Hey Coach!!! Winning Strategies for Behavior Change

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DISCLOSURES

- Lola Coke: Nothing to Disclose
- Nancy Houston-Miller: Nothing to Disclose
OBJECTIVES

1. Describe 3 evidence-based behavior change techniques for lifestyle modification that can be employed in a brief clinical encounter.

2. Critique a behavior change interaction using a case scenario.
THE CHALLENGE OF HEALTH BEHAVIOR CHANGE

• Managing multiple versus single health behaviors is difficult. Time is always an issue.
• Each health behavior is unique and thus strategies must also be different (e.g. addictive).
• Most effective strategies are multi-component: discussion and measurement.
• Health Care Provider skills must incorporate communication, behavioral coaching and education.
BEHAVIOR CHANGE THEORIES
The Transtheoretical Model describes the stages of behavior prior to change.

- Focuses on the individual’s decision making
- Involves state of feeling, awareness, judgments, perceptions, and behavior
- Has been used in a variety of problem behaviors
- Five stages of behavior
TRANSTHEORETICAL MODEL

- Precontemplation - no intention to change or take action within the near future.
- Contemplation - intention to change within the next 6 months.
- Preparation - plans to take action within the next month.
- Action - has made significant modifications in behavior and way of life.
- Maintenance - not working as hard as in the Action mode, but is working to prevent a relapse; confident of continuing to change.
SOCIAL COGNITIVE THEORY SELF-EFFICACY

Behavior

Personal Factors
(Cognitive, affective and biological events)

Environmental Factors
This clinical tool can be used to evaluate patient coping mechanisms and confidence in ability to change.

http://www.pcna.net
• Reflects the psychological factors that effect a person’s decision to participate with health services. It focuses on the attitudes and beliefs of the individuals.
  • Perceived Susceptibility – A patient may feel they have no choice because of a strong family history.
  • Perceived Seriousness – A patient may not have symptoms, are “fixed” by the interventional cardiologist and may not think their disease remains serious.
  • Perceived Benefits and Barriers – The barriers of cost and lifestyle regimen may outweigh perception of the benefit.
  • Self Efficacy – Use the Self-efficacy scale to determine ability to make decisions.
  • Cues to Action – What is the patient’s attitude toward lifestyle change and what have they done in the past.
Because each patient is different, health care professionals need to be familiar with, and utilize many behavior change theories and strategies.

Theories can be used as a framework to determine patient readiness and skills for behavior change.

Motivational Interviewing can be used, despite the theory to guide the patient toward successful behavior change by reducing ambivalence and resistance.

Coaching can be used to set goals and maintain health behaviors.
STEPS OF MOTIVATIONAL INTERVIEWING
Common human experience and stage in the normal process of change

Feeling two ways about something – “I want to but I don’t want to”

To explore ambivalence is to work on the problem of being “STUCK” (Miller, 2002)
Resistance is an interpersonal issue that needs to be diminished to move toward change
- Patient will bring resistance to the conversation

Predictive of change or non-change
- Avoid arguing
- Resistance is a signal to respond differently
- Alternative change options—mutual decisions
- The person is the primary source of answers and solutions

Resistance behavior
- Interrupting, Arguing, Ignoring
- Blaming, disagreeing, excusing, reluctance
STEP 3: BUILD MOTIVATION FOR CHANGE

• Resolve ambivalence and create discrepancy
  – Let the person express the arguments for change
  – Change is motivated by discussion between present behavior and important personal goals or values
  – Awareness of positive and negative consequences
    • Disadvantages of the status quo, advantages of change
• Assess confidence and importance = self-efficacy
• Listen for the patient to begin ‘confidence talk’
  – Envisioning, asks questions, less talk about the problem; more talk about the solution
STEP 4: DETERMINE READINESS

• More likely to succeed if a change feels important and there is confidence to achieve it.
• Need to enhance sense of importance or confidence to increase motivation to change.

How important is it to you to change this?
0...1...2...3...4...5...6...7...8...9...10
Not at all Extremely

How confident are you that you can change this?
0...1...2...3...4...5...6...7...8...9...10
Not at all Extremely
AGENDA SETTING

• Focus on stress of the clinical situation
  – Sense of being overwhelmed
  – Help the person take a broad view of their stress
  – Alleviates uncertainty and leads to change

• Prioritize and focus on one behavior
  – “What would you like to talk about”
  – “How do you want to spend this time together?”
COMMUNICATION PRINCIPLES

• **Open-ended questions** – Use inviting statements
  - Tell me more...
  - Please describe
  - Please go on...

• **Affirmation** – Confirming understanding of the underlying meaning of the conversation (nodding, uh huh, tell me more)

• **Reflective Listening** – Truly listening to what is said
  - Ask patients to share concerns about health behavior change
  - Acknowledge both positive and negative emotion/use non-verbal communication

• **Summarization**: Use few words – The patient should be doing the talking
BEHAVIORAL STRATEGIES THAT WORK: INTERVENTIONS

• Setting Goals
  – Must focus on behavior to be changed
  – Must be specific, measurable, realistic and w/a timeframe
  – HCP’s/pts. must record, re-evaluate and revise

• Self-Monitoring
  – Most important strategy for healthy lifestyle changes (e.g. diet, exercise, weight loss)
  – Includes self-observation, reporting and feedback
  – Logs, charts, diaries, electronic monitoring via computer/PDA
  – Frequency/duration varies by behavior
BEHAVIORAL STRATEGIES THAT WORK: INTERVENTIONS

- Uncovering Barriers/Problem Solving
  - Use when patients are reluctant to change, have low confidence, or don’t attain goals
  - Steps: Identify and define problem, list solutions, weigh pro’s and con’s, select 1-2 solutions to try, and repeat if needed
  - Common Barriers
    * Misinformation/lack of information
    * Previous experiences
    * Lack of social support
BEHAVIORAL STRATEGIES THAT WORK: INTERVENTIONS

• Feedback and Reinforcement
  – Focus on behavior to be achieved
  – Groups: offer support, increased willingness, and participant feedback
  – Adherence may diminish with loss of group unless other reinforcement is identified

• Rewards and Incentives
  – Patients will not reward themselves unless asked to do so
  – It is somewhat unclear about the benefits of incentives to improve adoption of health behaviors
BEHAVIORAL STRATEGIES THAT WORK: INTERVENTIONS

- Other Behavioral Techniques
  - Contracting
  - Cues/prompts (e.g. medications)
  - Social support (groups, individuals)

- Relapse Prevention
  - Highly effective strategy for weight loss, smoking cessation, and exercise
  - Focus is on identification of high-risk situations, developing coping strategies, learning how to mediate if a slip occurs
  - Individuals should be taught to expect lapses in any behavior

- Coaching
COACHING TECHNIQUES
• Unlocking a person’s potential to maximize their own performance. Helping them to learn rather than teaching them – a facilitation process.  
  *Whitmore, 1992*

• Directly concerned with the immediate improvement of performance and development of skills by a form of tutoring or instruction.  
  *Parsloe, 1995*

• The art of facilitating the performance, learning and development of another – a facilitation approach.  
  *Downey, 1999*
Health coaching is the practice of health education and health promotion within a coaching context, to enhance the wellbeing of individuals and to facilitate the achievement of their health-related goals.

THE COACHING PROCESS

Educate
Assess
Willingness

Set Goals
Assess Confidence

Follow-Up

Uncover Barriers
Problem-Solve
“You cannot push anyone up a ladder unless he is willing to climb himself.” — Andrew Carnegie

Step 1: Educate and Assess Willingness

- Be specific, personal, and positive. Persuasion is a powerful source of building self-efficacy.
- Readiness or willingness
  - “Are you ready to start walking 15 minutes each day?”
  - “Are you willing to attempt to quit smoking now?”
    - If yes → proceed to goal-setting
    - If no → explore barriers
"A goal properly set is halfway reached."  
Zig Zigler

Step 2: Set Incremental Goals and Assess Confidence

• Be specific: Realistic, measurable, defined time frame
  - “Eat at least 3 fruits and 3 vegetables every day this week.”

• Assess patient confidence to achieve goals
  "On a scale of 1 to 10, how confident are you that you can eat at least 3 fruits and 3 vegetables every day this week?"
• Step 3: Follow-Up
  – Helps patients to reinforce behavior
  – Gives added incentives for follow through
  – Checks for adherence
  – Stimulates problem-solving
  – Builds self-efficacy
  – Use EMR/paper record; ask to see monitoring logs
  – Assist with problem-solving, setting new goals
Uncovering Barriers: Use this Skill

– When patients are reluctant or unwilling to change (Step 1)
– Have low self-confidence to achieve a behavior change goal (Step 2)
– Did not attain their goal (Step 3)

Example: “What’s standing in your way?”
“What might prevent you from meeting your goal?”
Common Barriers

- Misinformation or lack of information - Use educational messages or add information about importance of change

- Previous experiences - Encourage patient to challenge themselves despite failed experience

- Lack of support - Help patient to identify resources within health care system, community or circle of contacts
“The best way to escape from a problem is to solve it.”

Alan Saporta

Five Steps to Problem Solving

1. Identify the problem and reasons
2. Select the main reason and list potential solutions
3. Weigh the pros and cons; Select 1-2 solutions
4. Try out the best solutions
5. Repeat the process if the initial solutions were not successful
Relapse occurs very early (1 month) with change in behaviors.

Lapses are extremely common and need to be acknowledged by Health Care Providers.

The relapse prevention model is highly related to maintenance of health behavior change.

Self-monitoring and problem-solving support return the relapse model.
Cognitive-Behavior Model of the Relapse Process

- High-Risk Situation
  - No Coping Response
    - Decreased Self-Efficacy
      - Positive Outcome Expectancies (for initial effects of substance)
  - Decreased Self-Efficacy
  - Positive Outcome Expectancies (for initial effects of substance)
- Increased Self-Efficacy
- Decreased Probability of Relapse
- Initial Use of Substance
  - Abstinence Violation Effect
  - Dissonance Conflict and Self-Attribution (Guilt and Perceived Loss of Control)
- Increased Probability of Relapse

• Negative emotions (35%): negative mood or feeling such as frustration, anger, anxiety, depression, boredom

• Interpersonal conflict (16%): ongoing or recent conflict associated with an interpersonal relationship, i.e. marriage, friendship, employer-employee relationship

• Social pressure (20%): direct or indirect response by others to pressure an individual to engage in a taboo behavior
HIGH RISK SITUATIONS: EXERCISE AND WEIGHT LOSS
HIGH RISK SITUATIONS:
EXERCISE AND WEIGHT LOSS

• Exercise
  - Bad weather
  - Being physically tired
  - Negative mood states
  - Being alone
  - Injury

• Weight Loss
  - Eating away from home
  - Travel
  - Eating late at night
  - Negative mood states
  - Craving for sweets
  - Feelings of poor eating control

Four strategies that influence maintenance:

- Self-monitoring
- Reinforcement
- Relapse Prevention
- Contracting

RELAPSE PREVENTION: SPECIFIC INTERVENTION STRATEGIES

- Self monitoring + Behavior Assessment (e.g. Situational Competency Test)
- Relaxation Training Stress Management + Efficacy Enhancing Imagery
- Contract to Limit Extent of Use + Reminder card (what to do when you have a slip)

High Risk Situation

- No Coping Response
- Decreased Self-Efficacy-Positive Outcome Expectancies
- Initial Use of Substance
- Abstinence Violation Effect

Relapse Fantasies + Descriptions of Past Relapse

- Skill Training + Relapse Rehearsal
- Cognitive Restructuring (Slip = Mistake Attribution to Situation vs. Self)

- Education about Immediate vs. Delayed Effects of Substances: Use of Decision Matrix
- Programme d Relapse

• Identification of high-risk situations
  – Self-monitoring: record daily cigarette use, include time of day, description of situation, rating of mood
  – Situational competency test: provide high-risk scenarios
  – Self-efficacy ratings: standard 14-28 item scales
  – Relapse fantasies: imagine high-risk situation
• Skills training
  – Problem-solving approach
  – Practice session (behavioral rehearsal, coaching/feedback)
  – Relapse rehearsal

• Relaxation training
  – Progressive muscle relaxation, meditation, stress mgmt.

• Education – problem of immediate gratification
  – Unbalanced lifestyle
  – Decision matrix
RELAPSE PREVENTION INTERVENTION STRATEGIES

• Global self-control strategies
  – Balanced daily lifestyle, *i.e.* “shoulds” vs. “wants”
  – Positive addictions, *i.e.* jogging, meditation, “body time”
  – Coping imagery and stimulus control techniques

• What if a slip occurs?
  – Teach behavioral skills to moderate or control the behavior
  – Instruct in cognitive restructuring procedures, *i.e.* use of reminder cards
• Cognitive-behavioral strategies: Class 1
  – Design interventions with specific proximal goals
  – Provide feedback on progress toward goals
  – Provide strategies for self-monitoring
  – Establish frequency/duration of follow-up contacts in accordance with individual needs
  – Utilize motivational interviewing

• Cognitive-behavioral strategies: Class 1
  — Provide direct or peer-based long-term support and follow-up to offset declining adherence
  — Incorporate strategies to build self-efficacy
  — Use a combination of $\geq 2$ strategies (e.g. goal setting, feedback, self-monitoring, follow-up, motivational interviewing, self-efficacy) in an intervention.

“The whole purpose of education is to turn mirrors into windows.”

Sydney J. Harris

• Deliver brief 1-3 minute messages
  – Use teachable moments
  – Enhance effectiveness by limiting content, tailoring, being clear and directive
  – Confirm a patient’s understanding

• Foster better education in all practice settings, e.g. office, exam rooms, staff
"Better to understand a little than to misunderstand a lot. “ Anonymous

- 90 million Americans have difficulty with literacy; 50% leave an office are perplexed about what to do

- Educate by:
  - Offering 1-3 minute credible messages
  - Using the repeat back method to clarify
  - Summarizing at the end of a visit
  - Writing down ALL important instructions
  - Offering 2 methods of information
  - Drafting educational materials focusing on health literacy and health behaviors
“Mr. Jones, giving up smoking is the single most important thing you can do for your health.

- **Directive/Persuasive Statement**
  Smoking decreases the amount of oxygen that is carried in the blood to your heart. Your angina is caused by a lack of blood flow to the heart muscle. Continuing to smoke is likely to cause you more chest discomfort.

- **Tailored and Personalized Statement**
  I would like to work with you to help you remain off cigarettes for good. Are you willing to make an attempt to quit smoking during this hospitalization?”

- **Warm/Empathy and Clear Question**
SELF-MONITORING: A KEY TO ADOPTION OF HEALTH BEHAVIORS

- Monitoring helps to determine whether a goal is too high to too low
- Tools include diaries, logs, calendars posted in plain view (e.g. refrigerator, exercise bike) to serve as cues
- The frequency/duration varies by behavior, but general guidelines apply
  - Adoption: Daily for 3 months
  - Maintenance: Once/week (3-6 months)
  - Lapse: Weekly (1-3 months)
Four important strategies that WORK for exercise:

- Goal-setting/Self-monitoring
- Feedback/Reinforcement
- Relapse Prevention
- Social Support
Goal Setting/Self-monitoring

- Focus on weekly goals. Be specific, measurable, realistic – record goals
- Use pedometers, diaries, logs, calendars, Iphone, and record FITT
- Post monitoring logs in plain view – refrigerator
- Monitor for 3 months during adoption, one week/month during maintenance, and weekly for 1-2 months for lapse
Feedback/Reinforcement

• Focus on behavior to be achieved

• Groups: offer support, increased willingness, and participant feedback

• Adherence may diminish with loss of feedback unless other reinforcement is identified – e.g. internet, email
"Nothing is better than the wind to your back, the sun in front of you, and your friends beside you."

Aaron Douglas Trimble

Relapse Prevention
• Focus on identification of high-risk situations (e.g. boredom, travel, weather, injury and time), developing coping strategies, learning to mediate a slip
• Remember the “one-week” rule

Social Support
• Offered from many people and through telephone, email, and contracts/written agreements
• Encouragement should be immediate and specific
• Health behavior change is a complex interplay of communicating, educating and coaching individuals to make changes

• Coaching is an interactive process that requires ongoing support to help individuals maximize their potential for change

• Coaches must rely upon the elements of health behavior change to help individuals engage in the change process