AN APPROACH TO PERSONS WHO ARE NOT WILLING TO ENGAGE IN BEHAVIOURAL CHANGE

OB OMOLE, DEIDRE PRETORIUS

26TH NATIONAL FAMILY PRACTITIONERS CONGRESS, CAPE TOWN

8TH SEPTEMBER 2024

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HOW COMMON ARE PATIENTS WHO ARE UNWILLING TO CHANGE LIFESTYLE BEHAVIOUR IN YOUR CLINICAL SETTING?

INTRODUCTION

- UNHEALTHY LIFESTYLE BEHAVIOURS SUCH AS SMOKING, EATING UNHEALTHY DIETS, ALCOHOL CONSUMPTION AND PHYSICAL INACTIVITY ARE PREVALENT AMONG PATIENTS ATTENDING PRIMARY CARE FACILITIES.
- OF THESE WHILE MANY PATIENTS ARE WILLING OR OPEN TO DISCUSSING CHANGE, OTHERS ARE UNWILLING OR IN PRECONTEMPLATION.
- 1:7 ADULT SMOKERS IN THE US NEVER PLAN TO QUIT WHILE IN A SOUTH AFRICAN STUDY, UP TO 21.7% DID NOT INTEND TO QUIT IN THE NEXT 6 MONTHS.
- THE PROPORTIONS OF OBESE/ OVERWEIGHT, HARMFUL ALCOHOL USERS AND PHYSICALLY INACTIVE PATIENTS THAT DO NOT WANT TO ENGAGE IN BEHAVIOUR CHANGE ARE NOT KNOWN.
- FOR MANY PATIENTS, THE BEHAVIOUR **"CHANGE TALK"** IS NEVER INITIATED, AND WHEN INITIATED, IT IS NOT SUSTAINED NOR ACTION.

1. Akindele MO, Useh U. Chronic diseases of lifestyle risk factor profiles of a South African rural community. J Public Health Afr. 2021.
2. Ngango JM, Omole OB. Prevalence and sociodemographic correlates of cardiovascular risk factors among patients with hypertension in South African primary care. Cardiovasc J Afr 2018; 29: 344–351.
3. World Health Organization. Toolkit for delivering the 5A's and 5R's brief tobacco interventions in primary care [homepage on the Internet]. 2014

SO, HOW DO YOU HANDLE THE PATIENTS WHO ARE UNWILLING OR NOT CONTEMPLATING LIFESTYLE CHANGE?

- TO MOTIVATE A PATIENT, THE CLINICIAN MUST GAIN AN UNDERSTANDING OF THE **UNIQUE PERCEPTIONS, EXPERIENCES** AND **CONTEXT** OF THE PATIENT, AS WELL AS **ASSIST** THE PATIENT IN ACHIEVING A BALANCE BETWEEN THEIR FEELINGS OF SHAME, GUILT AND PRIDE, BEFORE THE '**CHANGE TALK**' CAN PRODUCE A FAVOURABLE OUTCOME.
- THE **5AS** APPROACH TO MOTIVATIONAL INTERVIEWING COUNSELLING IS EFFECTIVE FOR THOSE CONTEMPLATING, THOSE UNWILLING OR NOT READY FOR CHANGE REQUIRE A DIFFERENT APPROACH.
- THE **5RS** APPROACH OF MOTIVATIONAL INTERVIEWING (MI) COUNSELLING OFFERS SOME PROMISE TO THE LATTER GROUP.

1. Popova L et al. Who are the smokers who never plan to quit, and what do they think about the risks of using tobacco products? Addict Behav. 2018.
2. Omole et al. BMC Family Practice 2010, 11:94.
3. Salemonsen E, et al. Healthy Life Centre participants' perceptions of living with overweight or obesity and seeking help for a perceived "wrong" lifestyle – A qualitative interview study. BMC Obes. 2018.

THE 5RS APPROACH

THE GOAL OF THE 5RS APPROACH IS TO EXPLORE PATIENT'S CONTINUED ENGAGEMENT IN THE UNHEALTHY BEHAVIOUR ("**SUSTAIN TALK**") AND TILT THE PATIENT'S INTRINSIC MOTIVATION TO MAKE DECISION FOR CHANGE ("**CHANGE TALK**"). THIS APPROACH HAS BEEN SHOWN TO BE EFFECTIVE IN ENCOURAGING "**LEARNING TALK**" AS A MEDIATION PATHWAY TO IMPROVING SMOKING CESSATION OUTCOMES IN PATIENTS WHO ARE UNWILLING TO PARTICIPATE IN QUIT ATTEMPTS.

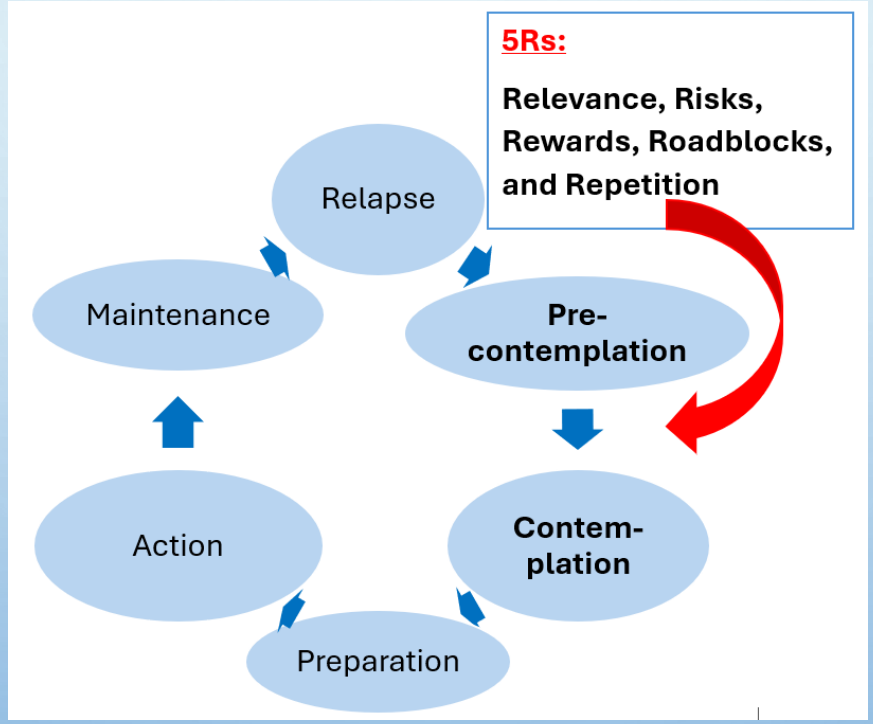
- IT IS NOT A STAND-ALONE CHECKLIST OF TASKS BUT BEST INTEGRATED WITHIN BEHAVIOURAL CHANGE FRAMEWORKS SUCH AS:

- THE TRANSTHEORETICAL STAGES OF THE CHANGE MODEL (*BY PROCHASKA & DICLEMENTE*)
- THE HEALTH BELIEF MODEL (*BY ROSENSTOCK*)
- THE SOCIAL COGNITIVE THEORY (*BY BANDURA*)
- THE SOCIAL ECOLOGICAL MODEL (*BY PANTER-BRICK*)

1. Parashar A et al. Effect of brief interventions to promote behavior change on clinical outcomes of selected non-communicable diseases: The WHO Package of Essential Noncommunicable disease Interventions for primary health care settings – study protocol of a quasi-experimental study. Contemp Clin Trials 2022
2. Prochaska JO, DiClemente CC. Toward a comprehensive model of change. In: Miller WR, Heather N, editors. Treating addictive behaviors: Processes of change. Plenum Press.
3. Rosenstock IM. The health belief model and preventive health behavior. Health Educ Monogr. 1974.
4. Bandura A. Social cognitive theory: An agentic perspective Asian. Am J Psychol. 1999
5. Panter-Brick C et al. Culturally compelling strategies for behaviour change: A social ecology model and case study in malaria prevention. Soc Sci Med. 2006

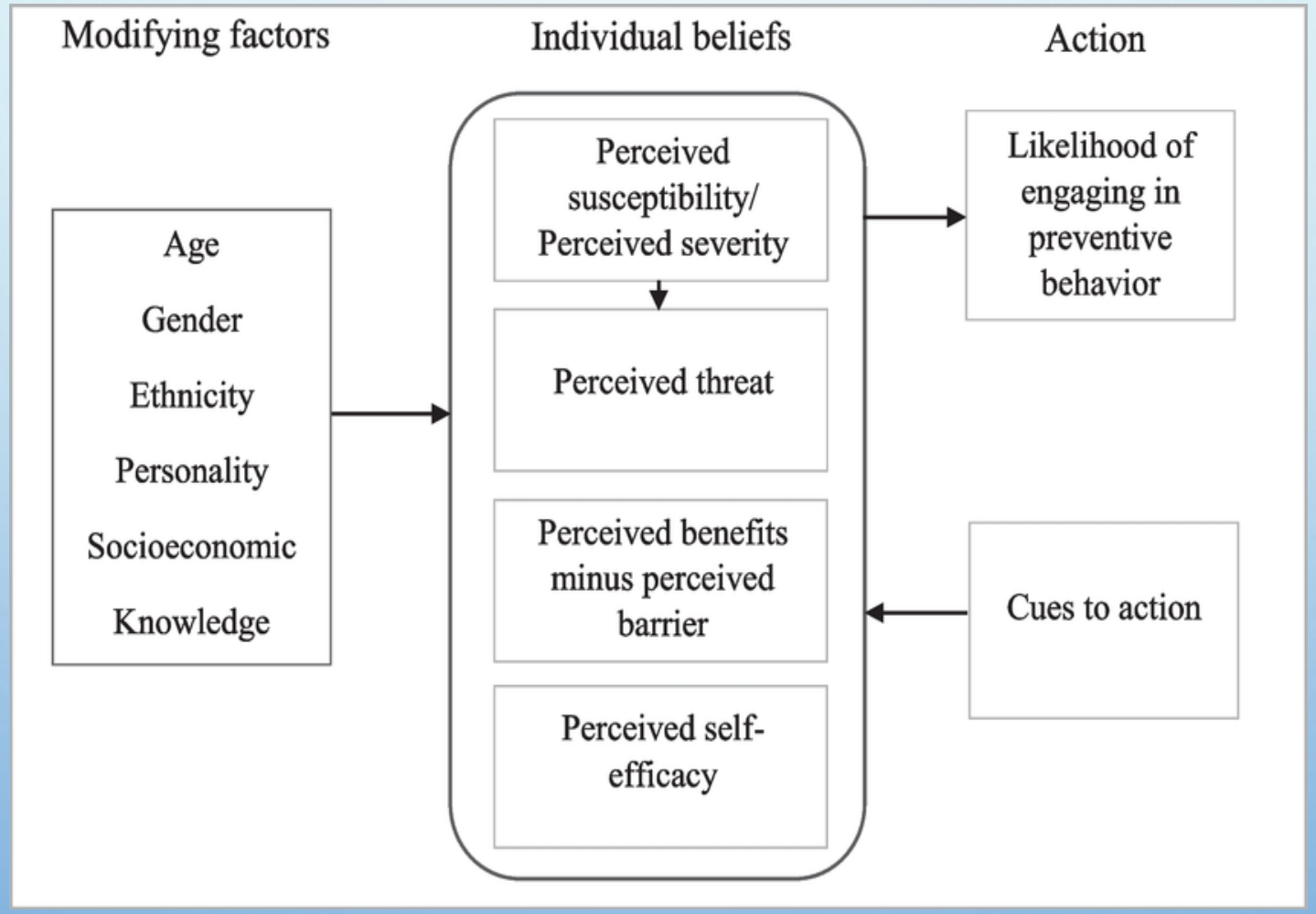
LET'S RECAP THE ESSENCE OF THE FOUR COMMONLY USED HEALTH BEHAVIOURAL FRAMEWORKS/ THEORIES

THE TRANSTHEORETICAL MODEL OF STAGES OF BEHAVIOUR CHANGE

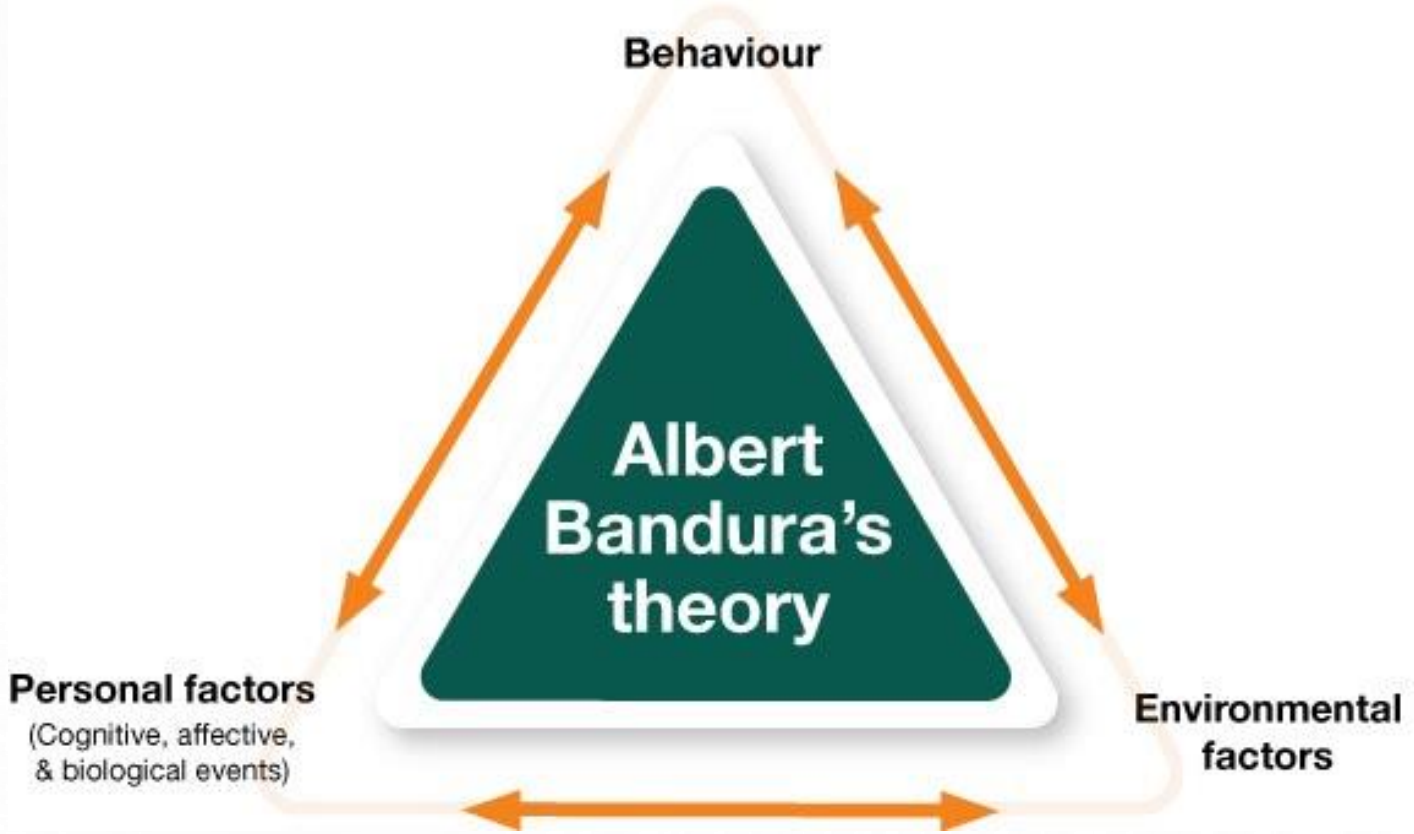


Omole OB, Pretorius D, Von Pressentin KB. An approach to persons who are not willing to engage in behavioural change. S Afr Fam Pract. 2024.

HEALTH BELIEF MODEL

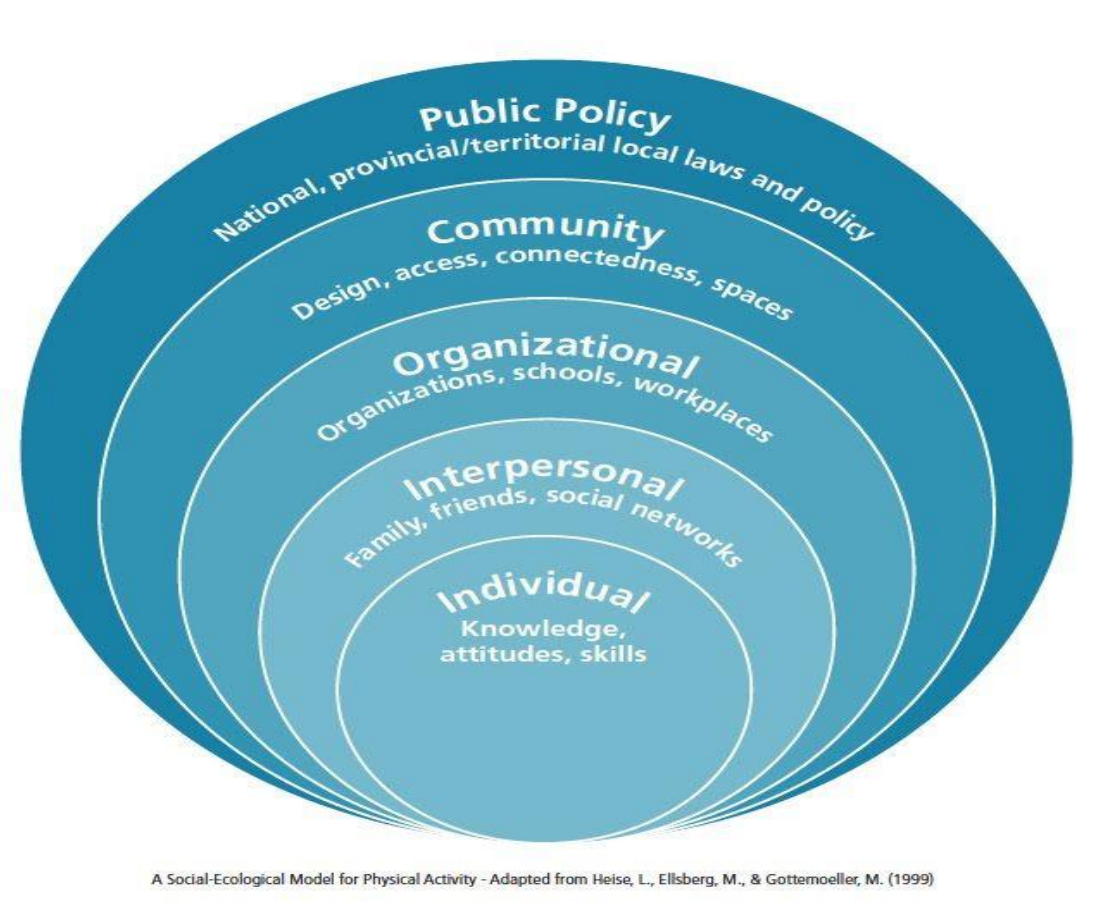


https://www.researchgate.net/publication/374724675/figure/fig1/AS:11431281199265709@1697563364361/Health-belief-model-Adapted-from-Rosenstock-1974.png



https://www.structural-learning.com/post/social-cognitive-theories

SOCIAL ECOLOGICAL MODEL



https://sites.uw.edu/somalttest1/2017/08/12/social-ecological-model/

THE COMPONENTS OF THE 5RS APPROACH

- **RELEVANCE**: MAKE THE HEALTH RISK RELEVANT TO THE PATIENT'S HEALTH, FAMILY OR PSYCHOSOCIAL CONTEXT. *FOR EXAMPLE, MAKING A SMOKING QUIT ATTEMPT BECAUSE THERE ARE CHILDREN AT HOME, FOR AN ASTHMATIC PARTNER, OR FOR A PERSON WITH PREDIABETES LOSING WEIGHT TO DELAY OR AVOID DIABETES AND ITS LONG-TERM COMPLICATIONS.*
- **RISK**: EXPLORE THE RISK OF CONTINUING THE BEHAVIOUR - ASK THE PATIENT TO IDENTIFY POTENTIAL NEGATIVE CONSEQUENCES OF CONTINUING THE UNDESIRABLE BEHAVIOUR AND AFFIRM THE PATIENT BY PROVIDING EVIDENCE IN SUPPORT OF THE PATIENT'S CORRECT VIEWS AND ADDRESS INCORRECT VIEWS.
- **REWARD**: EXPLORE THE REWARDS/BENEFITS OF BEHAVIOUR CHANGE. ASK THE PATIENT TO IDENTIFY POTENTIAL BENEFITS OF THE PROPOSED CHANGE, *FOR EXAMPLE, FEWER ASTHMA ATTACKS AND SAVINGS ON CIGARETTES FROM STOPPING SMOKING.* ***THIS AIMS TO HELP THE PATIENT SEE THE HEALTH BENEFITS AND IMPACT OF THE CHANGE.

1. Kaner EFS, Beyer FR, Muirhead C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Syst Rev. 2018.
2. Prochaska JO, DiClemente CC. Toward a comprehensive model of change. In: Miller WR, Heather N, editors. Treating addictive behaviors: Processes of change. Plenum Press
3. Bouton ME. Why behavior change is difficult to sustain. Prev Med. 2014

- **ROADBLOCK**: MOST PATIENTS WHO CONTINUE TO ENGAGE IN UNHEALTHY LIFESTYLE BEHAVIOURS HAVE MADE PRIOR ATTEMPTS AT CHANGING - *ASK THE PATIENT TO IDENTIFY BARRIERS TO CHANGE IN PREVIOUS ATTEMPTS, ACKNOWLEDGE AND AFFIRM THEM AND ATTEMPT TO PROVIDE PROBLEM-SOLVING COUNSELLING TO ASSIST THEM IN GENERATING SOLUTIONS*. NOTE THAT ***PATIENTS' SUGGESTIONS USUALLY REFLECT THEIR UNDERSTANDING OF THE PROBLEM, THEIR PERCEPTION OF SELF-EFFICACY, AND WHAT IS DOABLE WITHIN THEIR SOCIAL CONTEXT***.

- WHERE THE CLINICIAN IS ILL-EQUIPPED TO ASSIST, REFERRALS TO MEMBERS OF THE MULTIDISCIPLINARY TEAM/ SPECIALISED SERVICES SHOULD BE MADE E.G. THE **NATIONAL SMOKING QUIT-LINE OR YOUR LOCAL SANCA**.

1. Panter-Brick C et al. Culturally compelling strategies for behaviour change: A social ecology model and case study in malaria prevention. Soc Sci Med. 2006.
2. Skarin F, Wästlund E, Gustafsson H. Maintaining or losing intervention-induced health-related behavior change. A mixed methods field study. Front Psychol. 2021

- **REPETITION/RELAPSE:** MOST SUCCESSFUL BEHAVIOUR CHANGES OCCUR AFTER SEVERAL ATTEMPTS. CLINICIANS NEED TO ASSIST PATIENTS TO **NORMALIZE RELAPSE** AND TO ***REPEAT THE CYCLE OF BEHAVIOUR CHANGE.*** CLINICIANS SHOULD ASSIST THE PATIENT TO BUILD ON PAST SUCCESSES. MOTIVATE AT EVERY CLINICAL ENCOUNTER.

- MAKE THE ***DISCUSSION BRIEF*** BUT REPEAT THE AGENDA OF THE CLINIC VISIT IF BOTH PARTIES AGREE.

1. World Health Organization. Toolkit for delivering the 5A's and 5R's brief tobacco interventions in primary care [homepage on the Internet]. 2014.
2. Kaner EFS, Beyer FR, Muirhead C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Syst Rev. 2018.
3. Prochaska JO, DiClemente CC. Toward a comprehensive model of change. In: Miller WR, Heather N, editors. Treating addictive behaviors: Processes of change. Plenum Press

A FEW ROLEPLAYS AND REFLECTIONS?

LIMITATIONS OF THIS APPROACH

- PATIENTS OFTEN MAKE SUBJECTIVE CHANGE APPRAISALS BASED ON THEIR SOCIAL STRUCTURES THAT OFTEN REWARD PERSONAL SIGNIFICANCE AND THE NOTION TO FAVOUR MOMENTARY TEMPTATIONS AND NOT VALUED GOALS FOR HEALTH.
- UNHEALTHY LIFESTYLE HABITS DEVELOP OVER TIME, AND LONG-TERM BENEFITS OF CHANGE DO NOT GIVE IMMEDIATE GRATIFICATION AND IS THUS DIFFICULT TO SUSTAIN.
- BEHAVIOUR CHANGE CAN BE SELF-INITIATED OR EXTERNALLY MOTIVATED, IMPULSE CONFLICT, AS WELL AS SOCIAL CONFLICT CAN BE TRIGGERED THAT CAN COMPROMISE THE INTENTION TO CHANGE.
- STRESS AND CRAVINGS CAN BE BARRIERS TO CHANGE DESPITE THE BEST INTENTIONS.

1. Omole OB et al. Missed opportunities for tobacco use screening and brief cessation advice in South African primary health care: A cross-sectional study. BMC Fam Pract 2010
2. Catley D et al. Differential mechanisms of change in motivational interviewing versus health education for smoking cessation induction. Psychol Addict Behav. 2021.
3. Regmi K et al. Assessment of content, quality and compliance of the STaR mobile application for smoking cessation. Tob Prev Cessat. 2017.
4. Duckworth AL et al. Behavior change. Organ Behav Hum Decis Process. 2020.