UNIT NO. 3

BEHAVIOUR CHANGE

Dr Tan Yew Seng

ABSTRACT

The family physician's skill to facilitate behaviour change is becoming increasingly important, particularly in the context of chronic disease management. The challenge however, is to do so in the time-limited setting of the family practice consultation. The Trans-theoretical Model or Stages of Change Model developed by Prochaska and DiClemente provides a framework to understand the change processes. It also provides a guide for specific stage-based interventions. Central to the concept in facilitating change is the ability to the enhance patients' readiness to change, which may be characterised by his sense of importance and confidence about change. It must be realised that the models and guidelines are driven by principles of patient centredness, patient participation, empathy, therapeutic alliance and congruence, without which replicating the steps becomes meaningless. In practice, a simple sequence to facilitate change in a family practice consultation may involve establishing rapport; finding out what changes are acceptable to the patient; setting an agenda for change; and assessment and exploration of importance and confidence. It is however important to avoid the potential pitfalls, which includes doing too little, doing too much, and misinterpreting resistance and stage based interventions.

Key words: health behaviour change, stages of change model, family practice, counselling, chronic disease management

INTRODUCTION

Smoking, obesity, diabetes mellitus, ischemic heart disease, sexually transmitted diseases, are examples of conditions for which behaviour modifications are useful in disease prevention or chronic disease management. Increasingly, the family physician has to engage patients in behaviour change as the preventive and chronic disease management case-load expands.

Advice-giving has been the traditional approach to induce behaviour change. This can be defined as a sequence in a consultation in which the doctor describes, recommends or forwards a preferred course of action. Usually, the good doctor makes his stern recommendations as to what the patient should and should not be doing, and the patient obediently follows his advice. If things were so simple! The truth is more likely that after a string of dutiful explanation and advice, the patient replies as such: "*Yes Doc, I know __ [the behaviour is not good for me], but …*"

TAN YEW SENG, Family Physician, Evergreen Family Clinic and Surgery

Some doctors, in response, may continue to persuade at every opportunity, in the hope that the patient may somehow come to his senses one day. This strategy often leads to frustration and disappointment to both the doctor and the patient. Very frequently however, the patient becomes labelled as "resistant", "having poor motivation", or "non-compliant to advice" or even "hopeless". The fact is that while there are well-known strategies and protocols for the patients who want to change, there are not many programmes for those who decline change for any reason. The actions expected of the doctor is usually quite clear-cut once a patient agrees to change, but the doctor may run out of ideas and get stuck when the patient refuses to change. Labelling the patient in ways that absolve the doctor of the need to do anything can be perceived as a coping mechanism of the medical profession.

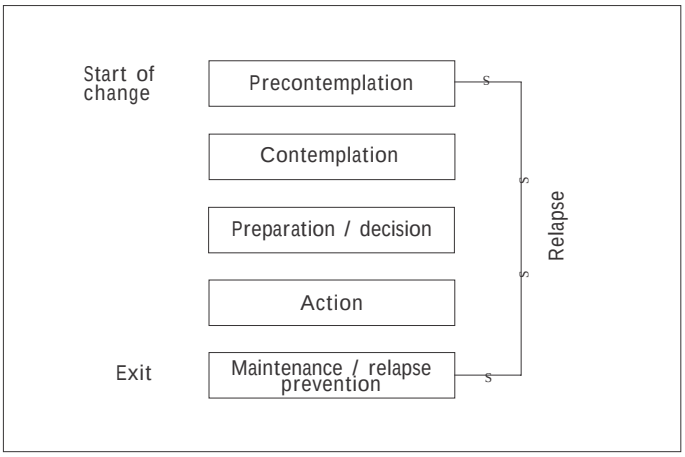
This is not to say that giving simple advice does not work. Some patients will keenly attest to the effectiveness of a single good talking-to by their doctors. Why this group of patients respond and not the former is the crux of this article. The article is organised into 3 parts: the first part deals with the general principles and concepts that will form a framework for understanding the change process; the second part offers a short sequence of tasks that are useful in the setting of a family practice consultation, applied in the framework provided by the first part; and the third part fine tunes intervention by highlighting the therapeutic attitude and pitfalls.

GENERAL PRINCIPLES

Why some patients respond to simple advice and not others can be understood by the idea of readiness to change. The stages of change model which was developed by Prochaska and DiClemente in the late 1970s and the 1980s can be said to be an attempt to describe readiness to change in terms emotions, cognitions and behaviour. In this model[1,2], the person attempting to change navigates gradually through five stages: from being uninterested or uninformed about change (*precontemplation*), to considering change (*contemplation*), to preparing for change (*preparation*), to taking genuine steps in changing (*action*) and finally actively incorporating the change (*maintenance/relapse prevention*). During the course of change, the person can move backwards or regress to the previous stages; relapse can also be expected. Several cycles of regression and relapse may be necessary before the behaviour change is completed (Figure 1).

At each of the stages, the concerns and issues of the person differ, which explains why people will not respond to the same intervention for change. In other words, there is no one method that fits all.

Figure 1. Stages of Change Model



Precontemplation Stage

During the precontemplation stage, patients do not consider changing in the foreseeable future, usually measured as the next six months. They may be in this stage because they are uninformed or under-informed about the consequences of their behaviour. Or they may have tried to change a number of times and become demoralized about their ability to change. Both groups tend to avoid reading, talking or thinking about their high risk behaviours. During discussions, they may down play the seriousness of their condition *("All my family members are obese"*), or fail to make the link between their condition and the complications *("I don't believe it will happen to me"*). They may be defensive in the face of other people's efforts to pressure them to quit. These patients are frequently labelled as being resistant or unmotivated. More will be discussed on precontemplators later on.

Contemplation Stage

During the contemplation stage, patients are more aware of the personal consequences of their bad habit and they spend time thinking about their problem. In this stage, the patients considers the benefits and costs of the behaviour change, so that ambivalence results. The possible barriers to change include time, financial costs, inconvenience, loss of pleasure, change of routines etc. The ambivalence may be so profound that the patient can remain in this stage for a long time.

Preparation / Decision Stage

Patients in the preparation stage get ready for change in the immediate future, usually measured as within the next month. The preparation may involve experimenting with small changes, reading self-help books, talking to their doctor about change, or trying out low-fat foods or low tar cigarettes.

Action Stage

The action stage is one in which the patient takes active steps to change their behaviour by a variety of techniques. The changes are generally specific overt modifications within the past six months that have clinical significance. Clinical significance implies that the changed behaviour would be likely to reduce the risks of complications of disease, for example, for cigarette smoking, the changed behaviour is abstinence; while for diet, 30% of calories should be consumed as fat. In this stage, relapse is common.

Maintenance / Relapse prevention

This is the stage in which the patient starts to incorporate the new behaviour into the lifestyle with efforts being directed to maintain the new status and prevent relapse. Most patients may find themselves recycling through the stages before the new behaviour is eventually established.

So what is the usefulness of knowing the Stages of Change?

Firstly, it recognises that the persons who need or seek change are not homogeneous. They ranged from the precontemplative ones who may not even think of change, to those who have tried in their own ways but come to the doctor for further advice or affirmation (preparation/action). Knowing where the patient's stage of change is avoids the unnecessary label of "non-compliance", or "poor motivation", which in turn reduces frustration and misunderstanding for both the doctor and the patient.

Secondly, there are stage specific strategies to move the patient along the stages of change. The processes involved in moving patients across stages and examples of tasks that are useful at the various stages are as shown in table 1 (See also Pitfalls later). In general, the earlier stages require more motivational approaches (for example, the use of motivational interviewing) and the later stages require more of cognitive and behavioural approaches (see 'Activities needed to move to next stage' in Table 1). In a nutshell, different people need different strategies at different stages of change.

Thirdly, it is important to recognise that the stage of change is patient determined. This is in contrast to simple persuasion. In persuasion, the process is usually to get another person to agree with the doctor's views or opinion.

When there is resistance during the change process, which is usually defined from the doctor's perspective of the patient becoming less responsive to his intervention, the cause may be one of mis-matching of patient's stage and the doctor's perception of his stage, or the use of interventions which is not appropriate for the stage. This underlies the need for the doctor to actively assess for the changes in the patient's stage.

In the Stages of Change Model, relapse does not equal failure. In fact, a relapse is an excellent opportunity to help the patient learn about what had led to the relapse, so as to prevent future relapses. On the other hand, relapse if not dealt with properly is not innocuous either, as repeated episodes may lead to loss of confidence and motivation to try to change again.

Finally, the Stages of Change Model assuages the doctor's urge to pursue change all the time. The concept of readiness to change explains that sometimes, it may be better to concentrate on preparing patients for change, rather than frustrate oneself and the patient with futile efforts to coerce change.

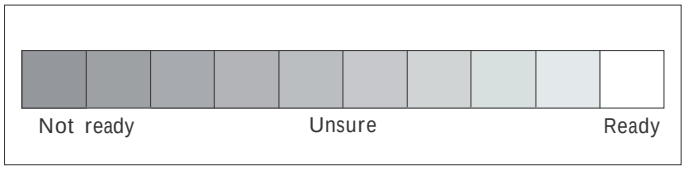
Table 1. Stages of change and the activities needed to move to the next stage

Stage	Description	Activities needed to move to next stage	Tasks for doctor
Pre-contemplative	Unaware of need for change; or aware but not considering change	Consciousness raising Re-evaluation of the environment Exploration of feelings about changing	• provide personalised feedback • give printed (educational) material • offer follow up • flag case notes
Contemplative	Considers behavioural change, seeks out information about personal advantages; may be ambivalent about changing	Self-evaluation	• motivational interviewing techniques – good, less good – outline concerns – decision matrix – highlight discrepancy – assess motivation and confidence (on 1 to 10 scale) – avoid labelling and generating resistance • provide written reinforcement • consider self-monitoring
Preparation/ decision	Actively makes plans to change, takes steps towards action	Perception of environmental and social supports for change	• discuss plans to change • affirm steps and support • offer follow up
Action	Actively modulates behaviour; learns new skills; effects changes in environment to support change	Belief in ability to change and commitment to act Rehearsal of new learning; substitution of new behaviour for old ones Management of reinforcers to maintain gain Restructuring of environment and experiences to avoid cues to old behaviour Creation of environmental supports	• affirmation • revise plan if necessary • range of behavioural strategies
Maintenance	Maintains gains made; requires environmental support for change to assist in maintenance	Maintenance of environmental supports for change	• follow up • attention to high risk situations • enlist social support • reinforce self rewards • ongoing review of goals and expectations

Readiness to change

Readiness to change is a central concept in the Stages of Change Model. This is a complex psychological state which determines the likelihood for the patient to execute a task. Some authors uses 'motivation' to mean the same thing. In practical terms, during assessment, the essential question is "how ready is the patient to change?" And in intervention, the question becomes "how can we improve the patient's readiness for change?" It is important to stress that the state of readiness is not dichotomous but a continuum that begins with 'not ready' to 'unsure' to 'ready' (Figure 2). Thus, even those patients whose readiness is closer to 'not ready' than 'ready' do have some elements of readiness. It is the task of the doctor to explore with the patient and build on the existing attributes.

Figure 2. The Readiness Continuum



Importance and Confidence

The readiness to change may be characterised by two determinants: importance and confidence.

Importance is about the why, the pros and cons, benefits and costs, or justifications of change. It also impinges on the personal and social values and expectations in the context of the change. Hence, a smoker who perceives that smoking is important because it helps him relax in the stressful office will be reluctant to stop smoking. On the other hand, when the same smoker gets retrenched, he may find it important to stop smoking because of the prohibitive prices of cigarettes. Similarly, diabetic patients who are poor may find it difficult to pay for food other than those that contain has high carbohydrate content, so that while they can acknowledge the importance of balanced diet, it is not the priority for daily living. Some useful questions to assess importance are as shown in Table 2.

Table 2. Useful questions to assess importance

- How do you feel at the moment about [change]?
- How important is it to you personally to [change]?
- If 0 was 'not at all important' and 10 was 'very important', what number would you give yourself?

Adapted from Rollnick S, Mason P, Butler C[3].

Confidence is about the 'how' and 'what' to do, and "whether I can" do. The main issues relates to the concept of "self-efficacy" – as described by Bandura as "people's beliefs about their capabilities to produce designated levels of performance that influence over the event that affect their lives"[4]. It is therefore more a "belief" or psychological state, than purely a lack of skills (capability), the latter of which may be remedied simply by the imparting of skills. For example, a smoker who has relapsed many times may suffer not from a lack of knowledge or skills about quitting cigarettes but from being demoralised after the repeated "failures".

Some useful questions to assess confidence are as shown in Table 3. When both importance and confidence are present, what remains for the patient would be to decide the when and mode of action. When importance is present but not confidence, the patient may engage in all the preparation to change but will not take action. On the other hand, when confidence is present but not importance, change will also not occur because the patient may not see the need to change – "*I am sure I can change* (or "*stop the habit*").., *if I want to*" is a frequent response. However, importance and confidence can sometimes overlap or influence one another. Thus, a smoker who has repeatedly failed to quit smoking many times (lost confidence) may come to believe that his health and even life will be in danger should he try to quit smoking (lost importance).

Table 3. Useful questions to assess confidence

ĸ If you decide right now to [change], how confident do you feel about succeeding with this?
ĸ If 0 stands for 'not at all confident' and 10 stands for 'very confident', what number would you give yourself?

Adapted from Rollnick S, Mason P, Butler C[3].

SETTING UP BEHAVIOUR CHANGES

Health behaviour change can be a challenging endeavour, particularly in the setting of a busy family practice. With the time constraint, the temptation is to dispense anything from words of encouragement, to cursory advice, to stern warnings and even admonishment that may provoke dramatic change. Some of the patients will change, but there will be many who remain resistant, oftentimes to the disappointment and frustration of both the doctor and patient. Some ideas are worth restating here. Firstly, change is usually gradual. It is therefore unrealistic to expect results after a one-off intervention. In other words, those that don't respond to such interventions are not "failures".

Secondly, useful change is more likely if it is patient-initiated. Active patient participation is the key to successful behaviour change. The role of the doctor is not to enforce or coerce change in a passive, if not resistant, patient, but to enable the patient to make his own changes. This can be accomplished by providing direction, structure, support and the necessary information as required by the patient. When the positions between the doctor and the patient are not concordant, the patient's views and aspirations should be respected, even as ***negotiations*** are underway for an alternative stance. Good or bad, there are always a rationale and function, principally *THEIRS*, to any behaviour.

The following is a general guide to setting up behaviour changes. Variations can exist between doctors, but what is important is not to know the exact protocol, but to appreciate the concept of the strategy.

1. Establishing rapport

This is an indispensable step to set up an open and honest exchange in a healthy therapeutic alliance. Without any rapport, attempts at change may be misconstrued as intrusive or coercive, and resistance invariably results. Rapport is also not an all-or-none entity. The level of rapport can fluctuate during the consultation depending on what has transpired and how the doctor responded to the patient. Constant monitoring of the rapport is necessary to ensure the strength of the therapeutic alliance.

2. Does the patient want change?

Although it seems obvious that the patient who comes to the doctor with some behaviourally related medical condition should want to change the behaviour, in reality, this may turn out to be the medical professional's hang-over from Parson's concepts of the sick role[5]. For example, patients with chronic bronchitis may not want to stop smoking, although they may agree to reduce smoking to the point where symptoms become tolerable. Similarly, an overweight patient may come to see the doctor to "lose weight", but not necessarily to alter his/her dietary habits. Being clear at the outset whether the patient wants change or what the patient is prepared to change therefore becomes important. Otherwise, to launch fully on changing behaviour, even if it were medically 'reasonable', may end up as a struggle for control. It follows from above that what and how change can be acceptable for the patient has to be clarified specifically too.

3. Setting an agenda

Many health behaviours do not exist alone, for example, dietary behaviour and sedentary lifestyle; cigarette smoking and alcohol consumption and so on. Not only do they coexist, they also influence one another. Patients too, may have other behaviours which they are keen to change or discuss when they express a desire for 'change'. Hidden agendas may also be lurking, such as mending relationships by quitting cigarettes, or losing weight to keep a boyfriend. Ignoring these 'external' agendas may lead to sabotage of the behaviour change

– extra-therapeutic/patient factors has been shown to have significant influences on the change outcomes[6,7]. Sometimes, dealing with what is troubling the patient elsewhere may change an unhealthy behaviour, such as dealing with a social issue when managing hypnotic dependence.

It is therefore useful to set the agenda from the start. This is a good way of laying out what are the possible behaviours that need attention as well as other issues that the patient feels are important to him or her. An agenda can also alert the doctor to an area of avoidance by the patient, and sometimes the doctor.

The consultation may start off with something like: "*With respect to the daily management of diabetes, we can talk about diet, exercise, tablets, smoking, and so on. Which of these would you like to discuss, or is there something else which is on your mind?*" Agenda setting is therefore not totally hands-off or *laissez-faire*. The role of the doctor remains directive, by negotiating goals and the agenda, and directing focus onto areas of neglect. The approach, however, remains one that emphasises patient choice and decision making.

4. Assessment

The impact of importance and confidence on readiness and some ways to assess them have been discussed earlier. Readiness can be assessed in a similar way; exploration to enhance readiness can too be done by adapting the questions in point 5.

5. Exploring importance and enhancing confidence[3]

Exploring importance

If scores were used in the assessment, we can follow up with questions like:

- *Can you tell me why you have given yourself a score of x instead of 1*? (Elicit patient's positive reasons for change)
- *How can you go higher?* (Explores perceived options)
- *What stops you from moving up from x to [higher number]?* (Explores the perceived obstacles)

Another way is to examine the costs and benefits of changing or staying the same. This process helps the patient self-reflect on the internal-external discrepancies, and the ambivalence about change. Doing so would generate internal tension which can motivate the patient to change[8,9]. This process may be achieved with the visual aid of a 'decision grid' as shown in Figure 3.

Figure 3. "Decision Grid" on To Change or Not To Change

	No change	Change
	Costs	Costs
	Benefits	Benefits

Enhancing confidence

Similarly, if scores had been used earlier, questions that follow could be:

- *Why had you scored x instead of 1?*
- *How can it go higher?*
- *What would help you to become more confident?*
- *What stops you moving up from x to [higher number]?*

Another method is to brainstorm with the patient the possible courses of action and then allow the patient to choose what is suitable. The purpose is to help the patient realise that there is choice among the many possible courses of action, while conveying optimism.

Sometimes, it may be appropriate to talk about the patient's past efforts and his or her successes and failures – to affirm previous attempts at change and past successes. It is not about emphasizing the success or dismissing the failures. Rather, helping the patient appreciate a balanced appraisal of the past performances (not the person) is the doctor's task.

It is however crucial that the patient is not over-hyped up about the importance of change or with over-confidence about change. Premature attempts at change situations ultimately set them up for disappointments and a sense of failure. The goals for the patient should be realistic and specific, even if they are "small gains" in the eyes of the doctor. What is important is that they represent the patient's choice and context.

6. Other interventions

Sometimes, it is necessary to provide certain specific interventions before the patient can proceed to make specific changes. For example, relaxation techniques may be useful for patients who are under 'stress' or anxiety. Social interventions should also be considered if mundane needs such as housing rental, child care, marital counselling, job placement etc are wanting. Depending on culture and social status, many such basic needs may rank above health concerns.

The 'Spirit' of Change

The strategies mentioned above must not be applied 'cook-book' fashion. The guiding principle for the use of all these strategies is patient-centredness. This is more than just being nice and polite to patients, and letting them have their way. In practice, it is about active listening and having a genuine interest in understanding the patient's world view. Research has also indicated that patient oriented communication patterns results in better satisfaction for both patients and doctors[10-13].

Indeed, the Stages of Change Model is highly based on patient responses and participation. The 'spirit' of Motivational Interviewing, a method developed from the Stages of Change Model to prepare people for change, also embraces Rogerian 'client-centred' values[8]. These values include unconditional positive regard, genuine congruent relationship

and empathy. However, in contrast to Roger's non-directive approach, strategies to change health behaviours may necessarily involve more directiveness. In this case, the doctor provides the necessary structure, and directions for change while maintaining a patient-oriented approach.

It is imperative to appreciate this 'spirit' of change because with all the various strategies, it is easy to become too focused on performing the techniques (see also Pitfalls later). Duncan and his colleagues have gathered evidence to show that rather than the type of therapeutic intervention provided or the techniques used, the factors that determine outcomes may have more to do with the patient's perceptions of the therapeutic relationship, how consistent the method used is with the patient's own theory about change, whether they feel comfortable and respected, and the level of active participation. Needless to say, the doctor's ability to find a complementary 'fit' with his patient affects these factors[6,7,14].

This is not to say that technique is not important. Having the right technique is still required to provide a consistent therapeutic framework for discussion and intervention, so long this framework is acceptable to both the doctor and his patient, and there is flexibility and creativity in the doctor's responsiveness to the patient. The relation between the 'spirit' and technique is analogous to a craftsman and his tools respectively: a bad attitude (towards his craft and his tools) but good tools, or a good attitude but bad tools – neither produces much result.

BEWARE OF THE PITFALLS

Change who?

Much time and effort could be spent on "trying to change the patient". The fact is however, this is NOT possible. Only the patient can change himself or herself, and at his or her own pace. The role of the doctor is therefore only to facilitate or to create the conditions for the patient to *make his own decision about change*.

What's in a stage?

When a patient tells us she is thinking about reducing her dietary fat intake, does that mean she is a contemplator? In reality, she may indeed be a contemplator with respect to reducing oil fried foods; but also a precontemplator when it comes to meats, which she loves; but may have already taken action to exclude eggs, shellfish and prawns. On a broader picture, the patient may really be thinking of changing her 'self-image' by losing weight. The 'stage label' is therefore specific to the individual behaviour and certainly does not represent the 'person'.

What moves the patient? After a rousing lecture or moving documentary on television, some patients may slip in and out of different stages. Patients may be 'convinced' into taking action by persuasion too, only to slide back to contemplation when they are back in their own environment. Even in a matter of minutes, poor rapport, insensitive responses, coercive or confrontational remarks during the consultation can easily engender defensiveness or resistance, and erode the state of the patient's readiness. Positive, empathic, and empowering remarks, on the other hand, moves the patient forward. It is a fluid rather than a fixed system.

Readiness therefore has to be defined specifically and in the context of the patient's own social or psychological environments. This can only come about with a willingness to explore with the patient his or her reality. One helpful way to look at the model is to consider the stages as milestones along a continuum, where overlap is the norm rather than the exception. The important question is not whether there is a discrete point at which one stage occurs and another disappears, but how the person got there and how he can be further moved along the continuum.

Using stage-based intervention

It is an attractive idea to have a model where intervention can be matched according to the stage of change. To a certain extent, this is true – motivational interventions are probably more useful in the earlier stages, while behavioural interventions are so in the later stages. Similarly, issues about importance tend to be more valid in the early stages like contemplation, than confidence, which may feature more when it comes to preparing for action. This is in a way common sense because the patient who is still ambivalent about change will benefit little from talking about skills in executing change. However, these notions are likely to be once again oversimplified. Not only because the stages tends to lie on a continuum, it is also known that issues such as importance (pros and cons) may continue to be concerns of people who are in preparation; confidence concerns can also emerge in the contemplative stages.

From the practical point of view, it is thus wise not to be hung up by the stage label and its corresponding intervention. Instead, making sure you are 'in sync' with the patient and maintaining a relationship that is congruent to and accurately reflects the state of the patient, should be an ongoing task throughout the change stages.

Do something

There are times when a patient has an obvious health behaviour issue but has no sense of importance in changing it. On further enquiry, you also find that he has no confidence that the problem can ever be solved. Examples can be found among smokers, alcoholics, obese persons, and those who engage in high risk sexual activities. In such instances, it is always tempting to want to do something, to probe or to so-called "intervene constructively" in some way. Here lies the need to have your antenna up and become very sensitive to the patient's response. To resurrect what might be considered by the patient to be a 'good as dead' issue is likely to stir up emotional dirt, conflicts and confusion. It is perhaps best to do little, terminate the discussion and wait for an appropriate moment in a later consultation. However, once

the topic is brought up, it is necessary to close it sensitively, lest it leaves the patient more demoralised than before:

Correct me if I am wrong, but it sounds like it may not be a good time to consider change now. What do you think?

I'd like you to know that you don't need to feel pressured about changing. Take your time to think about it. Whenever you feel ready, we can talk about considering change. Does that sound alright to you?

But even if the perceived importance or confidence is not that low, most decisions to change do not take place during consultation. Pushing the patient to set targets and commit themselves can run the risk of breaking down rapport and raising defences. It may be better to start by just raising the issue and leaving it as it is until such time that the patient is ready to consider change. A mutually respectful relationship leaves the door open for the patient to return, while high 'de-*fences*' prevent them from coming back.

Do nothing (for precontemplators)

Precontemplators are at risk of not receiving attention for several reasons: firstly, health services tend to cater to those who seek help; secondly, when labelled as 'not ready', they tend to be ignored; thirdly, doctors who may already be pressed for time usually prefer to divert their resources to 'those are likely to respond intervention'; fourthly, it may well be a defensive mechanism that doctors ignore precontemplators because they may be perceived as difficult to handle ("*Why waste time dealing with someone who is not interested in changing?*").

However, it has been shown that precontemplators are probably a group with mixed characteristics. After talking to thousands of precontemplators, Miller and Rollnick differentiate them by the four Rs: reluctant, rebellious, resigned or rationalising[8]. There is also no evidence that precontemplators are any more difficult to change than people in the other stages. The strategies that are useful in such cases include empathy and reflective listening, procedures that instil hope, explore pros and cons, and the decision grid (see 'resistance' below as well). Once again, it is necessary to be sensitive when trying to "raise the issue" as a matter of routine because the doctor-patient relationship can be damaged, even if the intention is "well meant"[15].

Resistance

Resistance is usually attributed to patient factors alone. This is true sometimes. It can also be said that resistance can even be expected because change is about disrupting a stable system; about bringing the patient first out of a comfort zone before a new stable system can be re-established with the change incorporated. The natural tendency in any homeostatic system is to resist change. However, resistance may be occult until the need for change becomes more real. For example, a patient who is progressing well in the change process may suddenly slow down or get stuck as a result of hitherto un-surfaced internal conflicts. This is not surprising because the stable system may, for the first time, be challenged by a real prospect of change. Other causes may be the appearance of new factors outside the consultation setting, such as social distress which may or may not be related to the impending changes. The strategy is therefore to explore with the patient his internal and extra-therapeutic landscapes:

What's on your mind when you think about changing?
Can you tell what is stopping you from changing now?
Is there anything happening around you now that is making change more difficult?

More often, resistance involves the dys-synchrony between the doctor and the patient. The very statement "*YOU are resisting ME*" implies the presence of 2 opposing forces; an interpersonal phenomenon. Most of the time, it is an indication that the doctor may have moved too far out ahead in the change process. Taking a step back and re-establishing relevance with the patient may resolve the problem. When there is a dead-lock, the tendency is to confront the patient, particularly when the patient is also belligerent. This happens especially when the doctor feel his position and control is being challenged. In general, confrontational approaches tend to lead to a self-prophesying deterioration, and should be avoided[8]. Rolling with the resistance, empathising with the patient's position, and sometimes even agreeing with the good points about the resistance (it is after all a sign of assertiveness) may be strategies:

You seem to have a point there. How do you think you can ___ [change] without doing ___ [what the patient declines]?

How can we compromise?

And if the impasse persist, it may be useful to acknowledge it honestly and say:

You know, we seem to be stuck here and I don't think I am reaching you very well. Do you have any ideas to get us unstuck?

That's quite a difficult position. What do you think we ought to be doing?

CONCLUSIONS

Changing behaviour has therefore to be understood as a complex, gradual process. While the doctor may facilitate change, it is the patient factors that decide the intervention required and the outcome. The approach is therefore necessarily patient-centred. The Stages of Change model offers a way of understanding the processes and also suggests stage appropriate strategies. The application of these strategies however requires that the doctor's approach remains congruent to the needs of the patient in the various stages, while promoting importance and confidence. The guidelines provided are therefore not meant to be protocol. No one way will work for everyone. The best bet for change remains the

ability to form a therapeutic alliance, to be responsive to the patient, to provide a method of behaviour change that the patient finds acceptable, and to actively involve the patient in his change process.

REFERENCES

1. Zimmerman GL, Olsen CG, Bosworth MF. A 'stages of change' approach to helping patients change behaviour. Am Fam Physician. 2000; 61(5):1409-16.
2. Cancer Prevention Research Centre. Detailed overview of the transtheoretical model. http://www.uri.edu/research/cprc/transtheoretical.htm. Accessed 30 May 2004.
3. Rollnick S, Mason P, Butler C. Health Behaviour Change – A guide for practitioners. Churchill Livingstone 1999.
4. Bandura A. Self-efficacy. In Ramachandran (Ed), Encyclopaedia of human behaviour. 4:71-81. New York, Academic Press 1994.
5. Weiss GL, Lonnquist LE. The Sociology of Health, Healing and Illness. Second Edition. Prentice-Hall 1996.
6. Duncan BL, Miller SD, Sparks JA. The heroic client: Principles of client-directed, outcome-informed therapy. Revised Edition 2004. San Francisco, California, Jossey-Bass.
7. Miller SD, Duncan BL, Hubble MA. Beyond Integration: The triumph of outcome over process in clinical practice. Psychotherapy in Australia 2004; 10(2):2-19.
8. Miller WR, Rollnick S. Motivational interviewing – preparing people for change. Second edition. Guilford Press, New York, London 2002.
9. Appendix 5: Assisting patients with lifestyle changes. In: Putting prevention into practice - A guide for the implementation of prevention in the general practice setting. RACGP, Melbourne 1998.
10. Bauman AE, Fardy HJ, Harris PG. Getting it right: why bother with patient-centred care? MJA 2003; 179 (5): 253-6.
11. William S, Weinman J, Dale J. Doctor-patient communication and patient satisfaction: a review. Family Practice 1998: 15: 480-92.
12. Kinmonth AL, Woodcock A, Griffin S, Spiegal N, Campbell MJ. Randomized controlled trial of patient centred care of diabetes in general practice: Impact on current wellbeing and future disease risk. BMJ 1998; 317:1202-8.
13. Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. BMJ 2001; 322:468-72.
14. Miller SD. Losing Faith: Arguing for a new way to think about therapy. Psychotherapy in Australia 2004; 10(2): 44-51.
15. Butler CC, Pill R, Stott NCH. Qualitative study of patients' perception of doctors' advice on smoking: implications for opportunistic health promotion. BMJ 1998; 316:1878-81.

LEARNING POINTS

- **The Trans-theoretical Model or Stages of Change Model developed by Prochaska and DiClemente provides a framework to understand the change processes and a guide for specific stage-based interventions.**
- **Central to the concept in facilitating change is the ability to the enhance patients' readiness to change, which may be characterised by his sense of importance and confidence about change.**
- **In practice, a simple sequence to facilitate change in a family practice consultation may involve establishing rapport; finding out what changes are acceptable to the patient; setting an agenda for change; and assessment and exploration of importance and confidence.**
- **It is important to avoid the potential pitfalls, which includes doing too little, doing too much, and misinterpreting resistance and stage based interventions.**