change over time. Changes, whether positive or negative, can affect the programme. Either way, it is worth noting the changes. If the treatment has benefitted, the exact cause should be recorded. If the treatment has suffered, it is also important to record the exact cause so that action can be taken.

Recommendation: Record changes to the programme

Use university students to conduct projects
Many students need to write a thesis to complete their course. If the RZAM has ideas for projects, but lacks time to conduct them, it could ask students to undertake them.

Recommendation: Present projects to universities so that students are aware of the opportunities for specific projects within the RZAM.

A sport theory test after the completion of the treatment programme
Sport theory is a part of the treatment programme. To assess the effect of sport theory in terms of symptoms, day-to-day activities and participation, it is important to determine what “sufficient” knowledge of sport theory is. This should be done by the person who gives the sport theory. This work plan could consist of a test at the end of the programme to assess whether what the patient has learned is sufficient. The instructor can use these results to decide whether the classes were informative. After some time, the patients could be asked to answer the same questions once again. This information could be used for studies on the effect of sport theory.

Recommendation: Make a written work plan for sport theory. Every sport theory instructor should be able to work with this plan.
Chapter 3: Statistics

Respondents
The respondents were selected from the RZAM database and had all participated in the Michel-2 programme in the past. Of the total number of former participants, only 182 were selected for inclusion in our study, because they met the following criteria: 1) they had participated in and completed the Michel-2 programme and; 2) they had completed the FABQ, FFbH-R and SF-36 post-questionnaires. These 182 subjects were originally part of another RZAM research project conducted by the RZAM psychologists. Subjects who were not included in that study did not complete post-questionnaires. The subjects were sent questionnaires by post. The return rate was 46.

Of the total group of 46 subjects, 16 were male, 28 female and 2 did not state their gender. The subjects ranged in age between 23 and 75, with a mean age of 49.49 years and a standard deviation of 11.35. One subject did not state his age.

All the subjects completed the Michel-2 programme between 2004 and 2009.

The subjects’ participation in various types of sport
As can be seen in table 1, “fitness” and “endurance” are, by far, the types of sport most frequently practiced immediately after the Michel-2 programme. This could be due to the sport therapists’ instructions or the overall experience in the RZAM.

Fitness
11 subjects who did take up fitness immediately after finishing the programme and are still active today. 22 subjects were active in fitness but have now discontinued it. 2 subjects did not start fitness immediately after the programme but are doing so today. It is unknown whether they are active in another type of sport than fitness. 11 subjects have neither participated in fitness directly after finishing the programme nor today.

<table>
<thead>
<tr>
<th>Type of sport immediately after Mi2</th>
<th>Frequency</th>
<th>Percent</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness</td>
<td>33</td>
<td>40.7%</td>
<td>73.3%</td>
</tr>
<tr>
<td>Endurance</td>
<td>25</td>
<td>30.9%</td>
<td>55.6%</td>
</tr>
<tr>
<td>Classes</td>
<td>8</td>
<td>9.9%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Ball sports</td>
<td>5</td>
<td>6.2%</td>
<td>11.1%</td>
</tr>
<tr>
<td>No sports</td>
<td>6</td>
<td>7.4%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4.9%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Total</td>
<td>81</td>
<td>100.0%</td>
<td>180.0%</td>
</tr>
</tbody>
</table>

Table 1
Endurance
17 subjects who took up an endurance sport immediately after the programme are still doing so today. 8 subjects were active in “endurance” but have now discontinued it. Again, is it unknown whether they are active in another type of sport. 2 subjects did not take up an endurance sport immediately after the programme but have taken it up in the meantime. 19 subjects have neither participated in endurance directly after finishing the programme nor today.

Classes
7 subjects took classes immediately after the programme and are still doing so today. Only 1 subject who took classes after the programme has stopped. 1 subject did not take classes immediately after the programme but is now active in this type of sport. 37 subjects have neither participated in classes directly after finishing the programme nor today.

Ball sports
1 subject who was active in ball sport immediately after the programme is still active in this type of sport and 4 became active immediately after the programme but have stopped in the meantime. 41 subjects have neither participated in ball games directly after finishing the programme nor today.

No sport
Only 6 subjects stated that they did not take up any kind of sport immediately after the programme. 4 and that they were still not active in some kind of sport, but the other 2 now participate in a sport. 14 subjects stated that they participated actively in sport immediately after the programme, but that they are now no longer active. 26 subjects were active in sport directly after the programme and are still active today.

Else
3 subjects stated that they participated in another type of sport immediately after the programme and that they are still active in that sport today. 1 became active immediately after the programme, but had stopped in the meantime and 6 subjects who did not participate actively in another type of sport immediately after the Michel-2 programme have taken up a sport in the meantime.

Frequency today

<table>
<thead>
<tr>
<th>Type of sport today</th>
<th>N</th>
<th>Percent</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fitness</td>
<td>13</td>
<td>19.1%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Endurance</td>
<td>19</td>
<td>27.9%</td>
<td>41.3%</td>
</tr>
<tr>
<td>Classes</td>
<td>8</td>
<td>11.8%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Ball sports</td>
<td>1</td>
<td>1.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>No sports</td>
<td>18</td>
<td>26.5%</td>
<td>39.1%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>13.2%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>100.0%</td>
<td>147.8%</td>
</tr>
</tbody>
</table>

Table 2

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Table 2 shows the frequencies that the subjects indicated for the type of sport in which they now participate. Again, the frequency of “fitness” and “endurance” is high, but also for “no sports”. Compared with immediately after the programme, it is clear that “fitness” has dramatically decreased - by almost 50%. Participation in “endurance” has decreased only slightly, but the percentage of “no sports” has more than tripled!

Of the subjects who completed their Michel-2 programme in 2005, 46.2% percent are presently not active in any kind of sport. 20% had become inactive by 2006, and 64.3% had become inactive by 2007. 2004, 2008 and 2009 have inactive subjects but it should be noted that these years have very few subjects (N=1, N=1 and N=2).

Of the 28 subjects who are still active in some type of sport, 21 stated that they participate on a regular basis. There would seem to be a trend that subjects who participate in a sport on a regular basis improve on the FABQ, FFbH-R and SF-36 on the subscales for general health, physical functioning and the role of (physical) limitations as compared with subjects who participate on an irregular basis. However, this could not be confirmed statistically.

The subjects were asked for their reasons for participating in a sport on a regular basis, giving the following options: 1) availability of a practice partner 2) sufficient room and access to material 3) super-compensation 4) time limitations 5) other. 2 subjects gave reason 1 (availability of a practice partner), 3 reason 2 (sufficient room and access to material), 6 reason 3 (super-compensation), 7 reason 4 (time limitations) and 4 gave reason 5 (other).

The knowledge of sport theory
A Chi² test was performed to see whether there was a significant difference in the knowledge of sport theory between subjects who are active in some type of sport and those who are not. Results show: Chi² = .486, df=1, p > .05. Conclusion: no relationship could be found.

Reasons for not actively participating in sports
If subjects stated that they were not currently active in a sport, they were asked to give one or more reasons.

Table 3 shows their answers. Because the subjects could give more than one reason, responses exceeded 100 percent. As stated above, only 18 subjects are not active in some kind of sport today. More than half stated that they are not active in sport due to health problems.
Reasons for being inactive in some type of sport

<table>
<thead>
<tr>
<th>Reasons for not participating Injured in a sport</th>
<th>Responses</th>
<th>Percent</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injured</td>
<td>2</td>
<td>9.1%</td>
<td>11.8%</td>
</tr>
<tr>
<td>No partner</td>
<td>2</td>
<td>9.1%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Health problems</td>
<td>11</td>
<td>50.0%</td>
<td>64.7%</td>
</tr>
<tr>
<td>Presently no symptoms</td>
<td>2</td>
<td>9.1%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Sport exacerbates symptoms</td>
<td>1</td>
<td>4.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>No motivation</td>
<td>1</td>
<td>4.5%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>13.6%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>100.0%</td>
<td>129.4%</td>
</tr>
</tbody>
</table>

Table 3

Did the former participants benefit from the programme?

The subjects were asked whether their symptoms had improved as a result of the programme. All 46 subjects responded. The percentages are set out in figure 1.

Figure 1

Below is a list which compares the subjective answers on an objective scale: the scores of the FABQ, FFbH-R and SF-36 questionnaires on the subscales for general health (GH), physical functioning (PF) and the role of physical limitations (RPL).

There are 5 different groups: A) subjects who stated that the programme had helped reduce their symptoms and who indeed recorded improved scores; B) subjects who stated that the programme had helped reduce their symptoms but who nevertheless recorded decreasing scores; C) subjects who stated that the programme had not helped reduce their symptoms and who recorded decreasing scores; D) subjects who stated that the programme was not helping them but nonetheless recorded improved scores; E) subjects whose scores were unchanged.
Comparison of objectivity vs. subjectivity

<table>
<thead>
<tr>
<th>Group</th>
<th>FABQ</th>
<th>FFbH-R</th>
<th>GH</th>
<th>PF</th>
<th>RPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>18</td>
<td>20</td>
<td>6</td>
<td>21</td>
<td>18</td>
</tr>
<tr>
<td>B</td>
<td>10</td>
<td>10</td>
<td>14</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>C</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>2</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>E</td>
<td>0</td>
<td>4</td>
<td>14</td>
<td>4</td>
<td>13</td>
</tr>
</tbody>
</table>

Table 4

SF-36, the subscale for health change

18 of the 46 subjects (37.0%) indicated that their health had improved compared with the previous year. 17 subjects (39.1%) indicated that their health had deteriorated compared with the previous year. 9 subjects (19.6%) indicated that their health was the same as the previous year, while 2 subjects (4.3%) did not complete this question.

Chi²-tests were performed to see whether subjects who resumed work immediately after the programme also had improved scores on above questionnaires. Subjects who resumed work immediately after the programme improved significantly, but only on the SF-36, subscale for the role of (physical) limitations (Chi² = .5.969, df=1, p < .05.). The other questionnaires showed no significantly improved scores.
Effectivity rating and experience rating

The subjects were asked if they could rate how effective the programme had been for them in terms of their symptoms (figure 2) and how they experienced the programme (figure 3).

Of the total of 34 subjects who benefitted from the programme, 32 rated the effectivity of the programme at a 6 or higher. 19 subjects gave the effectivity a 10, see figure 2. Of the 14 subjects who did not benefit from the programme, 11 rated the effectivity at a 5 or lower.

41 subjects gave the programme a 6 or more, but 29 gave a 10. Only 6 subjects gave the programme a 5 or lower.
Working respondents versus non-working respondents in two timeframes
Table 5 presents a return to work immediately after the programme and present employment. One case is missing, therefore N=45. As the table demonstrates, the majority of subjects who resumed work immediately after the Michel-2 programme, are still presently working. The majority of the subjects who did not resume work immediately after the programme presently do not have a job. The values are significant, as it means that subjects who had a job after the Michel-2 programme are also likely to be currently in work. Subjects who did not have a job immediately after the programme are likely to be unemployed today.

<table>
<thead>
<tr>
<th>Work resumed after Michel-2</th>
<th>Presently employed</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td>no</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 5**

How many weeks were the former participants unable to work?
The subjects were asked how many weeks they were unable to work in total between the end of the programme and today.
Figure 4 demonstrates number of weeks and the percentage of the respondents’ answers. N=46.

**Figure 4**
In 2004, 1 subject who did not resume work immediately after the programme had a total of more than 156 weeks off work.

In 2005, 8 of the 11 subjects who resumed work had less than 29 weeks off work. 1 subject who was unable to resume work had >156 weeks off work.

In 2006, all 9 subjects who resumed work immediately after the programme were unable to work for less than 29 weeks while 5 subjects who were unable to resume work had >29 weeks being off work.

In 2007, all 5 subjects who resumed work had had less than 29 weeks off work. Of the 8 subjects who did not resume work, 5 had >104 weeks off work, 1 had >30 weeks off work and only 2 had less than 29 weeks off work.

In 2008, 1 subject who did not resume work had >30 weeks off work.

In 2009, both subjects who resumed work had had less than 29 weeks off work. Data shows that only the subjects who resumed work immediately after the Michel-2 programme had zero weeks off work. In general, a tendency is seen: if a subject resumed work immediately after the Michel-2 programme, s/he was off work for fewer weeks than subjects who did not resume work immediately after the programme.

Which part of the programme was most effective?
The subjects were asked which part of the therapy they benefitted from most. Again, more than one answer was possible. Table 6 shows their answers. Because of the scope for giving more than one answer, the responses exceed 100 percent.

<table>
<thead>
<tr>
<th>Benefit from therapy forms</th>
<th>Responses</th>
<th>Percent</th>
<th>Percent of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>which therapy helped the most?</td>
<td>Physical training therapy</td>
<td>23</td>
<td>13.5%</td>
</tr>
<tr>
<td></td>
<td>Work Hardening</td>
<td>18</td>
<td>10.5%</td>
</tr>
<tr>
<td></td>
<td>Gymnastics</td>
<td>19</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>Physician's information</td>
<td>10</td>
<td>5.8%</td>
</tr>
<tr>
<td></td>
<td>Pain management groups</td>
<td>11</td>
<td>6.4%</td>
</tr>
<tr>
<td></td>
<td>Progressive muscle relaxation</td>
<td>16</td>
<td>9.5%</td>
</tr>
<tr>
<td></td>
<td>Individual psychology</td>
<td>17</td>
<td>9.9%</td>
</tr>
<tr>
<td></td>
<td>Individual physician</td>
<td>11</td>
<td>6.4%</td>
</tr>
<tr>
<td></td>
<td>Individual physiotherapy</td>
<td>17</td>
<td>9.9%</td>
</tr>
<tr>
<td></td>
<td>Combination of therapy</td>
<td>26</td>
<td>15.2%</td>
</tr>
<tr>
<td></td>
<td>No therapy has helped</td>
<td>3</td>
<td>1.8%</td>
</tr>
<tr>
<td>Total</td>
<td>171</td>
<td>100.0%</td>
<td>371.7%</td>
</tr>
</tbody>
</table>

Table 6
The number of physician contacts and types of therapy

Figure 5 represents the subjects’ contacts with physicians in the period between ending the programme and today. 3 of 46 subjects are missing.

No. of physician contacts

- No contacts: 43.45%
- 1-25: 6.52%
- 26-50: 26.09%
- 51-75: 10.87%
- 76-100: 4.35%
- 101+: 6.52%
- Missing: 2.17%

Figure 5
Feedback from former patients

There was room in the questionnaire for subjects to give ideas and feedback. This feedback is recorded below and has been translated as literally as possible.

- Pay more attention to individuals instead of the group as a whole. Look at the person behind the patient.
- Inform patients by email about coming classes at the RZAM.
- Give more individual coaching when patients are training on the fitness floor.
- Designate an area where patients can have/buy lunch. Patients now have to take food and drinks with them to the RZAM because there is no opportunity to buy it at the RZAM.
- After finishing the programme, patients want to get together so they can meet each other and the therapists and talk about their experiences and setbacks. For instance, once a year. In case of stagnation and/or setbacks, therapists can then again advise former patients and motivate them. Former patients can also motivate each other.
- Patients would like more after-care. Now all help suddenly stops after the 4-week programme.
- Create more time for training on the fitness floor. The training floor is too small.
- Create better schedules for patients in the Michel-2 programme.
- After finishing the programme, patients would like information or advice which other therapy forms could be useful for them.
- Patients who have specific problems in the spine and/or joints should be advised not to join the programme but to try other types of therapy.
- It should be made more clear that patients can only benefit if they also want this themselves.
- The dressing rooms are too small.
Reference