An Overview of Behavioural Interventions for Lifestyle Diseases

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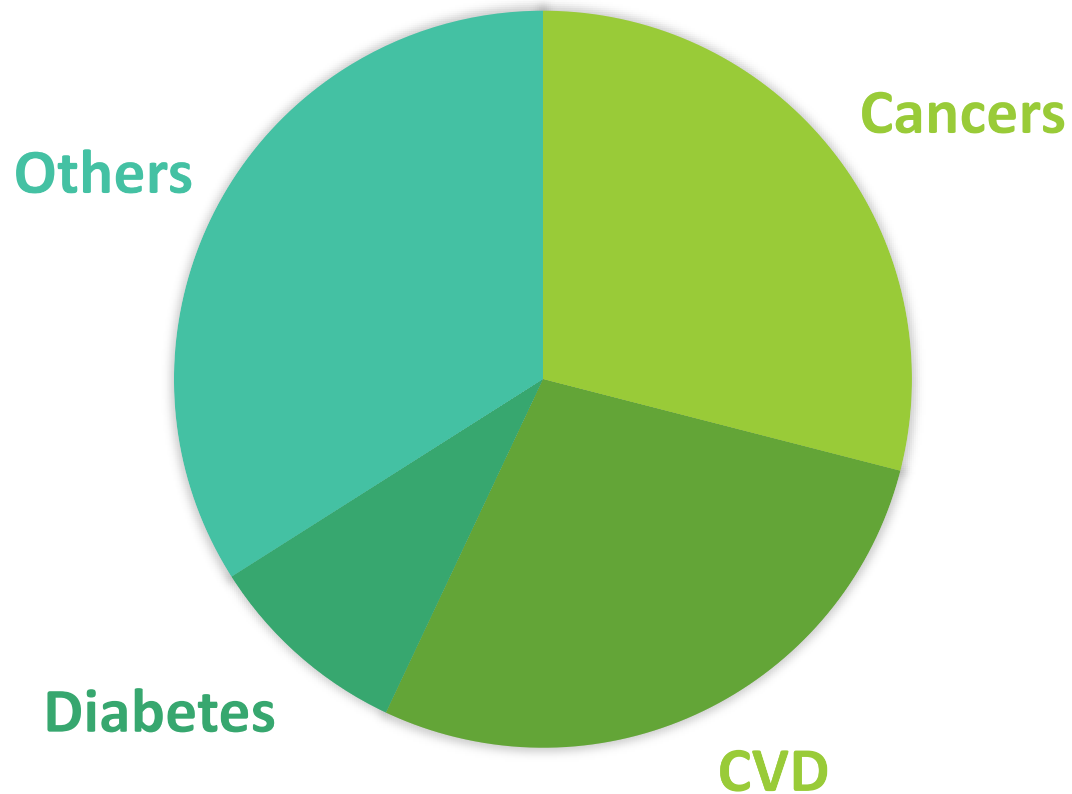
How would you manage these patients?

- 54 year old secretary with well-controlled hypertension, impaired fasting glucose and BMI 33kg/m^2
- 45 year old mechanic with alcohol dependence
- 62 year old businessman with 50 pack/year tobacco smoking history and no chronic illnesses

Objectives

1. Outline the rationale for behavioural interventions for lifestyle diseases
2. Describe prominent theories surrounding behaviour change
3. Describe a patient-centered approach to assessing lifestyle-related risk factors and readiness to change
4. Give an overview of behaviour change approaches and techniques

PROPORTIONAL MORTALITY IN BARBADOS - 2012
(% OF TOTAL DEATHS, ALL AGES, BOTH SEXES)



Lifestyle Diseases in Barbados: Key Prevalence Statistics

Among adults age 25 and over (HOTN Study):

- Obesity: 33.8%
- Hypertension: 40.6%
- Dyslipidaemia: 53%
- Diabetes: 17.9%
- Impaired Fasting Glucose: 15%

- Tobacco Use (age >15, WHO 2011): Males 13% Females 2%
- Alcohol (any age, WHO 2010): 23.9% binge, 8.9% ETOH disorder

WHO Definition of Health

"A complete state of physical, psychological and social wellbeing, and not merely the absence of disease or infirmity" (1948)

What is Behavioural Health?

- Refers to psychosocial care
- Broad focus:
  - Cognitions (thoughts & beliefs)
  - Environmental factors (culture, family, economics)
  - Lifestyle factors (behaviours & habits)

Where's the evidence?

- Health Belief Model
- Chronic Care Model
- The Common Factors Theory
- Cognitive Behavioural Therapy
- The Transtheoretical Model of Behaviour Change
- Motivational Interviewing

Behavioural Interventions

USPSTF Grade B recommendations:

- Brief Counselling
  - Alcohol abuse/dependence
  - Tobacco use
- Intensive Counselling
  - Obesity with other risk factors for CVD – diet/exercise
  - High risk sexual behaviour

Chronic Care Model

- Proactive & planned approach to care
  - Focus on empowering self management
  - Evidence-based protocols
- Patient-centered Medical Home
  - Biopsychosocial integration in primary care
    - Behavioural Health Specialist
    - Health Coach/Nurse Educator
    - Dietician & Physical Trainers

Health Belief Model: Factors Influencing Motivation to Change

- Perceived **susceptibility** to & **severity** of related disease
- Perceived **benefits** & **barriers** to making the change
- **Confidence** that efforts to make change will be successful
- **Cues** – events that alter perception

Transtheoretical Model of Behaviour Change

Patients vary in their ‘readiness’ for behaviour change:

- **Pre-contemplative**
- **Contemplative**
- **Preparation**
- **Action**
- **Maintenance**

Assessment

Screening - consider using screening tool

"Many people smoke… Have you ever smoked?"

Readiness for change:

"How do you feel about your smoking?"

"Have you ever thought about quitting?"

"On a scale of 1-10…?"

Assessment

Use open-ended questions to explore:

- **Beliefs** – HBM, TMBC
- **Environment** – family/friends, work, finances etc.
- **Behaviour**
  - Understand habits, previous attempts to change
- **Knowledge**
  - Disease, treatments, consequences of behaviour

Motivational Interviewing

- Patient-centered approach
- Focus: help the patient to explore & resolve ambiguity to behaviour change
  - Open-ended questions
  - Facilitation techniques
- **Direct persuasion is ineffective**

General Principles in MI

- Express empathy
- Support self-efficacy
- “Roll with resistance”
- Develop discrepancy

Decisional Balance

- Elicit ‘Pros’ & ‘Cons’ of behaviour/behaviour change
- Selectively reinforce points supporting change
- Legitimise points against change
  - Where possible, try to elicit solutions from patient

Example: Exercise

Pros:

1. Improved self image
2. Feel more energetic
3. Decrease risk of CNCDs

Cons:

1. Difficult to find time
2. Often feel too tired
3. Can’t afford gym fee
4. Knees hurt when I run

Behaviour Change Techniques

Stimulus control

- Explore triggers for harmful behaviour, barriers to behaviour change, & ways to avoid/manage these

Self-monitoring

- Diaries may assist in **problem-solving** and objective recollection

Goal setting

- Particularly effective for weight loss

SMART Goals

Specific

Measureable

Achievable

Realistic/Relevant

Timeframe

The Pre-contemplative Patient

May take many years to change - can be frustrating

Confrontation may harm the doctor-patient relationship

Focus on:

- Empathy - enhance the doctor-patient relationship
- Exploring/eliciting awareness of the problem only to extent acceptable to patient – respect autonomy
- Search for possible **cues**

Common Factors Theory

- Behaviour change predicted by:
  - Therapeutic alliance
  - Belief in treatment

- Patient-centered, non-judgemental approach
- Enhancement of self-efficacy

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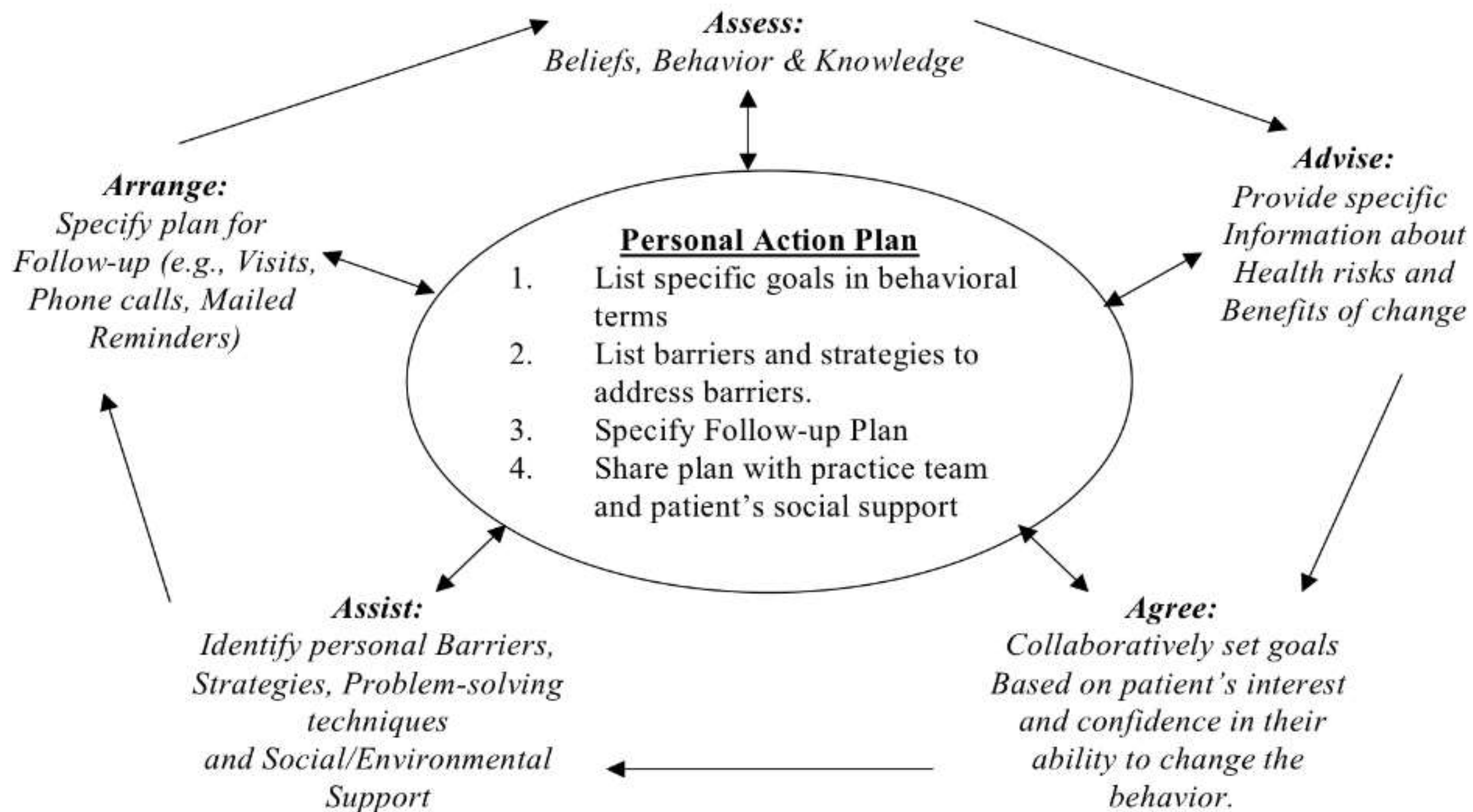
5 A's Behavioural Counselling Framework



Summary/Recommendations

- The need for integration of behavioural medicine is critical
- Key behaviour change techniques and consultation skills can be learnt by physicians
- Suggested starting point:

  HBM & TMBC

  Four Habits Model (Frankel *et al*., 1999)

  5 A's Behavioural Counselling Framework (USPSTF)

  www.motivationalinterview.net

References

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United States Preventative Services Task Force (Access to recommendations and systematic reviews: www.uspreventiveservicestaskforce.org)