Helping People Change Health-Related Behaviors

LEARNING OUTCOME AND OBJECTIVES: Upon completion of this continuing education course, you will be able to explain the concept of change and practical strategies for helping people change their health-related behaviors. Specific learning objectives include:

- Discuss the concepts of a change agent and the nature of change.
- Describe the stages of the Transtheoretical (Stages of Change) Model.
- Identify factors affecting an individual’s ability to change.
- Describe techniques that healthcare professionals use to facilitate behavioral change.
- Review the principles underlying motivational interviewing as applied in the healthcare setting.

INTRODUCTION

It is readily recognized that changing a behavior and forming new habits is a hard thing to accomplish, and healthcare professionals are often frustrated when patients do not follow medical advice or treatment recommendations. It may be difficult to understand the reluctance or unwillingness of a patient to make important changes that have been shown to improve health and well-being, especially after healthcare professionals have repeatedly stressed the importance of doing so. In the United States, for example:

- 3.8 billion prescriptions are written every year, but over 50% of them are taken incorrectly or not taken at all.
- $40 billion a year are spent on diet aids, but only 1 out of 20 individuals has success in losing weight and maintaining the weight loss.
- Two years following coronary bypass surgery, only 10% of patients manage to maintain the lifestyle changes that are necessary for a good future outcome.
• Even after hospitalization for acute myocardial infarction, only half of patients were still taking their medications two years later.

• Most people who quit smoking relapse within a year of quitting.
  (Caprino, 2015; Chesanow, 2014; Bold et al., 2015)

Recognizing both the difficulties and resistance to change, researchers continue to examine the nature of change and how healthcare professionals can motivate, educate, and support individuals throughout the process of change.

Borrowing from knowledge gained concerning efforts to make change within organizations, healthcare professionals have adopted the concept of a change agent whose role involves assisting individuals in understanding why change is necessary, but more importantly in understanding how change benefits them. An effective change agent is an active listener who provides tools, assistance and resources that will enable change to occur (Kennedy, 2014). To accomplish this, healthcare professionals must:

• Understand the nature of change
• Develop a collaborative relationship and negotiate an action plan
• Communicate in ways that facilitate behavioral change

THE NATURE OF CHANGE

Change is movement, alteration, adaptation, and action. Change is inevitable.

Change is a process and not an event; it occurs with or without a particular timetable, expert direction, or even planning. Sometimes change occurs slowly and subtly, sometimes quickly and dramatically. Even when it is planned and specific outcomes are identified, change occurs haphazardly and seldom proceeds in a straight line or at a steady pace because it is affected by multiple internal and external factors.

Types of Change

Because of its importance in every field of human endeavor, the concept of change has been the subject of study for several decades. The table below indicates the types of change identified in early, classic research on the topic.
TYPES OF CHANGE

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<td>• Interactional</td>
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<td>• Socializing</td>
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All of these pioneer researchers recognized **planned change**, that is, change that focuses on a specific, measurable outcome. This is the kind of change healthcare professionals seek to bring about in their patients.

**Planning Change**

All planned change has an end goal: a specific outcome the planner hopes to achieve. Even so, healthcare professionals differ regarding the most effective way to bring about such an end. Some clinicians take a content-driven approach to planned change, while others follow an outcome-driven approach.

Those who take a **content-driven approach** theorize that when patients receive information about a disorder or a harmful activity, they will “see the light,” apply the data to their personal situation, and change their behavior. This approach tells people what they need to change but does not build motivation to change. Content is necessary, of course, but not sufficient (Hamel & Zanini, 2014).

A more effective method of bringing about planned change in patients is to use an **outcome-driven approach**. This approach focuses on specific, measurable objectives. Information is personalized and related to specific goals.

**CASE**

Jim just learned he has type 2 diabetes. He knows nothing about diabetes and until now has paid little attention to his diet or health. Using a content-driven approach to patient education, the provider gives Jim several pamphlets about diabetes, refers him to a diabetes website, and suggests he attend classes offered by the local hospital. Though Jim reads the brochures and information he finds on the website, he does not understand how to apply it to his condition, nor does he grasp the seriousness of the red, swollen area on his foot that never seems to heal.

When Jim attended the class at the hospital, he realized he needed much more information as it applied to his own personal situation. He asked the patient educator who conducted the class for help. The educator consulted with Jim’s physician and, using an outcome-driven approach, identified specific, measurable objectives to help Jim meet his diabetes learning needs.
One of the objectives was: “Jim will accurately perform a blood glucose test, 100% of the time.” At a private session, the educator explained the reason for the test and its relevance to Jim’s disorder. She encouraged him to talk about his fear of blood and pain. Then, she demonstrated the procedure and discussed problems that might arise in performing the test. Jim mirrored her demonstration until he could do it accurately, every time.

Discussion

A patient educator, acting as a change agent, linked the rationale for performing a blood glucose test to Jim’s disease and diet, further motivating Jim to change his behaviors. In doing so, the educator helps Jim to develop an outcome-driven approach that:

- Clearly states each specific, measurable objective (i.e., Jim accurately performs a blood glucose test 100% of the time)
- Identifies barriers to changing behavior (i.e., Jim admits that he is afraid of blood and the pain associated with a needlestick)
- Looks for specific items and behaviors to facilitate change in the patient (i.e., the educator shows Jim how to use the blood drawing equipment to reduce the amount of blood drawn and the degree of pain felt with repeat tests)
- Arranges follow-up to help the patient maintain newly acquired healthy behaviors (i.e., the educator schedules regular clinic visits for Jim and enrolls Jim in a diabetes self-management program)

STAGES OF CHANGE

In order to help patients make change and to maximize the success of interventions, it is important that healthcare professionals have a theoretical understanding of change. Such theory comes from the accumulated knowledge about what mediates and moderates change behavior. There are currently at least 82 theories of behavior and behavior change (Davis et al., 2015).

FOUR MAJOR THEORIES AND MODELS OF CHANGE BEHAVIOR

- Theory of Planned Behavior (TBP): Change in behavior is determined by intention to perform the behavior.
- Health Belief Model (HBM): Behaviors are based on attitudes and beliefs.
- Social Cognitive Theory (SCT): Change is driven through interaction between environment, personal factors, and attitudes.
- Transtheoretical Model (TTM): There are six stages of change.
Of the four major theories and models, the most widely applied and tested of them is the Transtheoretical Model (TTM), also referred to as Stages of Change. This model identifies six sequential stages that people move through as they change from old behaviors to new ones:

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance
6. Termination

(Prochaska, 1994; USDHHS, 2007; UMBC, 2013; Gold, 2016)

Stage 1: Precontemplation

Precontemplation is the stage when there is no conscious intent to make a change. A precontemplator may have a sense that a behavior is not beneficial but is reluctant to consider change. Some individuals may be rebellious or resistant to being told what to do. Others may be resigned, having given up hope about any possible change. And others may use rationalization to deny that there is a need to change a behavior.

Stage 2: Contemplation

Contemplation is the stage when individuals are aware that the behavior is a problem and intend to change behavior relatively soon, but they may vacillate for a long period of time. Often, people in the contemplation stage are not yet truly ready to change. They may procrastinate or doubt their ability to change. Individuals in this stage are often highly ambivalent, may be interested in learning about how to make change, but still cannot make a decision.

Stage 3: Preparation

Preparation is the stage in which individuals know they must change and become committed to take action to change. Often something happens to motivate a person to take action, such as an emotion-laden crisis, recent illness, or plea from an important person in their life. During this stage, not all ambivalence has been resolved but it no longer is an impossible barrier to overcome. Preparation involves creation of a realistic action plan with achievable goals, often with the help of a healthcare professional.

Stage 4: Action

This is the stage where people believe they have the ability to change behavior and are actively involved in taking steps to do so. They develop new habits and work toward what some have called “SMART objectives.” These objectives are specific, measurable, attainable, realistic, and time-bound.
SMART OBJECTIVES

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<tr>
<th>Objective</th>
<th>Example</th>
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<td>S Specific</td>
<td>“I will no longer smoke cigarettes or any other substance.”</td>
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<tr>
<td>M Measurable</td>
<td>“I will keep not one cigarette, even an ‘emergency smoke,’ in my environment.”</td>
</tr>
<tr>
<td>A Attainable</td>
<td>“I have overcome other cravings. Other folks have stopped smoking, and I can too.”</td>
</tr>
<tr>
<td>R Realistic</td>
<td>“Smoking is not necessary for survival, and in fact, it may kill me.”</td>
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<tr>
<td>T Time-bound</td>
<td>“I will stop smoking on January 1, the beginning of a new year.”</td>
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Stage 5: Maintenance

Many people relapse into old behaviors. Relapse is common and may even be inevitable. Maintenance is the stage in which people work to prevent relapse. They are tempted to go back to their old behaviors and need ongoing support to develop new patterns of living. Such support is enhanced by encouragement from primary care providers, colleagues, friends, and members of self-help groups or counseling groups. Most people spiral up and down these five stages of change several times before they make a lasting change. But it is said that as long as the person is in the spiral, he or she is making progress.

Stage 6: Termination

Termination is that time when temptation to relapse is no longer a threat. The person now has complete confidence that change has been accomplished and no longer fears relapse.

CASE

Kathy has smoked cigarettes for more than 35 years. She’s aware that the habit is bad for her, and she tried to quit in the past without success. Family members have urged her to quit, but she tells them to stop pestering her about it.

Recently Kathy developed a cough, especially at night, excessive sputum, and some shortness of breath. She has also felt more fatigued lately. She thought she had a cold, but it has lingered for more than two months. She made an appointment to see her healthcare provider, who eventually diagnosed chronic obstructive pulmonary disease (COPD).

Faced with this new diagnosis, Kathy was strongly urged to discontinue smoking. She was given information about the disease process and pamphlets that offered suggestions for stopping smoking. She took them home, read them, thought a lot about quitting, and even had days when she thought she might really quit this time. But the lure of the cigarette was too strong. She loved the taste of her cigarette, especially after a cup of coffee, and really couldn’t imagine giving that up. On the other hand, she thought, “I’m not really enjoying this coughing and shortness of breath.”
One day, the temperature outside was below zero and she walked down the long driveway to
the mailbox. On her way back, she became shorter and shorter of breath. Her chest felt tight,
and she began to wheeze. She couldn’t stop coughing. She barely made it back into the house,
went in, lay down, and waited fearfully until she could breathe again. At that point, she knew
she was going to quit smoking. That same day, she decided how she was going to do it. She
called her provider’s office and asked about the smoking cessation classes mentioned in the
pamphlets she was given.

Kathy was now ready to quit. First she attended the smoking cessation classes offered by the
local hospital. The educator helped her identify times when she usually smokes, plan other
activities at those times, and arrange with friends for support when she needs it. One simple
trick she learned was that eating citrus fruit after her coffee took away her craving for a smoke.
Kathy learned of the “SMART” objectives and set January 1 as her date to quit.

Once the new year rolled around, Kathy realized she’d need help to maintain her goal, so she
joined a community support group of other long-time smokers, all of whom were determined to
stop smoking. Over the weeks, the other members encouraged Kathy and gave her tips to
prevent relapse.

One year later, Kathy no longer smokes and no longer wants to. In fact, she is turned off by the
smell of secondhand smoke. Her COPD has not progressed any further, and she intends to keep
it that way.

**Discussion**

Kathy was in the **precontemplative** stage initially, did not recognize any need to discontinue
smoking, and was resistant to the idea. She entered the **contemplative** stage of change when
she received a diagnosis of COPD. When she experienced the extreme effects of cold on her
COPD, she entered the **preparation** stage, which quickly led her that same day to the **action**
stage, at which time she called for information and then joined the smoking cessation classes.
Her ongoing participation in the community support group represents the **maintenance** stage,
and the **termination** stage had occurred at the end of one year.

**FACTORS AFFECTING CHANGE**

**Motivation and Willpower**

In order for an individual to alter a behavior, it is important to understand the significance of
motivation and willpower and how they affect the change process. Motivation is often described
as “why” we do something, the explanation for a behavior. Motivation includes the decision to
initiate a goal, the persistence or continued effort to achieve that goal, and the intensity or
amount of effort the individual puts into the pursuit of the goal (Nevid, 2013).

Willpower is the conscious effort to regulate the self. It is defined as the ability to delay
gratification, to resist short-term temptation, and to override unwanted thoughts, feelings, or
impulses in order to meet long-term goals. Willpower is the ability to do what is needed while having an awareness of long-term goals. Together these qualities give an individual self-control and self-awareness. Extrinsic and intrinsic values create external and internal motivations, but willpower is the most powerful reason that a behavior can continue beyond the initial motivation (APA, 2016a).

**Knowledge and Skills**

Another major factor in helping patients commit to a plan with proven results is the acquisition of the right knowledge and problem-solving skills. The healthcare professional is often the source for such knowledge, offering appropriate resources, including formal training, to enhance skills needed to accomplish and maintain behavioral change (APA, 2016b).

**Support**

Multiple studies have shown that social support is a significant influence on a person’s ability to make a successful behavior change. Individuals who receive support for change can strengthen willpower and stay on track toward meeting their goals. With appropriate support from family, friends, and healthcare professionals—such as a nurse or therapist—the individual can develop the skills necessary to make lasting change.

Support can also come from having access to models of behavior in the form of peer support groups, group counseling members, as well as people who help form the individual’s view of what is normal. Coaches may be specialists in helping to change, and fans may provide praise and motivation (Evans, 2013; Patterson et al., 2012).

**TECHNIQUES FOR FACILITATING CHANGE**

To bring about behavioral change, healthcare professionals use a variety of techniques to support clients in making significant, health-promoting changes in their lives. Techniques used for this purpose include:

- Applying motivational interviewing in practice
- Eliciting change talk
- Arranging follow-up
- Encouraging those clients who do not seek change
Motivational Interviewing (MI) in the Healthcare Setting

All of the following supportive techniques help to bring about behavioral change and constitute what is called motivational interviewing. Those who practice motivational interviewing:

- **Show nonjudgmental empathy.** Nonjudgmental empathy is the ability to encourage patients to fully express themselves, allowing the patient to dominate the discussion. The empathic listener is attentive to what is being said, does not judge, does not interrupt, is sensitive to the emotion being expressed, and attempts to see the world through the patient’s eyes.

- **Listen attentively and reflectively** to patients to draw out rather than impose ideas. Attentive listening involves the use of positive body language such as facing the person and making frequent eye contact to actively be “seen” as listening. Reflective listening involves expressing back to the patient what has been heard using either the patient’s own words or rephrasing them.

- **Develop and examine the discrepancy** between the individual’s goals and current behavior. This involves helping the person focus on how current behavior differs from desired behavior by describing what the person’s values are and how current behavior is in conflict with them.

- **“Roll” with resistance** by recognizing, acknowledging, and exploring the patient’s resistance rather than opposing it. Resistance is evident by such behaviors as rejecting an idea, disagreeing, excusing, minimizing, inattention, ignoring, or being defensive. The clinician avoids arguing for change and addresses the underlying concerns and fear of change.

- **Empower** the patient to make change and give responsibility to the patient, rather than being a passive recipient of healthcare. Empowerment is a process that involves collaborative interaction, education, counseling, coaching, as well as self-education.

- **Support self-efficacy.** Self-efficacy is the patient’s belief that change is possible and that he or she has the ability to make change. The clinician focuses on eliciting and supporting optimism by recognizing past successes, highlighting skills and strengths.

  (Miller & Rollnick, 2002; Ingersoll, 2015; MINT, 2014; Lochte & Markgraf, 2015; Tartakovsky, 2016)

MI is a particular type of conversation about change in which the patient rather than the healthcare professional brings forth the arguments for change. MI is also a collaborative process, a partnership that respects the patient’s autonomy, empowers, and gives responsibility for change to the patient. It requires the provider to recognize each patient’s worth and potential. Using empathy, the healthcare professional strives to understand the patient’s perspective while affirming strengths and efforts. Through collaboration, the patient and provider **negotiate** a plan to help make change happen.
Developing a partnership for change involves the willingness of the healthcare professional to **suspend the reflex to give expert advice** and to ask questions that allow for the exploration of the patient’s motivations. The basic communication style of motivational interviewing, referred to by the mnemonic **OARS**, involves:

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<td>Reflective listening</td>
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<td>Summary</td>
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**OPEN QUESTIONS**

Open questions invite the patient to elaborate and **cannot be answered with a yes or no**:

- Open question: “What makes change hard for you?” (“I’m not sure, but …”)
- Closed question: “Change is hard for you, isn’t it?” (“Yes, it is.”)
- Open question: “Tell me how drinking fits into your life.” (“I like to relax after work with a few drinks and …”)
- Closed question: “Do you think you drink too much?” (“No, not really.”)

**AFFIRMATIONS**

Affirmations are statements that recognize the patient’s strengths. They assist in building rapport and help the patient see him or herself more positively.

- “You are really taking this seriously.”
- “You’ve been successful in changing your smoking behaviors in the past.”
- “You showed a lot of courage in dealing with that problem.”

**REFLECTIVE LISTENING**

Reflective listening is a crucial skill in which the listener paraphrases and restates both the feelings and the words of the speaker. It does not involve asking questions. Techniques of reflective listening include mirroring and paraphrasing.

**Mirroring** is repeating back key words or the last few words spoken while using the person’s tone of voice, pace of speaking, and body language.

- Patient (sarcastically): “I really am angry with everyone telling me to eat right and get more exercise!”
• Clinician: “You really seem angry to me!”

**Paraphrasing** is putting the patient’s message into your own words in an abbreviated form.

• Patient: “I wish I could wake up in the morning and feel ready to face the day.”
• Clinician: “You want to feel motivated to get up and do things.”

**ROADBLOCKS TO LISTENING**

- Commanding, directing, ordering
- Threatening, warning
- Providing solutions, making suggestions, or giving advice
- Using logic, lecturing, or arguing in order to persuade
- Preaching, moralizing, using “should do’s”
- Judging, disagreeing, blaming, or criticizing
- Approving, praising, agreeing
- Ridiculing, labeling, shaming
- Interpreting or analyzing
- Sympathizing, consoling, or reassuring
- Probing with questions
- Humoring, changing the subject, distracting, withdrawing

Source: MINT, 2014.

**SUMMARY**

Summary is a type of reflection in which the clinician recaps what has occurred in all or part of the interaction. Summaries communicate interest and understanding. They can also be used to shift attention and prepare the patient to move on.

• Clinician: “It sounds like you’re concerned about how much alcohol you are drinking because it’s caused difficulties at home, and your wife wants you to stop. But you also said how important it is to have a few drinks when you get home from work so you can relax. That sounds like a difficult choice.”

**Eliciting Change Talk**

The more an individual talks about change, it is said, the more likely they are to change. Change talk consists of responses the clinician elicits from patients. Patients’ responses normally contain
reasons for change that are important to them personally. Elements of change talk can be remembered using the mnemonic DARN-CAT.

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The clinician elicits change talk by:

- Asking evocative questions (what, when, where, how) and avoiding why questions
- Exploring decisional balance (pros and cons of change)
- Asking for elaboration or example (“Tell me more about …”)
- Looking back to the time before the onset of the behavior (“How was it different/better?”)
- Looking to what life would be like a few years from now (goals and values)
- Asking about extremes (“What are the worst things that may happen if change does not occur, and what are the best things if it does?”)
- Siding with the status quo (“Drinking is so important to you that you won’t stop no matter what it costs you.”)

The clinician may use change rulers, such as a scale from 1 to 10, to determine how important it is for the patient to change and how confident the patient is about making the change.

- “On a scale of 0 to 10, how convinced are you of the importance of this change?”
- “On a scale of 0 to 10, how confident are you that you can change this behavior?”

It is important that the clinicians elicit more information than they provide, ask rather than tell, and listen rather than advise. In order to provide information to the patient, the clinician should first find out what the patient already knows, and then ask permission to add more.

- “What do you know about how smoking affects your circulation?”

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• “I have some information about how to begin an exercise program. Would you be interested in hearing about it?”

**CASE**

Janet is a 62-year-old woman who is 5 foot 7 inches tall and weighs 201 pounds. She has been diagnosed with type 2 diabetes and is taking Glucophage, 500 mg, twice a day. Today Janet is returning to the clinic for her three-month follow-up visit. Her A1C level from yesterday was 7.9%, and her log of blood sugar readings shows less than optimal control.

Clinician: “Hello, Janet. Nice to see you again. Tell me how things are going with you?” *(open question)*

Janet: “Well, pretty good. I’m not very happy about my blood sugar readings, though.” *(evoked elaboration)*

Clinician: “Your blood sugar readings are not where you want them.” *(rephrasing)*

Janet: “No, they’re not! And I’m really upset about that because I thought I was doing pretty good with everything.” *(evoked emotional elaboration)*

Clinician: “You sound quite upset!” *(mirroring)*

Janet: “I am! I know it’s my fault. I’m having a real hard time sticking to this diet and trying to lose weight.” *(evoked elaboration)*

Clinician: “You’re blaming yourself for not sticking to the changes needed to keep your blood sugars under control.” *(reflecting)*

Janet: “That’s right. I have a hard time passing up desserts, and I love my wine with dinner.” *(evoked elaboration)*

Clinician: “Giving up desserts and wine is very hard for you.” *(reflecting)*

Janet: “Yes. I’m a foodie and a wino (laughs).” *(asking for empathy)*

Clinician: “I understand and can certainly relate to that!” *(empathy)*

Janet: “You know, I just can’t understand why it’s so hard for me to lose weight. I’ve lost at least 500 pounds during my lifetime. But eventually I gain it all back.” *(elaborating)*

Clinician: “You’ve been successful at losing weight in the past.” *(affirmation)*

Janet: “Yes I have, but eventually it gradually creeps back on.” *(elaborating)*

Clinician: “It sounds like you want to stick to your diet and lose weight, but you still want to enjoy the foods you like. That sounds like a dilemma to me.” *(summary)*

Janet: “It is. I know how important it is to manage my diabetes, and I really want to change things. I want to live long and healthy to see my grandchildren grow up. I know I can change, but just can’t quite manage to.” *(change talk)*
Clinician: “Let’s see now, you’re telling me how important it is to be in good health in order to see your grandchildren grow up. At the same time, you’ve told me how eating the foods you like and drinking wine are important to you.” (developing and examining discrepancy)
Janet: “Both of those are true. But I really do want to be there for them, and I believe I really can make some changes.” (change talk)

Clinician: “You have strong motivations for wanting to change, and you believe you are capable of changing.” (supporting self-efficacy)
Janet: “Yes, yes. I do.” (change talk)

Clinician: “Well, Janet, tell me what you think you can do to make these changes.” (finding out what the patient already knows)
Janet: “Well, I know about the Atkins Diet, the South Beach diet, the Grapefruit Diet, and any other weight loss program you can name.” (elaborating)

Clinician: “That’s a lot of information you already have. Tell me, though, would you be interested in learning some other ways to accomplish your goals?” (asking permission to give information)
Janet: “I could be. What other suggestions do you have?” (collaborating)

Clinician: “Would you perhaps be interested in attending meetings with other people who have diabetes and are experiencing the same difficulties you are?” (collaborating)
Janet: “Well …, I don’t really think that would be good for me.” (resisting)

Clinician: “You think that you wouldn’t want to be in a group?” (rolling with resistance)
Janet: “Well, group ‘therapy’ always seems to me to be about being too weak to do something on your own.” (evoked elaboration)

Clinician: “You believe others in the group will consider you a failure.” (reflecting)
Janet: “Yeah. But … maybe I could give it a try.” (collaborating and negotiating)

Clinician: “Would you like me to arrange for you to attend our diabetes education classes?” (collaborating, negotiating a plan, empowering)
Janet: “Yeah. Okay. Why don’t we try that.” (collaborative response)

Arranging Follow-Up

As change agents, healthcare professionals realize that even when their patients are well along on the path toward their objective, they must work to prevent relapse. Though patients are confident they can continue their identified change, they are still vulnerable. For this reason, caregivers need to arrange and encourage follow-up measures to help people maintain the changes they have worked so hard to achieve, such as ongoing visits, membership in support groups, participation in managed care that emphasizes wellness, and mentoring.
When patients do “crash” and regress to an earlier stage of change, their self-confidence may vanish and they may feel they have failed. Happily, research indicates that in the case of smokers, only 15% regress all the way back to the precontemplation stage of change. Most of those who crash go back only one or two stages and then move forward again. It is during these times that encouragement by healthcare professionals helps people achieve their goal.

**Encouraging Those Who Do Not Seek Change**

Many patients want to change and only need the encouragement of a professional. However, some people with problems do not want to change. These people may be:

- Afraid of the consequences of seeking help
- Ignorant of resources for help
- Discouraged because they have been unsuccessful in the past
- Angry because of their lot in life
- Believers of some untested theory or miracle cure

Caregivers cannot force adults to seek help to change, however they can encourage patients and assure them that professionals are there to help them flourish.

**CONCLUSION**

Change is hard, but change is not impossible. This is a fact healthcare providers should remember when feeling frustrated by a patient’s failure to make changes known to improve their health and well-being. Understanding the nature of change, the stages of change, and factors affecting change can assist the clinician to remain supportive rather than dismissive of someone’s ability or willingness to change.

By using the supportive techniques discussed in this course, healthcare professionals can help guide their patients through the process of change by collaborating with them, negotiating action plans with them, empowering them, and supporting their self-efficacy. Making change possible can result in a well-deserved sense of satisfaction for both clinicians and patients.

**RESOURCES**

Motivational interviewing
http://www.motivationalinterviewing.org
REFERENCES


**DISCLOSURE**

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**ABOUT THIS COURSE**

You must score 70% or better on the test and complete the course evaluation to earn a certificate of completion for this CE activity.

**ABOUT WILD IRIS MEDICAL EDUCATION**

Wild Iris Medical Education offers a simple CE process, relevant, evidence-based information, superior customer service, personal accounts, and group account services. We’ve been providing online accredited continuing education since 1998.

**ACCREDITATION INFORMATION FOR WILD IRIS MEDICAL EDUCATION**
1. To be an effective change agent, healthcare professionals must:
   a. Allow the patient to make changes without assistance from others.
   b. Disregard the patient’s resistance to change.
   c. Develop a collaborative relationship with the patient.
   d. Write action plans based solely on clinical guidelines.

2. Which method of bringing about planned change is more effective?
   a. Information-driven approach
   b. Content-driven application
   c. Interpersonal communication technique
   d. Outcome-driven approach

3. The most widely tested theory of behavior change is called the:
   a. Theory of Planned Behavior (TPB).
   b. Health Belief Model (HBM).
   c. Transtheoretical Model (TTM).

4. The stage of change when the individual is most highly ambivalent to change is the:
   a. Precontemplative stage.
   b. Preparation stage.
   c. Action stage.
   d. Contemplative stage.

5. The factor that most influences behavior change beyond initial motivation is:
   a. Willpower.
   b. Knowledge.
   c. Skills.
   d. Support.
6. Helping a patient focus on how current behavior differs from desired behavior is known as:
   a. Rolling with resistance.
   b. Empowering.
   c. Supporting self-efficacy.
   d. Developing and examining discrepancy.

7. Motivational interviewing states that an important step in developing a partnership for change with a patient is to:
   a. Suspend the reflex to give expert advice.
   b. Provide evidence-based solutions.
   c. Point out shortcomings in a matter-of-fact tone.
   d. Talk about the latest research on the problem.

8. A type of reflection where the clinician recaps what has occurred in all or part of an interaction with a patient to communicate interest and understanding is called:
   a. An affirmation.
   b. A summary.
   c. Collaboration.
   d. Mirroring.

9. Clinician’s elicit “change talk” in patients by:
   a. Siding with the status quo.
   b. Asking yes-no questions.
   c. Focusing on only the pros and not the cons for change.
   d. Avoiding looking back to before the onset of the behavior.