Choices and Changes: A New Model for Influencing Patient Health Behavior

Vaughn F. Keller, MFT, and Maysel Kemp White, PhD

Introduction

From the standpoint of improving clinical outcomes, one would be hard pressed to find a factor more important than patient behavior. Seven of the ten most deadly diseases, including cardiovascular disease and diabetes, are associated with patient behavior [1]. When all causes of death are considered, fully half of the deaths in the United States each year can be associated with patient behavior [2]. It is understandable that clinicians are beginning to look more closely at ways of influencing patient behavior as a means to improve clinical outcomes.

Influencing patient behavior, however, is difficult. Since 1989, the Bayer Institute for Health Care Communication has conducted workshops for more than 18,000 clinicians in North America and Europe. When clinicians at the workshops are asked to describe the frustrations they encounter in working with patients, most commonly mentioned is the impact of patient behavior on the ability of clinicians to employ their healing arts. These behaviors can be classified into three groups: self-destructive behaviors (eg, smoking, alcohol and drug abuse), nonadherence to the therapeutic regimen (eg, taking an incomplete course of antibiotic therapy, failing to monitor glucose levels), and avoidance of healthy behaviors (eg, exercise, sleep hygiene, stress management).

Given the degree to which patient health behaviors vex the clinician, it is no wonder that a vast body of literature has emerged that both describes the challenges of dealing with health behavior and presents techniques for the clinician to employ in intervention. To develop a workshop for clinicians interested in addressing this clinical problem, we spent a year studying the available literature [3–20], attending training programs presented by leading theoreticians, and applying suggested strategies. Most of the models we examined grew out of the field of addiction medicine and had been developed by psychologists. Many were complex and based on the 50-minute counseling session. We came to believe that a new model was needed, one that would be easy for a clinician to use in the setting of a brief office visit and would address enhancement of health and adherence to therapy as well as the problem of self-destructive behaviors.

The Therapeutic Relationship

No model is likely to be helpful in the absence of a supportive environment. A therapeutic relationship marked by rapport, trust, and respect provides the necessary groundwork for helping patients change. Without interpersonal rapport, any information conveyed to a patient is likely to go unheeded. We offer three approaches for establishing rapport and furthering the therapeutic relationship.

Elicit the Patient's Experience Through the Use of Open-Ended Questions

An open-ended question invites the patient to tell a story: "Tell me about your experience trying to give up smoking." Allowing patients to give spontaneous and unguided responses in their own words helps build rapport and helps the clinician learn about the patient's problem from the patient's perspective. Closed-ended questions (questions that can be answered in one word) can diminish rapport.

Use Reflective Listening

Reflective listening is more than simply repeating back to patients what they have said. Using reflective listening, the clinician becomes a mirror for the patient and communicates his or her understanding of what the patient has experienced. All reflections are invitations to the patient to confirm, correct, or expand upon what the clinician has reflected. This process fosters an alliance between the clinician and the patient and, at its most basic level, lets the patient know that the clinician is trying to understand.

Empathize with the Patient

Empathy is identifying with the patient's story and communicating one's understanding and acceptance of it. Empathic

Vaughn F. Keller, MFT, Lecturer in Medicine, Yale University School of Medicine, New Haven, CT, Associate Director, Education, Bayer Institute for Health Care Communication, West Haven, CT; and Maysel Kemp White, PhD, Assistant Director, Research, Bayer Institute for Health Care Communication, West Haven, CT.

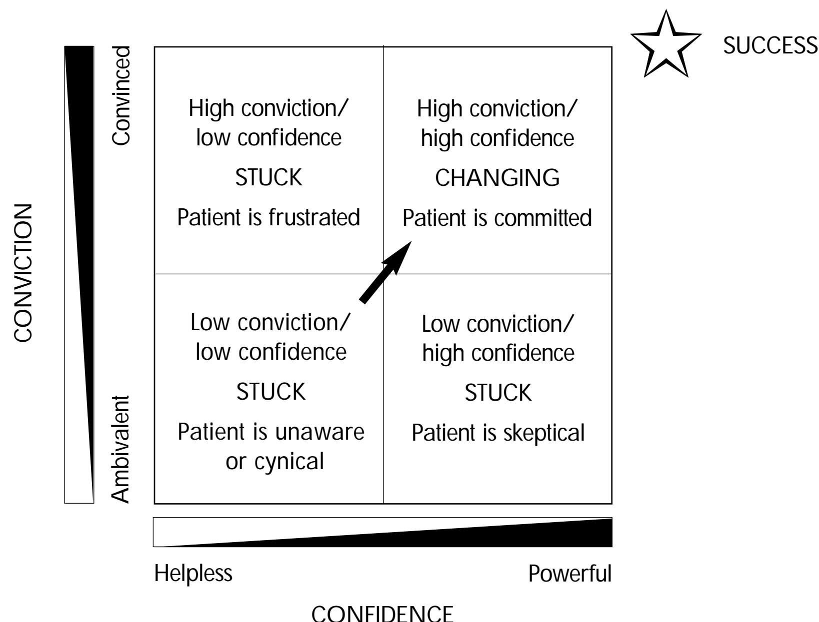

Figure 1. A new model for influencing patient behavior. The clinician assesses the patient's readiness for change within two dimensions: confidence and conviction. An intervention to increase the patient's confidence, conviction, or both, can then be applied with the goal of helping the patient move into the top right-hand quadrant and beyond.

communication promotes a supportive and safe environment and helps the patient to feel understood. It is useful to think of empathy in terms of breathing: The clinician "inhales" the patient's experience through careful listening, acceptance, and profound curiosity. Through this inhalation, the clinician is impacted by the patient's story and processes that story through his or her own experience. Then, the clinician "exhales" a statement that communicates his or her response. Sometimes the response may be as brief as "Wow." Other times it is more elaborate: "I can certainly understand why you are hesitant to try yet another diet. You feel you've tried so many times to lose weight and you've given it your best shot."

A New Model

In our review of the literature we found that change involves two distinct processes. First, patients engage in a thoughtful assessment and decision-making process about the change itself: "Do I believe that making this change will enhance my well-being?" Second, patients engage in personal reflection and a self-evaluation of their capacity to work through the change: "Do I believe I can make this change?" We labeled these two dimensions "conviction" and "confidence."

For change to occur, the patient must be convinced that a given change is in his or her best interest. Sometimes a patient's assessment will focus on the danger of not making the change (eg, to what extent is a smoker convinced that smoking is harmful and that it is in his or her best interest to quit?). Other times the assessment focuses on the benefit to be gained from making the change (eg, to what extent is a sedentary person convinced that it is in her or his best interest to start exercising?). In addition, without confidence, or self-efficacy, the patient will lack the energy to sustain the change process. Confidence is affected by many factors, including social support, identification with models, the clinician-patient relationship, and past history. A history of failure experiences can turn self-efficacy to a pile of dust: "I've been on a million diets and I just can't lose weight."

Figure 1 represents how conviction and confidence may coexist in patients and the emotions or attitudes that are associated with each combination. For example, a patient who is confident but not convinced is probably skeptical about taking a course of action. A patient who is convinced but has little confidence is probably frustrated. A patient who is neither convinced nor confident may simply be unaware or possess some degree of cynicism.

The easiest way to assess a patient's conviction and confidence levels is to ask the patient. Using a scale can make things easier for both patient and clinician: "Mr. Smith, on a scale of 1 to 10, how convinced are you that giving up smoking is in your best interest?" or "Ms. Jones, on a scale of 1 to 10, how confident do you feel that you can walk 2 miles three or four times per week?" This way, conviction and confidence can be given a crude value that can be included in the patient's chart.

Why assess these dimensions? We believe that knowing the patient's conviction and confidence provides a framework for understanding obstacles to change and can guide clinicians in choosing appropriate interventions [3–6].

Applications for Practice

After identifying the quadrant in the model into which a given patient falls, a clinician can tailor his or her intervention to increase the patient's confidence, conviction, or both. The following techniques may be useful:

Patient with Low Conviction and Low Confidence

- Provide information that is new to the patient: "Would you be interested in borrowing this new videotape we just received on diabetes?"
- Offer to help the patient when and if the patient wants to consider the issue: "I understand that a diet does not seem to be a high priority to you just now. If that changes, I would like to help in any way I can."
- Accept the situation and the patient without making a judgment about either: "If I understand what you are saying, you don't believe that you could do any exercise right now and you are not sure that it would benefit you at your age."
- While accepting the situation and the patient, suggest to the patient that he or she might want to think about the issue: "Would you be willing to give some thought to the possible benefits of testing your glucose on a regular basis?"

Patient with High Conviction and Low Confidence

- Emphasize to the patient the importance of making choices about the issue, rather than treating it as something beyond the patient's volition: "These are difficult choices, but you have made hard choices in your life before. How did you go about making them?"
- Build on the patient's personal assessment of competence by reviewing other times when the patient has tackled difficult challenges: "You mentioned that you gave up smoking years ago. Let's talk about that. We might learn something from it that you could apply to beginning an exercise program."
- Work with the patient to develop a plan consisting of small steps that the patient believes are likely to be accomplished: "You are the expert on your schedule and what is possible. Let's focus on one or two things that you could do right away that seem realistic to you."

Patient with Low Conviction and High Confidence

- Build on the natural ambivalence that is present. Make the patient aware of the ambivalence so that it can be discussed: "You mentioned that at times you thought about the benefits of reducing the stress in your life, but you are afraid that giving up or changing your second job would be too much of a hardship for you and your family. Let's consider both sides of the situation."
- Help the patient to identify and discuss discrepancies between what he or she wants and what may exist, or discrepancies in the information that the patient may possess: "You say that you have read some things that tell you that reducing weight is essential and you have read other things that say that weight isn't all that important. I'd like to know what your thoughts are and how you think about these two points of view."
- Discuss the patient's hierarchy of values and help the patient to consider what is more or less important at this point in his or her life: "You have talked about how important it is to you to see your children grow into adulthood. You have mentioned that you wonder if smoking is really so bad. Let's spend a few minutes considering how these two things affect one another."

Patient with High Conviction and High Confidence

- Work with the patient to anticipate difficult times and plan ways to handle them: "For me, family parties are the toughest times to stick with my diet. What do you think will cause you the most trouble? It would be good to have a plan for how to handle these times."
- Identify and remove obstacles to maintaining the desired course of action: "What would make taking this medication at meal times difficult?"
- Attend to progress by noting and affirming it: "It's clear from this last test that the medication is working. Your cholesterol is now down to 154. That's a big drop. It looks to me like you are taking it on a consistent basis. Is that true?"

Conclusion

There are many conceptual models that explain patient motivation and a host of techniques that have been developed for influencing patient behavior. The model presented in this paper was created specifically for the clinician to use in the time-limited setting of the medical interview. Greater educational opportunities for clinicians to develop the skills necessary for using these techniques will likely lead to increased confidence and greater motivation to apply the model in practice.

References

1. National Center for Health Statistics. Mortality patterns. Preliminary data, United States, 1996. MMWR Morb Mortal Wkly Rep 1997;46:941–4.
2. Richmond J. Healthy people: the Surgeon General's report on health promotion and disease prevention. Washington (DC): U.S. Government Printing Office; 1979.
3. Prochaska JO, Velicer W. Measuring processes of change:

applications to the cessation of smoking. J Consult Clin Psychol 1988;56:520–8.
4. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Am Psychol 1992;47:1102–14.
5. Prochaska JO, Norcross JC, DiClemente CC. Changing for good. New York: William Morrow and Company; 1994.
6. Prochaska JO, Velicer WF, Rossi JS, Goldstein MG, Marcus BH, Rakowski W, et al. Stages of change and decisional balance for 12 problem behaviors. Health Psychol 1994;13(1):39–46.
7. Miller WR, Rollnick S. Motivational interviewing: preparing people to change addictive behavior. New York: Guilford Press; 1991.
8. Miller WR, Benefield G, Tonigan JS. Enhancing motivation for change in problem drinking: a controlled comparison of two therapist styles. J Consult Clin Psychol 1993;61:455–61.
9. Miller WR. Addictive behavior and the theory of psychological reversals. Addict Behav 1985;10:177–80.
10. Rollnick S, Heather N. The application of Bandura's self-efficacy theory to abstinence-oriented alcoholism treatment. Addict Behav 1982;7:243–50.
11. Rollnick S, Heather N, Bell A. Negotiating behaviour change in medical settings: the development of brief motivational interviewing. Journal of Mental Health 1992;1:25–37.
12. Rollnick S, Kinnersley P, Scott N. Methods of helping patients with behavior change. BMJ 1993;307:188–90.
13. Marlatt GA, George WH. Relapse prevention: introduction and overview of the model. British Journal of Addiction 1984;79:261–73.
14. Marlatt GA, Gordon JR. Relapse prevention: maintenance strategies in the treatment of addictive behaviors. New York: Guilford Press; 1985.
15. Marlatt GA, Fromme K. Metaphors for addiction. Journal of Drug Issues 1987;17:9–28.
16. Marlatt GA, Baer JS, Donovan DM, Kivlahan DR. Addictive behaviors: etiology and treatment. Annu Rev Psychol 1988; 39:223–52.
17. Bandura A. Self-efficacy: toward a unifying theory of behavioral change. Psychol Rev 1977;84:191–215.
18. Bandura A, Adams NE. Analysis of self-efficacy theory of behavioral change. Cognitive Therapy and Research 1977; 1:287–310.
19. Bandura A, Adams N, Beyer J. Cognitive processes mediating behavioral change. J Pers Soc Psychol 1977;35:125–39.
20. Bandura A. Social foundations of thought and action: a social cognitive theory. Englewood Cliffs: Prentice Hall; 1986.

Copyright 1997 by Turner White Communications Inc., Wayne, PA. All rights reserved.

The *Journal of Clinical Outcomes Management* acknowledges and appreciates the support of the Bayer Institute for Health Care Communication, West Haven, CT, whose staff provides the content for this special feature.