Choices And Changes * Presentation

I. Introduction and Overview (OVERHEAD)
   A. Physician frequently frustrated by inability to change negative patient behavior and impact of pt behavior on health outcomes (smoking, obesity, addictions, medications, exercise, therapeutic regimens)
      1. Actual causes of death in the United States (OVERHEAD)
      2. Incidence of nonadherence (OVERHEAD)
   A. Responses (EXAMPLES: HOW DO YOU RESPOND?) range from giving up to power struggling with pt to getting angry
      1. There is no point in even talking about this problem anymore
      2. I'll do whatever it takes to make you change
      3. I can't stand seeing this pt's name on my clinic schedule
   C. Will present model for facilitating change with patients, as well as specific skills and techniques

II. CONTEXTUAL ISSUES: CREATING A SUPPORTIVE ENVIRONMENT
   A. Premise: Change is a process (OVERHEAD)
      1. Takes time
      2. Not a straight line
   B. Establish a supportive clinical relationship to promote change (OVERHEAD)
      1. Use open-ended questions
      2. Use reflective listening (paraphrasing, clarification)
      3. Use empathy
      4. Avoid argument
      5. Accept and roll with resistance
   C. Establish a collaborative clinical relationship to promote change (OVERHEAD)
      1. Acknowledge and support patient's right to make autonomous choices
      2. Recognize and respect patient's competence
      3. You can do this. Let me help
      4. Be available to help whenever pt is ready
   D. Assess patient's understanding of the resources s/he needs to change
      1. What resources does the patient have?
      2. What does the patient believe is needed to make change?
      3. What access does the patient have to resources?

III. TYPES OF BEHAVIOR CHANGE (OVERHEAD)
   A. Increasing or initiating health promoting behaviors, adherence to therapeutic regimen
      1. Health: What are you doing these days that you believe contributes to your health?
      2. Medication/Therapy: Most of us forget to take medication as it is prescribed or don't follow thru with diet or exercise at some point or other. What difficulties do you anticipate having with this treatment regimen? (preventive); What difficulties are you currently having? (curative)

B. Decreasing or eliminating self-destructive behaviors

1. All of us at one time or another do things that aren't good for us. It might be not wearing a seatbelt or drinking more than we think we should. Are you doing anything right now that you would put into this category?

IV. MYTHS ABOUT BEHAVIOR CHANGE

A. Self-change is simple (OVERHEAD: *For every complex problem there is an easy answer, and it is wrong - HL Mencken)*
B. Self-change just takes willpower
C. I've tried everything - nothing works
D. People really don't change

V. ASSESSMENT (GROUP ACTIVITY)

A. Assess patient stage of change (THINK ABOUT AREA OF PERSONAL CHANGE AND ASSESS YOUR STAGE) (OVERHEAD)
    1. Pre-contemplation (don't know they need to change; don't think they can change or there is any reason to change)
    2. Contemplation (thinking about change)
    3. Preparation (have actually taken some preliminary steps toward change)
    4. Action (have implemented actual change strategies)
    5. Maintenance (have established behaviors to maintain change)
    6. Termination (change has become established part of repertoire)
B. Assess patient's conviction and confidence (GROUP) (OVERHEAD)
    1. Conviction - How important is this change to you? How committed are you to making this change?
    2. Confidence - How confident are you that you can make this change? How likely is it that you can make this change?
    3. Quantify - On a scale of 1-10, how important… how confident?
    4. Use these two dimensions to assess likelihood of success
        a. Continuum: no conviction, no confidence - change unlikely
        b. Knows change is necessary, but lacks confidence
        c. Is confident about ability to change, but skeptical about importance of change
        d. High conviction, high confidence - change most likely

VI. MOVING A PATIENT TO A DIFFERENT STAGE OF CHANGE

A. Precontemplation (OVERHEAD)
    1. Increase pt's perceptions of risks and problems with current behavior
    2. Encourage patient to be on guard against defenses, rationalizations
    3. Don't push into action before they are ready
    4. Don't nag - repetitive, insistent comments usually backfire
    5. Don't give up
    6. Don't enable - strengthens denial
B. Contemplation (OVERHEAD)
    1. Tip the balance - evoke reasons to change, risks of not changing
    2. Avoid premature action (without preparation)

3. Collect data about the problem (monitoring)
4. Define specific goals
5. Create a new self-image
6. Encourage pt to let people who care about them help them

B. Preparation (OVERHEAD)
   1. Turn away from old behavior
   2. Make change a priority
   3. Set a date
   4. Go public - tell other people what you are going to do
   5. Create an action plan

D. Action (OVERHEAD)
   1. Substitute healthy behaviors for unhealthy behaviors
   2. Environmental control (avoidance, cues, rewards)
   3. Contracting
   4. Social support

E. Maintenance (OVERHEAD)
   1. Anticipate difficulties
   2. Avoid overconfidence, daily temptation, self-blame
   3. Avoid problematic environments
   4. Create a new lifestyle
   5. Have a "helper" on call
   6. Learn from relapse (stress precipitates relapse)

VII. IMPROVING CONFIDENCE AND COMMITMENT

A. Enhancing patient confidence (OVERHEAD)
   1. Pt, family, friends, doctor recalls times in past , or point out current behaviors when pt successful making changes
   2. Have pt talk to similar person who was able to make change successfully
   3. Discourage either/or thinking; suggest change is cyclical, and although pt may not be confident now, may become more confident later
   4. Have pt break down change behavior into small steps that s/he feels have more likelihood of being accomplished; and acknowledges any positive steps toward change
   5. Frame slips as occasions for problem-solving rather than self-recrimination
   6. Emphasize patient's competence

B. Enhancing patient conviction
   1. Provide new information that you have not presented before
   2. Bring in additional authority figure (another doctor) to emphasize points
   3. Have significant others talk to patient about importance of problem
   4. Have pt talk to someone similar who used to feel problem was not important, but then changed their perspective

5. Point out discrepancies in pt values (says it's important, but chooses not to do anything about it); ambivalence means part of pt believes it is important to change
6. Find the source of motivation (ie., won't stop smoking for self, but for children)

C. Maintaining confidence and conviction
1. Plan for relapse, and define as part of the process
2. Identify and remove obstacles that interfere with maintaining change
3. Attend to and support any signs of pt progress

VIII. FUNDAMENTALS OF BEHAVIOR MODIFICATION

A. Identify target behavior (more of/less of)
B. . Functional analysis: antecedents, behavior, consequences
D. Strengthen existing behavior - skills already within repertoire
1. Strengthen antecedents
2. Strengthen consequences (positive reinforcement, rewards)
3. Proximity to desired behavior is important
4. Reinforcing agent - prestigious person

E. Developing new behaviors
1. Successive approximation (intermediate steps, increasing accuracy, longer intervals of good behavior, increasing effort)
2. Never ignore desired behavior (ignoring extinguishes behavior, attention encourages)
3. Modeling the good example
4. Role-playing - behavioral rehearsal

F. Extinguishing undesirable behavior
1. Ignoring
2. Substituting positive behavior (countering)
3. Consequences

IX. BASIC TECHNIQUES TO PROMOTE BEHAVIOR CHANGE

A. Education
B. Resource identification
C. Reinforcement/encouragement (cheerleading)
D. Empowerment of patient
E. Optimism/hope (crisis as opportunity)
F. Reframing (look on the bright side)
G. Theory of natural consequences (step out of the way; life is a teacher)
H. Solution-oriented approach (that's the question, now what's the answer):
1. Answer lies within patient (what have you done in the past?; what do you think might work; what existing resources do you have that you can bring to bear on the problem; what are you doing now that sometimes works?)
2. Answer lies in others: new suggestions to break out of old patterns (one patient I know approached the problem by…)

I. Brief Interventions
1.Identify something new and positive that happened in your life that you want to continue to happen (patients tend to focus on the perceived stability of their

problematic patterns; this focuses on the possibility that positive change can occur spontaneously in their lives)

2. Do something different (patients tend to believe they have used up their repertoire of available responses to the problem; this shows them other options exist)

3. Pay attention to what you do when you overcome the temptation to perform the behaviors associated with the complaint (patients tend to view their problem behavior as compulsive and beyond their control)

4. A lot of people in your situation would have… (patients tend to assume that what they are doing in response to their problem is the only logical thing to do)

X. RESISTANCE

A. Resistance is usually an indication that the clinician has:
   1. Not established rapport with pt
   2. Lost rapport with pt
   3. Chosen an inappropriate intervention strategy for pt

B. When encounter resistance, best approach is to shift strategies (rolling with resistance)
   1. Reflective listening: let the pt know you hear what the pt is trying to tell you (You're concerned you will never be able to stop smoking)
      a. Amplified reflection: exaggerate what the pt is saying as an invitation to have the pt disagree with the exaggeration (So, there is no possible way that you could stop smoking as long as you continue to live with your husband)
      b. Double-sided reflection: feedback both sides of pt ambivalence (On the one hand, you'd love to quit smoking because you'd feel better and be healthier; on the other hand, you feel smoking is a part of who you are. That's a tough dilemma)
   2. Shifting focus: Take a detour around the barrier to change presented by patient (So you don't think that smoking has anything to do with your breathing problems and feeling winded. You seem quite convinced there is no relationship. Tell me a bit about other explanations you have been thinking about)
   3. Agreement with a twist: Agree with a portion of the pt's premise, but use the agreement as a starting point to explore a new direction (I understand what you're saying. In your house it is impossible for you to give up smoking because everyone else is smoking. This sounds like an issue that involves the whole family. Let's talk about how this family issue can be dealt with)
   4. Emphasizing personal choice and control: A response to pt's feeling loss of control over need to make behavioral change (This choice is up to you. No pushing or shoving from your wife or children, or me can take this away from you. You are the one who will make the final decision)
   5. Reframing: Use the information that pt has provided in a new way that opens up possibilities rather than closes them down (I understand you are worried you will never be able to stop smoking because you've

tried in the past, and were not successful. Actually, I see this as a good sign because it demonstrates your long-term commitment to stop. It's clear you are motivated to stop, we just have to find the right approach).

6. Paradox: Create a situation for the patient in which resistance to the clinician brings about movement in the desired direction (What you're telling me is that smoking is not something you do, it is who you are and you can't imagine changing that part of yourself. So maybe you should keep smoking as a way of protecting your sense of who you are. Maybe you would lose too much of who you are if you stopped smoking).