Behaviour Change Counselling

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Counselling patients about the impact of behaviour on their health is an important part of the consultation process for Family Physicians. This article attempts to summarise key points for effectively motivating behaviour change.

Common scenarios where counselling on behaviour change is relevant include:

1. Dietary change,
2. Increased exercise,
3. Smoking cessation,
4. Alcohol cessation
5. Medication adherence, and
6. Safe sex practices.

Stephen Rollnick, one of the co-founders of motivational interviewing, established the concepts of **Importance, Confidence and Readiness**. Clinicians who are familiar with the *Stages of Change Model* can think of discussions surrounding these concepts as potential areas to explore reasons a patient happens to be in the stage that they are in and barriers to be overcome in order to progress. Simply put, this framework can be used as a tool to assess the impact of bio-psycho-social barriers to change and discuss them in the consultation as part of good patient-centred care.

Dr Ian Koh with his 2 children, Esme and Ezra

I. IMPORTANCE

This covers the "why" of the proposed change. Most patients are well aware of the general benefits of behaviour change such as eating healthily, exercising more and smoking cessation, but how they can benefit an individual patient in a tangible way may be less clear to them.

All change comes at a cost, be it the time and effort taken to exercise, the negative experience of nicotine withdrawal, or the inconvenience of taking medicines on a regular basis. The patient must perceive the benefit to themselves as greater than the cost, as a prerequisite for behaviour change. The primary goal in discussion on *importance* is to explore beliefs and expectations about health, and impact of behaviour change.

The relative importance of a specific change is dynamic, and is dependent on multiple factors. For example, in a patient with overwhelming psychosocial stressors or acute medical conditions, behaviour change may be less important at that point in time. Therefore, it should not be seen as a failure on the part of the clinician to defer a discussion on behaviour change in some of these possible scenarios.

Value conflict is also a common source of frustration in many clinician-patient interactions. Family Physicians commonly view our patient's optimal health as the utmost priority in their lives, but our patients are entitled to feel otherwise for a variety of reasons. Even with good intentions, forcing these values on an unwilling patient is often counterproductive and damaging to the doctor-patient relationship.

To allow patients the opportunity to speak positively about change, consider using scaling questions with patients.

These can include:

- How important is it for you to (proposed change)?
- On a scale of 1 to 10, with 1 being "not important" and 10 being "very important", what number would you give yourself?"

The selected number can be used as a springboard for further discussion.

For example, if the patient states "5", you can then ask:

- o Why is it a "5" and not "3"?
- o What is a "5" and not "7"?
- o What would it take for you to move to a "7"?

These questions allow clinicians to better understand any issues at hand.

II. CONFIDENCE

Confidence pertains to "how" and relates to self-efficacy. In general, a sufficiently high sense of *importance* should precede deeper exploration of *confidence*.

The patient should consider themselves how they will perform a specific change. The clinician can then assess confidence to uncover barriers and allow their patients to think of ways to address them. A similar scaling question

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as described above can be used for confidence in a similar manner to structure the conversation. If confidence is low, the problem might be that the foreseen barriers are too great to overcome, or that the proposed change is too drastic.

For example, for a patient who had been sedentary for most of their life, advising them to perform 150 minutes of moderate intensity exercise every week can be too high a bar. Instead, ask how much exercise your patient is confidently able to do and work from there.

SMART goals can be incorporated when discussing confidence; the patient can assess their confidence at performing a **S**pecific, **M**easurable, **A**chievable, **R**elevant and **T**ime-bound goal.

An example of a SMART goal is as below:

- Start to brisk walk from the bus stop to home after work for 15 minutes, 3 times a week to improve cardiovascular fitness by the next appointment in 3 months' time.

III. READINESS

If *importance* and *confidence* are sufficiently high, the only question left is "when"?

Discussion will then focus whether the patient will start immediately or on a specified date and how they might manage other priorities. At the follow-up appointment, the clinician can check on progress, acknowledge effort and address difficulties that arise.

We usually work in highly time pressured settings where applying this model may seem laborious and time consuming. However, with the opportunity afforded by continuity of care that Family Physicians provide, the entire process can take place over multiple consultations opportunistically.

A deep understanding of our patients' psychosocial characteristics common in doctor-patient relationships enables us to more easily engage in a rich discussion on behaviour change.

CM

Interview with Dr Zuraimi Mohamed Dahlan and Dr Elly Sabrina

About Marital Bliss

Interviewed by Dr Lim Khong Jin Michael, Family Physician, Editor (Team B)

College Mirror (CM): Hi Dr Zuraimi and Dr Elly, thank you for kindly agreeing to open up to us about your marriage so that we can all learn from each other. Please begin by sharing with us how you met your spouse.

Dr Zuraimi Mohamed Dahlan (ZMD): We met for the first time at Jam N Hop @ NUS ARTS. Those were the days before COVID-19. I was a freshman and Dr Elly was a third-year senior at NUS Medical School. I knew her prior to the encounter via newspaper.

The first time meeting her in person, and I was immediately charmed by her. Seniority was never a hindrance to me. We kept bumping into each other thereafter at Medical Library and outside Lecture Theatres.

Dr Elly Sabrina (ES): We first met to the strains of "I hate myself for loving you ", that NUS Jam N Hop anthem which used to kickstart the new matriculation year.

I was in my third year of medical school and he was fresh out of the army, disrupted from national service. He walked right up to me and said, "Hi. Aren't you that girl on Berita Harian who scored 9A1s for O level exams?" I was not impressed with his pick-up line as I was appalled that he could still remember my "nerdy" me during secondary school days.

At that point of time, I was busy trying to shed my previous "chow mugger" look with contact lens and a new hairstyle. Anyway, I was not keen about dating a junior.

CM: How did you know you were right for one another?

ZMD: We decided to stay as friends at first. Medical school was tough. Getting by first year was a big hurdle for me. Failing Anatomy and Physiology meant that I had to sit for the Re Exams and there was no time for social activities.

Only after I passed my Re Exams that I paused to take a breather and started seeing Dr Elly more regularly. Both of us were on the lookout for a life partner. I was lucky I met her at the right time. We remained close friends for 7 years before we finally got married. Those 7 years were important as that was the time, we got to know each other well enough to commit to each other.

In any relationship, time is important. Time enables us to be sure that who we are meeting is genuine towards us and