UNIT NO. 4

BEHAVIOUR MODIFICATION

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ABSTRACT

Addressing health threatening behaviours will be an increasingly important issue in general practice. However, it is known that simply telling or advising patients to change is insufficient to change behaviour. This article will focus on two key approaches, the Transtheoretical Model and Motivational Interviewing, which are known to be useful in facilitating such changes, and their implications to everyday clinic practice. An understanding of the process of changes highlights the heterogeneity of patients in terms of their stages of change which suggests the need for different strategies to facilitate change. The practitioner is also more likely to succeed by adopting a guiding style as opposed to either being directive or passive. The guiding style, which emphasizes collaboration and respecting the patient's autonomy, enables the practitioner to explore and enhance the patient's own motivation to change. Together with the setting of specific and achievable goals, such approaches may provide the framework and methods for the busy practitioner to respond effectively and efficiently to health threatening behaviours.

Key words: behaviour change; general practice; transtheoretical model; motivational interviewing; chronic disease management

SFP2011; 37(4) (Supp 1): 22-30

CHANGING HEALTH THREATENING BEHAVIOURS

The trouble with health related behaviours is that they matter significantly in disease and death. In the United States, behavioural causes account for 40% of premature deaths, with the pair of obesity and inactivity, and smoking being the top two behavioural causes of premature deaths[1]. But beyond the "big four" lifestyle habits (smoking, excessive drinking, lack of exercise and unhealthy diet), change may also be desired to enhance health related activities such as the use of aids, devices and medicines[2]. Therefore, to manage a patient's condition adequately, the practitioner is often required to address the topic of behavior change. The traditional approach employed by many practitioners is one of "directing" the patient to change. This generally comprise highlighting the risk of developing a disease and the consequent need to change, followed perhaps by prescriptions about how to change. The actual manner in which it is done vary according to the practitioner's style and temperament as well as whom is being helped to change. These include explaining, reasoning, cajoling, instructing, lecturing, preaching, admonishing, and even pleading and threatening. Unfortunately, those who have attempted to do so would be familiar with these common replies:

"My grandfather smokes like a chimney and he lived to 93 years old"

"My friend was diagnosed with cancer the year he decided to stop smoking"

"I know it is important for me to watch my diet, but…"

"We only live once, so what's the point of living if you can't enjoy eating"

"Yes, I'll try" (As a somewhat polite way of NOT agreeing but helps avoid an otherwise protracted consultation)

While some patients do seem to respond to practitioners telling them to change their behavior, most consultations about changing unhealthy behaviours are more likely "heart-sink" experiences that threatens the practitioner-patient relationship. It is not surprising that many practitioners choose either to deal with it cursorily, or just avoid it altogether. Sometimes, when change remains elusive despite the practitioner's well-meaning efforts, these patients are labeled as "stubborn" or "recalcitrant" - perhaps only to mitigate the practitioner's impotence as this does nothing to resolve the deadlocked situation. Wouldn't it be wonderful if there were a "magic pill" to deal with unhealthy behaviours!

But it is known that just simply telling patients that they are at risk of developing a disease is rarely sufficient to change behavior [2,3]. Behaviours can be said to be products of complex interactions between an individual's biological, social, developmental and psychological processes, and the environment[4]. The biomedical context at the clinic is only a part of the wider web of equations that the patient has to contend with consciously or unconsciously when contemplating or attempting a behavior change. Fortunately, much is now known about how people change their health behaviours and this has improved our understanding about change and refined our strategies to change health behaviors. This article will first introduce some concepts about changing unhealthy behaviours and later, discuss strategies that the practitioner can use to obtain better outcomes in facilitating the patients' health

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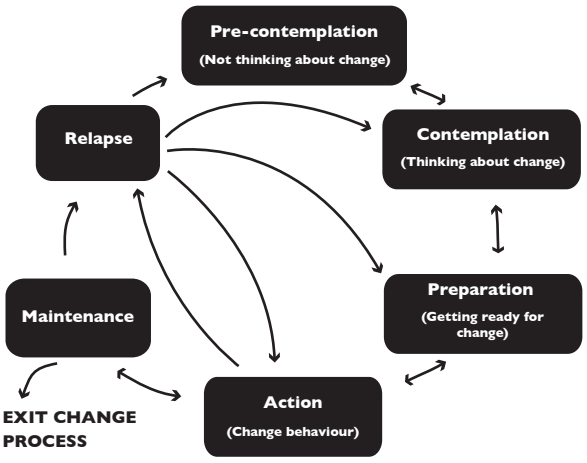
behavior change.

Figure 1. The Trans-theoretical Model



UNDERSTANDING HOW CHANGE TAKES PLACE

When people change behaviours, they tend to go through a number of fairly stereotypical psychological processes before the change becomes sustained. Change that is evoked by intervention or therapy resembles that which occurs spontaneously. A framework that describes this natural sequence is the Transtheoretical Model (TTM) or Stages of Change model, described by Diclemente and Prochaska in the late 1970s and the 1980s. In this model [5,6,] the person attempting to change navigates gradually through processes that may be classified into five stages: from being uninterested or uninformed about change (precontemplation), to considering change (contemplation), to preparing for change (preparation), to taking genuine steps in changing (action) and finally actively incorporating the change (maintenance/relapse prevention) (Figure 1). During the course of change, the person can move backwards or regress to the previous stages; relapse can also be expected after change occurs, thereafter starting another round of change stages. Several cycles of change and relapse may be necessary before the behaviour change is completed and stable. While this model was first described in patients with addictive behaviours, it has since been found to provide a useful framework for understanding change in many other health related behaviours [7, 8].

Precontemplation Stage

During the precontemplation stage, patients do not consider changing in the foreseeable future, usually measured as the next six months. They may be in this stage because they are uninformed or under-informed about the consequences of their behaviour. Or they may have tried to change a number of times and become demoralized about their ability to change. Both groups tend to avoid reading, talking or thinking about their high risk behaviours. During discussions, they may downplay the seriousness of their condition ("All my family members are obese"), or fail to make the link between their condition and the complications ("I don't believe it will happen to me"). They may be defensive in the face of other people's efforts to pressure them to quit. These patients are frequently labelled as being resistant or unmotivated.

Contemplation Stage

During the contemplation stage, patients are more aware of the personal consequences of their bad habit and they spend time thinking about their problem. In this stage, the patients considers the benefits and costs of the behaviour change, so that ambivalence results. The possible barriers to change include time, financial costs, inconvenience, loss of pleasure, change of routines etc. The ambivalence may be so profound that the patient can remain in this stage for a long time.

Preparation / Decision Stage

Patients in the preparation stage get ready for change in the immediate future, usually measured as within the next month. The preparation may involve experimenting with small changes, reading self-help books, talking to their practitioner about change, or trying out low-fat foods or low tar cigarettes.

Action Stage

The action stage is one in which the patient takes active steps to change their behaviour by a variety of techniques. The changes are generally specific overt modifications. In this stage, relapse is common.

Maintenance / Relapse prevention

This is the stage in which the patient starts to incorporate the new behaviour into the lifestyle with efforts being directed to maintain the new status and prevent relapse. Most patients may find themselves recycling through the stages before the new behaviour is eventually established.

WHAT'S IN TTM FOR THE PRACTITIONER? (IT ISN'T ALWAYS BAD WHEN THERE'S NO "CHANGE")

Firstly, the TTM acknowledges that patients who need or even seek change are not homogenous and may be in different stages of change. Some will therefore respond to gentle reminders while others are probably not ready to process anything told to them. This implies also that different strategies may be required at each stage. It is notable that many of the common strategies to encourage change tend to work well with people who are already in the preparation or action stages, in contrast to those in the pre-contemplative or contemplative stages. An approach tailored to the patient's stage may be necessary. Some stage-specific

strategies are shown in Table I.

Secondly, a rather simple truism that some practitioners just have to get over: the stage that the patient is in is determined by the patient and not the practitioner. This may avert the often frustrating question about why some patients are so hard to change – Q: Why can't they change? A: Because they are not at a stage where the behavior change happens. An important corollary to this fact is that the pace of change is also patient determined. The more appropriate role of practitioners is therefore the facilitation of the patient's movement through the stages.

It also follows that when there is resistance during the change process, which is usually defined from the practitioner's perspective of the patient becoming less responsive to his intervention, the cause may be one of mis-matching of patient's stage and the practitioner's perception of his stage, or the use of interventions which is not appropriate for the stage. This underlies the need for the practitioner to actively assess for the changes in the patient's stage, and respond accordingly. In other words, if the patient does not change, the practitioner changes (his ideas, expectations and methods).

Thirdly, when we survey the continuum in the stages of change, it may be evident that an overt change in behaviour may be observed only in the preparation or action stages. In other words, the patient may be proceeding positively along the stages of changes but yet there is little in the way of a changed behaviour. What should not be ignored is the increased positive intention or readiness to change; one can be gratified when the patient is assessed to have moved along the stages, whether the behaviour has changed or not. This beats frustrating oneself and the patient with the unrelenting expectation and pressure to see an overt change in the patient's behaviour.

By now, one would realise that the patient's stages in the TTM, tend to be fluid and dynamic. The flux of the stage of change is often determined by the patient's context outside the clinic. Hence, even after a rousing pep talk that appears to have convinced the patient that a change in his diet is in order, by the time he returns home, passing by his favourite restaurant and settling down in the sofa, the enthusiasm may be blunted and doubts about wanting to change resurface. And even when a behaviour change has occurred, it is still not permanent. There is a need to maintain the change until it becomes integrated into the person's routine or lifestyle.

Finally, practitioners and patients alike should be pleased to

Table 1. Stages of Change and approaches that are most appropriate at each stage [9]

Stage	Explanation of stage	Approach suitable for stage
Pre-contemplation **(Not thinking of change)**	Stage during which a person does not even consider the need to change: • Have not had sufficient experience with negative consequences • Tipped toward negatives	Reflective listening • Empathy • Effective questioning • Provide objective information in a non-judgmental manner • Explore barriers (Action-oriented messages are not appropriate)
Contemplation **(Thinking of Change)**	In this stage, a person considers changing a specific behaviour: • Beginning to seek relevant information • Re-evaluating behaviour • Obtaining help of others to support future attempts • Still weighing up options • Not ready to take action	• Reflective listening • Empathy • Effective questioning • Provide non-judgmental objective information that may be taken away • Encourage the patient to accept ownership of the problem • Increase awareness of negative questions • Recognise how situations effect illness
Preparation/Determination **(Ready for change)**	The stage where a person makes a serious commitment to change • Ready to take action in the next 30 days • Need to set goals and develop priorities in order to manage illness	• Encouragement • Empathy • Goal setting • Support of self-efficacious behaviour
Action **(Changing Behaviour)**	Change begins (this can be large or small changes) • Efforts made to modify habits and environment • Increased use of behavioural processes of change (eg restructuring one's environment, removing alcohol)	Encourage stimulus control • Skills training interventions • Encourage support from others
Maintenance **(Maintaining change)**	Change is sustained over a period of time • Substituting alternatives for problem behaviours eg relaxation • Taking responsibility for actions • Susceptible to relapse. Need to remain aware of stimuli that may trigger problem behaviours	• Do not view relapse as failure, but as a way to gain knowledge of triggers • Decrease environmental and internal stimuli that trigger problem behaviours

know that in TTM, relapse does not equal failure. In fact, a relapse is an excellent opportunity to help the patient learn about their own life circumstances, the precipitants of the relapse and the weaknesses of the change strategy. In other words, a relapse provides learning about how things may be done to secure a more sustainable change. It is known that for a behaviour change to take place, it may be necessary for one to cycle through the stages of change several times. However, relapse if not dealt with properly is not innocuous either, as repeated episodes may lead to loss of confidence and motivation to try to change again.

BUT THE PATIENT IS JUST NOT MOTIVATED TO CHANGE!

When patients do not respond positively to the sound advice of practitioners, it is frequently assumed that the patient has "poor" or "no" motivation, as if deficient motivation is a stable personal trait. Such beliefs are simply untrue as no one is truly unmotivated; patients may just be more motivated NOT to change due to circumstances unknown to the practitioner. They may also be motivated to change in ways that are more ecological to their circumstances. For example, a patient may be motivated to stop cigarette smoking most times but not ready to decline cigarettes when with his business friends. Being able to explore, understand and enhance the patient's motivation therefore becomes important steps in facilitating patient's change in behaviour.

Motivational Interviewing (MI) offers another model for understanding and dealing with the readiness for change. MI was developed by Rollnick and Miller as a strategy for addictive behaviour change, and like TTM, MI has found many applications in helping patients change other health related behaviours[10-12]. MI was initially defined as a client-oriented, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence[10]. It was updated in 2008 as a collaborative, person-centred form of guiding to elicit and strengthen motivation for change[13]. The idea of the practitioner as a guide in a consultation for change contrasts with the more commonly subscribed role of the practitioner as the "expert" directing the change process, but neither does it imply submitting to the patient's wishes. The guiding stance, whilst respecting the patient's autonomy and the patient as the agency of change, maintain controls of the direction and structure of the consultation to evoke the patient's own arguments and strategies for change. The guiding process thus avoids the struggle or "fights" with the patient over changing behaviour and has been likened more to "dancing" with the patient-partner[13].

The core communication skills that the practitioner needs to employ in MI are

"Asking"	Open questions that invite the patient to consider why and how they might change	
"Listening"	Not only to understand their experience, but also to respond actively with statements of interest, understanding or acknowledgement e.g. using summaries of what was said, Or with reflective listening statements; All of which conveys empathy and encourages the patient to further elaborate, and could also reduce resistance from the patient	("Hmm, please tell me more") ("There are many things you wished you could do, and these are _____") ("You are tired of people expecting you to change_____, you have tried so hard")
"Informing"	Giving information and then asking about the impact of the information on the patient	("There is another way of achieving what you wanted; I am wondering if you would like to hear about it?" then "How does knowing _____affect the way you look at/feel about changing?")

Using the core skills, MI explores the patients' inner motivations and helps them to recognize and be responsible for it. It also directs them towards the discrepancies that already exist between what they want and how their behavior impacts these goals. Such discrepancies reflect a state of ambivalence that many patients have about changing. In MI, ambivalence is a natural state that patients can be expected to pass through (but not stay) as they change. Ambivalence is therefore not generally interpreted as an undesirable state, and patients (and practitioners) can therefore feel comfortable about discussing about their conflicting issues and dilemmas. The practitioner assists the patients work through their ambivalence and guides them to decide for change.

Another important concept in MI is the idea of self-efficacy. Bandura describes self-efficacy as "people's beliefs about their capabilities to produce designated levels of performance that influence over the event that affect their lives" [14]. It is therefore more about a "belief" or psychological state than just the presence or absence of skills. The latter, also known as capability, differs from the former in that it may be more simply remedied by the imparting of skills. For example, a smoker who has relapsed many times may suffer not from a lack of knowledge or skills about quitting cigarettes but from being demoralised after the repeated "failures", hence the belief that change is not possible. Setting achievable goals may be one of the strategies that restore the sense of self-efficacy, and therefore the likelihood of eventual successful behaviour change.

Talking about change

What is also known to reflect the patient's motivation to change is the patient's use of commitment language in a dialogue about change[15]. Generally, those who talk about change, in particular about the desire, ability, reasons, need, and commitment for change tend to change. Conversely, those who talk against change are less likely to do so. Facilitating the patient to process and speak more about why and how to change then becomes one of the strategies to motivate change. In MI, this is known as change talk. Change talk may not be so peculiar when we reflect that people often self-talk before doing something they are not so confident or capable of doing, such as speaking on stage or an athletic event. The content of such self-talk often includes expressions of the **importance** and **confidence** to change, which are the determinants of readiness to change in the MI model. Knowing that patients can literally talk themselves into or out of behaviour change, evoking commitment language becomes a key part of change dialogue.

Yet, it is also not uncommon that conversations between practitioners and patients often suppress change talk instead. One of the common impediments is the practitioner's behaviour of trying to fix the "unhealthy" lifestyle or behaviour of the patient for "his/her sake". Examples of such behaviour include attempts to convince patients that they have a problem; arguing for the benefits of change; telling clients how to change; and warning them of the consequences of not changing. This behaviour has been termed the righting reflex in MI. And while it may have originated from positive intentions, it failed to recognise the phenomenon of ambivalence - an ambivalent patient would in such circumstances be encouraged to respond by arguing against changing. An example of such a conversation is shown in Table 2.

In MI understanding, the practitioner has played the wrong role by encouraging the patient to speak against change. The person who should argue for change is the patient and not the practitioner. Evoking the patient's own arguments for change is therefore the appropriate role of the practitioner.

Table 2. Talking against change

Practitioner	Patient
Do you smoke?	Yes
How much are you smoking now?	About 20 cigarettes a day
Do you intend to stop smoking now?	Not really
Not really?	Yeah
Why not?	I just don't feel like stopping cigarettes at this time. I tried stopping last time and I can't concentrate at work after that.
I must inform you that the cough and breathlessness that you are having is caused by smoking As your doctor, I must tell you that smoking is harmful to you and your family. Don't you care for them?	It isn't so bad. It is just a temporary cough; it gets better with the cough mixture. I can still carry on doing my work in spite of the cough. My family is not really complaining since I cut down from 2 packs to one and a half a day.
I think you should start on medication to stop smoking	No need lah! I think I can stop smoking when I really want to.

Table 3. How a change consultation may be done

How a change consultation may be done
1. Build rapport
2. Remember the key principles
- Be curious and interested
- Resist the righting reflex
- Guide rather than direct
3. Set the agenda for discussion collaboratively
4. Exploring about and enhancing readiness to change
- Change talk
- Others:
o Providing information
o Exploring importance
o Enhancing confidence
5. Setting goals and action plans
- Specific
- Proximal
- Enhance the action plans with step 4. Strategies
6. Review and follow-up

HOW CAN WE DO IT BETTER?

With the background information about how change happens and the different ways in which change may be facilitated, we can attempt to derive a neat model of practice for the busy practitioner, bearing in mind that responding to the patient and in accordance to the principles are probably more important than following a cook-book manner of implementation (Table 3).

1. Build rapport

This is an indispensable step to set up an open and honest exchange in a healthy therapeutic alliance. Without any rapport, attempts at change may be misconstrued as intrusive or coercive, and resistance invariably results. Rapport is also not an all-or-none entity. The level of rapport can fluctuate during the consultation depending on what has transpired and how the practitioner responded to the patient. Constant monitoring of the rapport is necessary to ensure the strength of the therapeutic alliance.

2. Remember the key principles

Be curious about the patient as a unique individual with his/her set of behaviours! To explore aspects of what is presented at the consultation, one has to be non-judgemental and sensitive. Resist the righting reflex. Remember that you are only the "guide". The patient is the one who has to justify the change, decide how to change, and more critically, live out the behaviour change, NOT you. Use the core skills of asking, active listening and informing.

3. Setting an agenda collaboratively

Many health behaviours do not exist alone, for example, dietary behaviour and sedentary lifestyle; cigarette smoking and alcohol consumption and so on. Not only do they coexist, they also influence one another. Patients too, may have other issues when they express a desire for 'change'. Examples of hidden agendas include mending relationships by quitting cigarettes, or losing weight to keep a boyfriend. If ignored, the efforts to change may be sabotaged by these external factors. The practitioner should be mindful that extra-therapeutic/patient factors have been shown to have significant influences on change outcomes [16, 17]. Be interested in the circumstances of the patient, even if it means having to go beyond the realms what is commonly perceived as "medicine". Sometimes, dealing with what is troubling the patient elsewhere may also change an unhealthy behaviour, such as dealing with a social issue when managing hypnotic dependence.

It is therefore useful to set the agenda from the start. This is a good way of laying out what are the possible behaviours that need attention as well as other issues that the patient feels are important to him or her. An agenda can also alert the practitioner to an area of avoidance by the patient, and sometimes the practitioner. The consultation may start off with something like: "With respect to the daily management of diabetes, we can talk about diet, exercise, tablets, smoking, and so on. Which of these would you like to discuss, or is there something else which is on your mind?" Agenda setting is therefore not totally hands-off or laissez-faire. The role of the practitioner remains directive, by negotiating goals and the agenda, and directing focus onto areas of neglect. The approach, however, remains one that considers patient choice and decision making.

4. Exploring and enhancing the readiness to change

Getting patients to talk about changing

Maintain a sensitive curiosity about the stage of change or state of readiness that the patient presents with, e.g. Why is it important for them to change now? What's difficult about staying unchanged? How do they think they can change? Understand the motivation of the patient and reflect it back to them. Elicit "change talk", the content of which includes acknowledging the problems of remaining the same, recognising the benefits of change, intent and commitment to change, and optimism for change. Once change talk is elicited, the ways by which the practitioner can respond are:

- Elicit more (with open questions)
- Affirm
- Reflect
- Summarise

Some other helpful strategies include:

Providing information

While simply telling or giving advice to patients has not been found to be useful, patients nevertheless need appropriate information in order to self-manage. One technique is "elicit, provide, elicit". In this technique, after the patient's understanding about a matter is elicited, the practitioner provides some other supporting information and then checks back with the patient, the personal implications of the information that has been provided [2]. For example, "Can I check what's your understanding about the control of your diabetes so far?"; then "You are quite right about…, and in addition, other similarly important aspects might be…"; and finally, "So, now knowing these aspects about care, how might that affect the way you deal with your diabetes condition?".

Another similar technique is the "ask, tell, ask" technique that Bodenheimer and his colleagues described[18]. The technique is similar in the first two steps of the earlier technique but in the final step the practitioner asks whether the patient had understood and what additional information is desired. The technique therefore addresses the problem of a lack of information in a manner directed by the patient so that only information is that is useful for the patient is given without information excess. Hence, using the earlier example, the final "ask" may be "So, of all these aspects of care at home, which one would you like to know more about?"

Exploring importance

We can explore and assess the importance for change with the following questions:

- "How important is keeping up with the medication daily for you right now?" (Explores the patient's sentiments, fears and possible competing issues)
- "On a scale of 0 to 10, where 0 is not important and 10 is extremely important, what would you say the level of importance for changing is?"
- "Can you tell me why you have given yourself a score of x instead of 1?" (Elicit patient's positive reasons for change); "How can you go higher?" (Explores perceived options); "What stops you from moving up from x to [higher number]?" (Explores the perceived obstacles)

Another way is to examine the costs and benefits of changing or staying the same. This process helps the patient self-reflect on the internal-external discrepancies, and the ambivalence about change. Doing so can generate tensions within the patient's internal "world views" which can motivate the patient to change [10]. This process may be achieved with the visual aid of a 'decision grid' as shown in Figure 2.

After listing down in the boxes, ask: "What are your thoughts as you look at the advantages and disadvantages of changing and not changing?" You may also reflect to the patient the considerations involved in changing.

Figure 2. Decision Grid

	No change	Change
Cost		
Benefits		

Enhancing confidence

The following sequence may help assess and enhance confidence:

- "How confident are you right now in changing?"
- "On a scale of 0-10, how confident would you say you are now?"
- "Why had you scored x instead of 1?"; "How can it go higher?"; "What would help you to become more confident?"; "What stops you moving up from x to [higher number]?"

Another method is to brainstorm with the patient the possible courses of action and then allow the patient to choose what is suitable. The purpose is to help the patient realise that there is choice among the many possible courses of action, while conveying optimism. Sometimes, it may be appropriate to talk about the patient's past efforts and his or her successes and failures – to affirm previous attempts at change and past successes. It should not however be misconstrued as emphasizing the success or dismissing the failures. Rather, the practitioner's task is to help the patient appreciate a balanced appraisal of the past performances (not the person).

Similarly, it is vital not to over inflate the importance of change or the patient's confidence about change. Premature and ill-prepared attempts may lead to disappointments and a sense of failure. The goals for the patient should be realistic and specific, even if they are "small gains" in the eyes of the practitioner. What is important is that they represent the patient's choice and context.

Other interventions

Sometimes, it is necessary to provide certain specific interventions before the patient can proceed to make specific changes. For example, relaxation techniques may be useful for patients who are under 'stress' or anxiety. Social interventions should also be considered if mundane needs such as housing rental, child care, marital counselling, job placement etc are wanting. Depending on culture and social status, many such basic needs may rank above health concerns. Adopting this stance may be easier said than done, as many practitioners can feel compelled to revert back to the directing style because of time constraints or if they perceive an urgent need to impose change because of dire medical state of the patient.

Some useful questions in talking about change are shown in Table 4.

Table 4. Top 10 useful questions [2]

Top 10 useful questions [2]
What changes would you most like to talk about?
What have you noticed about …?
How important is it for you to change…?
How confident do you feel about changing…?
How do you see the benefits of …?
How do you see the drawback of …?
What will make the most sense to you?
How might things be different if you…?
In what way…?
Where does this leave you now?

5. Setting goals and action plans

An important component of behaviour change is goal setting, a process which has been associated with improved health-related behaviours [19, 20]. As discussed earlier, goals that are unachievable only frustrates and demoralises the patient, some of whom eventually becoming precontemplators[10]. On the other hand, a well set series of achievable goals can increase the patient's sense of self-efficacy and put the patient on track for a successful change of behaviour. The following recommendations come from our understanding of how goal-setting affects performance:

- Goals that are specific ("I will walk for 30 minutes on Mondays, Wednesdays and Fridays in the park"), preferably including aspects of what, when, how much and how often, are more likely to succeed than vague ones ("I will try to control my food intake", "I will lose some weight")

- Proximal (short term and specific) goals are associated with better performance than distal (long-term and general goals). Short-term goals, also known as action plans, are more likely to result in early success (which enhances self-efficacy), which in turn leads to setting of higher level goals subsequently. Hence, a proximal goal may be "I will bring my own drinking water to work and not consume any soft drinks during lunch", which while not really achieving a holistic dietary modification, may be more useful in the long run than the goal of "I will lose 10kg of my body weight".

Needless to say, the goal setting process must be done in collaboration with the patient, with the patient having the final say.

Once the goal or action plan is set, continue to enhance the likelihood to doing it by applying Step 4 ("Exploring and enhancing the readiness to change") discussed earlier.

6. Review and follow-up

Finally, even when goals are set, it is important to follow-up and review the outcomes. Remember that the inability to achieve the goal at the next review does not equate failure. Learning from the episode and dealing with the identified barriers or changing direction altogether will enable the patient to try again. The same approach applies in a situation of relapse. Conversely, TTM tells us that even if the behaviour appears to have changed, it may not be permanent and other steps or behaviours may need to be installed to maintain the change.

CONCLUDING COMMENTS – ALL THESE SEEM RATHER DIFFICULT

Changing behaviour is not easy, but the stakes in changing unhealthy behaviours in patients with chronic medicalconditions are high. Yet, even as the practitioner feels the urgency to get the patient to change, the reality is that once outside the hospital or clinic setting, it is the patients who decide what and how much to eat, whether to exercise or take medication; and how much cigarettes or alcohol they will use. It is not possible to install or reasonably force lasting or meaningful change onto people. What practitioners can do is only to enable patients to help themselves, and we need to learn new skills to do so.

Some practitioners may find applying these ideas and methods awkward. This is to be expected in the initial stages as it requires a different way of thinking about and talking to patients. Such an experience is not so different from learning a new language or learning to swim or cycle (where every movement seems strange to the body). For those who feel these methods are rather "unnatural", "artificial" or "unreal", it is probably so because we have long been accustomed to the "usual" doctor-centric relationship which is incidentally more suited to the sporadic and exceptional situations of acute medical care provision and less applicable to caring for patients living in the community with chronic disease. In other words, maintaining the status quo, where patients have to abide by the practitioner's model, is in reality more contrived, and hence the difficulties faced by practitioners because of the resulting tensions and dilemmas in care.

Is there a best way to behaviour change?

No one style fits all patients. Indeed, some patients may respond best with a directing style or relationship. Ultimately, the practitioner needs to have a respectful attitude to the patients and be open to changing styles and methods to be in tandem with the patient's responses. Imposing the practitioner's ideas about change, even if this in accordance with some well used guideline may not necessarily lead to successful change. Duncan and his colleagues have gathered evidence to show that rather than the type of therapeutic intervention provided or the techniques used, the factors that determine outcomes may have more to do with the patient's perceptions of the therapeutic relationship, how consistent the method used is with the patient's own theory about change, whether they feel comfortable and respected, and the level of active participation. In other words, the practitioner's ability to find a

complementary 'fit' with his patient affects these factors [16, 17, 21].

Will I be able or have the time to do this?

By now, it should be obvious that it takes time for the patient to change his/her behaviour. It also requires that the practitioner spend time guiding the patient. But this investment in time may be more efficient and sound, when compared with the time spent on futile advice, or the situation where the patient has repeated consultations for complications arising from the failure to change.

Fortunately, the practitioner may find some solace that even brief interaction, if skilfully done, may have a significant impact on the patient's behaviour change[7, 12]. Understanding and applying what we know about the processes of behavioural change, and making the shift towards a guiding style, which encapsulates principles such as collaboration, negotiation, respecting patients' autonomy, and supporting self-efficacy, might be good beginning steps. The guiding style, on which MI is based, would be within the reach of the busy practitioner[2].

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LEARNING POINTS

- **Telling or advising patients to change is insufficient to change behaviour.**
- **The transtheoretical model (TTM) highlights the heterogeneity of patients in terms of their stages of change which suggests the need for different strategies to facilitate change.**
- **Motivational interviewing is a guiding style which emphasizes collaboration and respecting the patient's autonomy, enables the practitioner to explore and enhance the patient's own motivation to change.**
- **Together with the setting of specific and achievable goals, the transtheoretical model provides the framework and the motivational interview the method for the busy practitioner to respond effectively and efficiently to health threatening behaviours.**