CLINICAL COMMUNICATION SKILLS THEME

STAGE/LEVEL 3: 2010-2011

HEALTH BEHAVIOUR CHANGE

FACILITATORS' PACK V.11 (01/11/2010)

CCS Stage/Level 3 Co-ordinator:
Sally Quilligan
Lecturer in Clinical Communication Skills

Standard Course Contact Details:
Karen Enright
CCS Administrative Manager
(01223) 769286
ke242@medschl.cam.ac.uk

CGC Course Contact Details:
Jacqueline Keens
Undergraduate Medical Education Assistant
(01284) 712985
jacqueline.keens@wsufftrust.org.uk

Introduction

The **health behaviour change** course takes place during students' stage/level 3 attachments when they are either working in Addenbrooke's, West Suffolk or at a nearby regional hospital. It is one of several Clinical Communication Skills courses specifically designed to prepare students to work effectively with patients in their FY1 year.

Here we concentrate on **health behaviour change and motivational interviewing**. The course builds on students' learning from the Explanation and Planning course in stage/level 2 and also the shared decision-making, concordance and informed consent course which students will have experienced earlier in stage/level 3. It also seeks to highlight further the shift towards the supportive facilitative approach which is essential when we consider patients' motivation and confidence to change. A collaborative partnership approach underpinned by careful regard for rapport and relationship building is a key element for patients undertaking the difficult challenge of health behaviour change.

The health behaviour change approach can be summed up by this over 300-year-old quote:

> *People are generally better persuaded by the reasons which they have themselves discovered than by those which have come into the mind of others.*
> Pascal (1623-1662)

Acknowledgements
This course has been developed with the considerable help of Johanna Sommer from Switzerland and Petrea Fagan from Co-Creating Health and takes much from Steve Rollnick's work and in particular his book "Health Behaviour Change - A Guide for Practitioners" by Rollnick, Mason and Butler, Churchill Livingstone 1999.

Additional materials have been included from The Health Foundation's Co-Creating Health Advanced Development Programme for Clinicians.

Aims of the Stage/Level 3 Health Behaviour Change course

1. to help students further develop their explanation and planning and shared decision-making skills and continue to build on rapport & relationship building with a partnership approach.
2. to understand a model for health behaviour change consultations and how this differs from a more traditional model
3. to have considered the benefits and challenges of using importance and confidence scaling
4. to be able to use importance and confidence scaling appropriately and effectively
5. to understand the concept that there is always a cost and a benefit to the individual with regard to a behaviour change and that feelings of ambivalence are a normal part of this process
6. to understand that sensitive and structured support for the patient to explore their ambivalence will minimise resistance and help the patient come to a decision

Overall, remember that in the time available we are trying to give students a model to use and an opportunity to understand the spirit of health behaviour change rather than being able to use a detailed set of skills.

Format of the Course

The course is in two parts

Introductory material on the ER Web (Page 4337)
Students will be asked to engage with introductory material delivered on the ER Web to

- orientate them to the course
- introduce them to the theoretical and research basis of this subject
- explore the skills that they will be practising in the experiential session

Experiential small group work

- students will work in four groups of 6, each group with the same facilitator and simulated patient throughout the session
- sessions will run from 2:00 p.m. till 5:30 p.m.
- student feedback on the sessions will be made using the CCS system

Recording equipment will be available in all sessions so, please make sure that any role plays are recorded.

What are we teaching: facilitator knowledge

This course covers interesting new areas in communication skills teaching. Before teaching the course, facilitators need to have an effective knowledge of the subject matter. To help us all here, we have compiled the following notes. **They are far in excess of what we are going to teach the students - for the students, we have much more limited aims.**

Explanation and planning
The students will come with a good grounding in explanation and planning skills following the Explanation and Planning course in stage/level 2 and also the shared decision-making, concordance and informed consent course which students will have taken earlier in stage/level 3. For those who have not taught the E&P course before, could we recommend that you read ***Chapter 6 (Explanation & Planning) in our 'Skills for Communicating with Patients' book*** on so that you know what we have already covered.

PROVIDING THE CORRECT AMOUNT/TYPE OF INFO FOR THE INDIVIDUAL PATIENT
1. **Chunks and checks**, using patient's response to guide next steps
2. Assesses the **patient's starting point** *(and carefully tailors explanation)*
3. Discovers what **other information** would help patient, seeks and addresses patient's info needs
AIDING ACCURATE RECALL AND UNDERSTANDING
4. **Organises** explanation *(uses signposting/summarising)*
5. Checks **patient's understanding** *(asks patient to restate information given)*
6. Uses clear **language,** avoids jargon and confusing language
ACHIEVING A SHARED UNDERSTANDING: INCORPORATING THE PATIENT'S PERSPECTIVE
7. Relates explanations to patient's **illness framework**
8. **Encourages** patient to contribute reactions, feelings and own ideas *(responds well)*
9. Picks up and responds to patient's **non-verbal and covert verbal cues**
PLANNING: SHARED DECISION MAKING
10. Explores management **options** with patient *(signposting pos^{n} of equipoise or own preferences)*
11. **Involves** patient in decision making *(establishes level of involvement patient wishes)*
12. Appropriately **negotiates** mutually acceptable action plan

Health behaviour change

Here we are trying to enable students to move into the arena of health behaviour change and learn the techniques suggested by Rollnick et al. These techniques attempt to reconcile the lessons from the patient-centred and behaviour modification approaches. This model, based on the techniques of motivational interviewing, avoids the criticism that implicit within behaviour modification must be an element of 'doctor knows best', of influencing and manipulation, and of attempting to achieve a predetermined outcome dominated by the professional's agenda of what is 'right'. In this approach, Rollnick clearly establishes that the patient must first be allowed to decide what he would like to do with the help of patient-centred interviewing and shared decision making. The practitioner's role is therefore to help people to make decisions within their own frame of reference and only then, once the patient has identified an outcome they would like to achieve, does the practitioner try to work with and help the patient to assess the importance of the issue, their confidence level in achieving what they would like to do and their readiness to move.

Fig 1 illustrates the key differences between a directed and collaborative interaction

Fig 1 Traditional vs Collaborative Interactions

Traditional Interactions

- Information and skills are taught based on the clinician's agenda
- There is a belief that knowledge creates behaviour change
- The patient believes it is the clinician's role to improve health
- Goals are set by the clinician and success is measured by compliance with them
- Decisions are made by the clinician

Collaborative Interactions

- Patient and clinician share their agendas and collaboratively decide what information and skills are taught
- There is a belief that one's confidence in the ability to change, together with skills and knowledge, creates behaviour change
- The patient believes that they have an active role to play in changing their own behaviours to improve their own health
- The patient is supported by the clinician in defining their own goals. Success is measured by an ability to attain those goals.
- Decisions are made as a patient-clinician partnership

cfep
UK Surveys

Based on Bodenheimer, California Health Care Foundation 2005:7

Two examples

A classical interview

Mr Banks is a 48 year old financial analyst who had a serious depression last year in the context of stress at work and home. He is treated for high blood pressure and takes sleeping pills. He is also overweight and sedentary.

Doctor	Mr Banks, as we have already discussed, we will need to add another drug to your blood pressure treatment as your blood pressure isn't within target levels anymore.
Mr B	Is it really necessary to take yet another pill…I was rather hoping to have less pills to take, not more. I feel fine, is it really worth changing my treatment?
Doctor	I'm really not happy with the blood pressure measurements. We have already discussed the life-style changes that you should do, but you haven't done much about it…
Mr B	I know! I can't manage to do more physical exercise as I told you. Of course I know I should move more, my wife keeps on at me about my belly… but, I'm really too busy now!
Doctor	But you know that if your blood pressure remains high, with you being overweight and your sedentary life, your arteries have a hard job and might give up some day!
Mr B	Yes, but you know... You've already tried to convince me to get off the Underground a few stops earlier and to walk the rest of the way to work. It's easy for you to say that! I already get up at the crack of dawn as it is to be on time for work…there's no way I'm going to jump my ten-minute breakfast…
Doctor	What about your weight? What could you do about that?
Mr B	My breakfast is quite ok, but as you know I eat in the restaurant most of the time with my clients... and there I can't eat just vegetables!
Doctor	And in the evenings at home?
Mr B	Yes…in the evenings… but my wife loves to cook for me, and it's really a good moment we share together, and I'm so tired, I need to eat a proper supper, otherwise I can't manage to finish my work in the evening.
Doctor	But you know you are overweight, close to the range of what is called medically obesity, and that makes your risk of cardiovascular disease even higher!
Mr B	Hum
Doctor	You see, if you can't do more exercise or at least eat healthier food, I'm sure we will have to put up the medication and you will need one drug more, maybe even two when we think of the cholesterol pill we talked about…
Mr B	I take so many already…
Doctor	I wonder if you manage to take them regularly?
Mr B	Sure I do… maybe I do forget a pill from time to time: but usually I take them every morning with my breakfast, my wife prepares them for me! So if I forgot to take them, she reminds me to take them in the evening…
Doctor	Fine! So think about it, but really, we will have to do something about your blood pressure! Remember what happened to your aunt! If she had taken better care of her blood pressure, maybe she wouldn't have had that massive stroke.

Mr B	But she was 80! I wouldn't mind living that long. Her health wasn't that bad until the stroke.
Doctor	I think that you have a better chance of staying well until that age if you do something about your blood pressure.
Mr B	I've got a few years ahead before I get to 80. Let's talk about it next time. I'll definitely have more time when I've finished the big project I'm on at the moment.
Doctor	That's what you said last time….

Health behaviour change motivational counselling interview:

Mr Banks is a 48 year old financial analyst who had a serious depression last year in the context of stress at work and home. He is treated for high blood pressure and takes sleeping pills. He is also overweight and sedentary. (The skills used are labelled in red).

Doctor	Mr Banks, I'm sorry to say your blood pressure is on the high side today despite your medication. What are your thoughts about your blood pressure? (Exploration)
Mr B	I do worry about it – I don't want a stroke or anything. I seem to be taking all these pills and they don't do any good.
Doctor	I can understand that must feel frustrating for you (Empathy)
Mr B	Yeah it is. I was hoping it was going to be normal today
Doctor	Shall we talk about things we might be able to do to get your blood pressure lower? I don't want you to have a stroke either (Ask before advise)
Mr B	Well I don't want any more pills if I can help it. I've just got stable on these and I don't want to be messing around with others
Doctor Mr B Doctor	OK. Do you have any ideas about what might help bring your blood pressure down? I know my weight doesn't help and I'm not very active. You're right, doing some more exercise or losing weight could help bring it down. What thoughts do you have? (Explore beliefs)
Mr B	I'm not sure really. I don't do any exercise at all as you know. I know I should move more, my wife keeps on at me about my belly…maybe if it did my blood pressure some good, I would do some.
Doctor	So would it be helpful/alright to talk about doing some more exercise? (Ask before advise)
Mr B	I guess so. One of your colleagues already tried to convince me to get off the underground a few stops earlier and to walk the rest of the way to work. It's easy for him to say that! I already get up at the crack of dawn as it is to be on time for work…there's no way I'm going to miss my ten-minute breakfast…
Doctor	It's good that you have a regular breakfast and it sounds like you don't really have any spare time first thing. Do you have some ideas about how you might increase your activity? (reflection and positive reinforcement)
Mr B	I do enjoy walking it's just that it's so stressful in the mornings as it is. My wife always chooses the mornings to nag me about this and about that.
Doctor	It does sound like a stressful time of the day for you and wouldn't be a good time to get some walking in. (reflection)

	I'd like to check how important it feels to you right now to be more active on a scale of 0 -10 with 0 being not important at all and 10 being your top priority? (anchoring the scale at both ends)
Mr B	If I knew regular walking would definitely help bring my blood pressure down and I wouldn't have to take more pills it would be 9 or 10.
Doctor	So on the one hand it feels really important to you to take more exercise if it brought your blood pressure down and at the same time you can't quite see how to fit it in to your busy day, that's a real dilemma for you (double reflection with empathy to explore ambivalence about fitting exercise into the day).
Mr B	Well… I guess if I took a proper break at lunch there is no reason that I can't walk to the restaurant where I often eat with the clients, but I wonder would it really make a difference?
Doctor	That's a good question, what benefits you would get out of getting some walking in. In your case, if you managed to do some brisk walking everyday, your blood pressure might well improve enough so we wouldn't have to change the treatment. (information giving to support resolution of ambivalence about fitting exercise into the day.)
Mr B	Really?
Doctor	Yes, I'm pretty sure. Just tell me, how confident are you that you will be able to change your lunch-time routine? If 0 is no confidence and 10 is very confident, what number would you give yourself? (anchoring the scale at both ends)
Mr B	I don't know. You are right. I'm pretty convinced that I have to do something about my blood pressure as you suggested…maybe I would say 5 or 6 for actually doing it
Doctor	Can you tell me why you say 5 or 6 and not 3 or 4?
Mr B	I managed to give up smoking before and that was a real achievement. Also I know my wife really worries about me and I feel guilty about that so it is important to me. (more powerful for the patient to identify than for the clinician to state)
Doctor	So you are feeling relatively confident and willing to do something for your health. How could your confidence increase to say 7?
Mr B	I just need to get organized. I think that I would have to try it out a few times and be sure that I'm not putting too much pressure on myself.
Doctor	So, you want to avoid having to take extra medication for your blood pressure and want to do some regular exercise without putting too much pressure on your busy weekday schedule. If you can do some walking over lunch without getting behind in your work, you would feel more confident about the decision. (reflection).
Mr B	That's it exactly.
Doctor	That sounds like a plan, and as you said, you managed to stop smoking last year; I believe that you'll manage this too! (positive reinforcement)
Mr B	Thanks, I'll hope so too! And my wife will be glad!
Doctor Mr B Doctor	When do you think you it would be most helpful to see you again? I think in about a month. Any longer and I'll put off starting. So you'd like to meet again in a month. I'll check the blood pressure and you will be able to tell how the walking is going. (collaborative)

Summary;

In the second example above we have demonstrated a range of communication skills and these are shown with a brief explanation in the skills descriptor list below. Patients who highly rate their clinician's ability to demonstrate these skills have higher levels of confidence to self manage (Powell, Powell Baker 2009). When considering health behaviour change consultations we must be mindful of the essential component of collaborative agenda setting. A patient will not be keen to discuss an area that we have identified in a directive or judgemental fashion. Open ended questions, reflection and empathy allow us to collaboratively explore the consultation agenda. When we feel that it is important to raise an issue the 'ask before advise' technique (as illustrated in second script) can act as a helpful introduction. Adopting a structured approach to exploring the importance and confidence for the health behaviour change will elicit the optimum environment to support the patient in undertaking this change.

Initially an importance scaling should be sought. It is essential to use clear anchors at either end. Importance scaling has many benefits. It allows us to confirm our understanding of our patients level of motivation, reinforces to the patient their feelings regarding the change (hearing their own words is very powerful), gives us a repeatable measure and contributes to building an effective consultation structure, thus enabling us to progress to the next steps of either confidence scaling or support to explore ambivalence. Clinicians often feel that use of scaling can be patronising and difficult for patients, however our local experience does not support this. Patients often report that they find it very helpful to consider this themselves and are pleased that clinicians are sufficiently interested to ask.

When a high importance scale is reported it is appropriate to move to seeking a confidence scaling. Equipoise is a key for exploring scaling for example when asking why 6 rather than 5. We should always encourage the patient to consider the positive aspects and should encourage them to cite all the positive elements. This can then be followed with exploration of what might need to happen to increase their confidence to say 7.

Where a patient reports a low importance scaling we can support them to explore their ambivalence. Again equipoise is key and it is essential that we do not allow any of our own feelings to influence our tone or phrasing. Ambivalence for difficult behaviour change is normal (I am sure we have all experienced this at some point) and it is helpful to acknowledge this with the patient. Using open ended questions, reflection and empathy we can facilitate the patient to consider the benefits of staying the same and the benefits of changing. This information allows us to use the technique of double sided reflection using the patient's own words and beliefs. This can be further strengthened by the use of empathy to demonstrate that we understand how hard this is for the patient. One example of this might be; 'so on the one hand smoking is really expensive and you are worried about what it is doing to your health and on the other hand the only social contact you have in the week is with friends who all smoke – that must be really difficult for you'. The double sided reflection with empathy is then followed by a pause space to enable the patient to consider their own dilemma. We should resist the urge to break the silence; this space for contemplation is one of the key elements of the technique.

From this point patients may chose to go on to select something that they wish to work on. It is key we support their autonomy and choice, even if it is not the area that we consider most important. The ability to achieve small successful goals is the key to increasing a patient's confidence to change. Equally a patient may not follow this up further at this stage but may go away and reflect on the conversation. Commonly we do not see the benefits of these discussions until future consultations and it is important that we are aware of the value of the interactions as preparation even if we do not experience immediate feedback.

When we consider these principles within the experiential sessions with the simulated patient the students should begin by negotiating the agenda and establishing a partnership approach. We initially suggests to our actor that she/he reports a high level of importance. Thus the student can go on to explore confidence scaling and what would need to happen to increase the confidence. Subsequently students progress their learning by the actor reporting a low importance scaling resulting in exploration of ambivalence by seeking reasons to change and not to change and using double sided reflection and empathy. It is helpful for students to seek confirmation of importance with all patients, even if it seems high, as this is inherent for successful goal setting later and inaccurate assumptions can negatively impact the relationship and the patient's confidence at a later date.

Detailed background

Health behaviour change principles

The aim of this approach is to address the all too common problem where the practitioner wishes to talk about health behaviour change but the patient appears to lack motivation. It's all too easy to advise the patient about their medication use, to eat less or drink less alcohol, yet this simple exercise in persuasion just seems not to work and leads to "yes, but….." replies. Just telling patients what to do does not seem to be the most effective or rewarding approach. Resistance can come because the patient does not view the importance of change equally as the practitioner or because he or she does not feel confident about succeeding. Resistance however can also arise because of the way the patient is being spoken to and is often the consequence of the use of direct persuasion by the practitioner which increases the potential for disagreement. To succeed in behaviour change requires the patient to become an active decision-maker rather than a defensive receiver of wisdom.

The model is based upon the principles of patient-centred consulting, but says that patient-centeredness is not enough by itself and that there are some additional tools that can be useful in the specific context of behaviour change discussions. In these consultations, there is a different quality, with discussions about commitment and resolutions, strategies and obstacles, timing and fine tuning. The subject of change is often introduced by the practitioner and resistance from the patient is much more likely to arise. Moral judgements can be close to the surface of the discussion. Attention is usually focused on what the patient might do themselves outside the consulting room.

So in addition to patient-centred consulting, health behaviour change consultations need a structure to the discussion which enables patient and practitioner to get the best out of the consultation. **This structural framework** is what we're going to attempt to teach in this module, together with **the skills** that enable this to be put into practice.

So what are you aiming for? You will all know consultations which have not worked in terms of behaviour change. The patient seems to say "yes" verbally but "no" nonverbally, or remains rather passive in the consultation, or constantly bats away your suggestions with reasons for not taking up the behaviour in question.

So how do you know when you have got it right? Some of the key signals would be:

- *you are speaking slowly*
- *the patient is doing much more of the talking than you*
- *the patient is actively talking about behaviour change*
- *you are listening very carefully and gently directing the interview at appropriate moments*

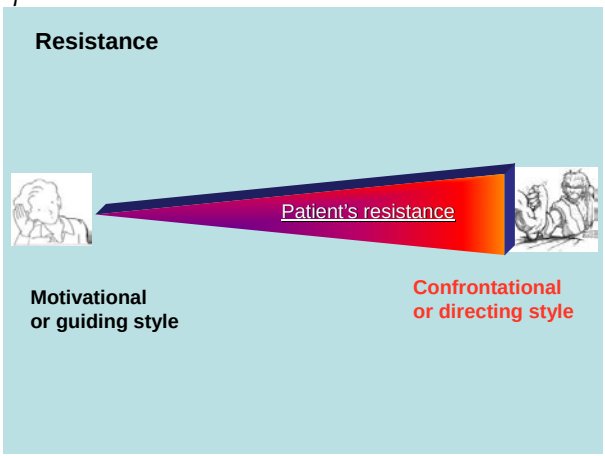
- *the patient appears to be "working hard", often realising things for the first time*
- *the patient is actively asking for information and advice*

What assumptions on your part might get in the way off this happening? Thinking:

- *the person ought to change*
- *the person wants to change*
- *this patient's health is the prime motivating factor for him/her*
- *if he or she does not decide to change, the consultation has failed*
- *patients are either motivated to change or not*
- *now is the right time to consider change*
- *a tough approach is always best*
- *I'm the expert, he or she must follow my advice*

Effective principles of health behaviour change include:

- *respect for patients' autonomy and their choices is paramount*
- *the patient should decide what behaviour if any to focus on*
- *a confrontational interviewing style is usually not productive*
- *the aim of the interview is to enable the client to articulate and resolve ambivalence*
- *ambivalence is a normal and expected conflict between two courses of action, each of which has perceived benefits and costs*
- *reasons for change come from the patient and not the practitioner*
- *the relationship is more like a partnership than expert/recipient*



Two key important words central to this approach:

Ambivalence

Miller and Rollnick in 1991 defined motivational interviewing as an approach for eliciting behaviour change *by helping clients to explore and resolve ambivalence*. The central purpose of motivational interviewing is enabling the patient to explore and possibly resolve their ambivalence. The practitioner's task is to facilitate expression of both sides of the ambivalence impasse, guiding the client towards an acceptable resolution that triggers change. The specific strategies employed are designed to elicit, clarify and resolve ambivalence in a patient-centred and respectful atmosphere taking into account his stage of readiness to

change. Ambivalence is normal and by exploring it, the practitioner is helping the patient to think about the reasons for change.

Resistance

Awareness of resistance during the interview is the single most important practitioner skill in health behaviour change interviews. Signs of resistance to look out for include the patient saying "yes, but….", arguing, putting up objections or justifying current behaviour, denying a problem or ignoring a problem. It is an observable pattern of behaviour. Use of the confrontational interviewing style will increase resistance. Assuming greater readiness to change than is the case by, for instance, talking about action when the patient is not ready for this, will also increase resistance. So resistance is not something that the patient brings into the consulting room, a character trait, but a consequence of the interview exchange and the way in which practitioners speak to the patient. It is a fluctuating product of interpersonal interaction and gives feedback regarding the practitioner's behaviour.

Resistance is not always avoidable. But the aim of the interview is to use your skills to minimise resistance as much as possible by building the patients confidence in their ability to succeed and, where it does occur, to use it as a signal to the practitioner that a change in consulting behaviour is required. This aim is to return the consultation to a position where the patient can feel less pressurised and more able to consider the situation. Patient resistance is often a signal that the practitioner is assuming greater readiness to change than is the case and would be better realigning themselves with the patient. So resistance is often a signal of dissidence in the relationship and a signal for the practitioner to change strategy.

Roy Powell, Helen Powell, Laurence Baker Patient Partnership in Care: A new instrument for measuring patient–professional partnership in the treatment of long-term conditions Journal of Management & Marketing in Healthcare. VOL. 2 NO. 4. PP 325–342. NOVEMBER 2009

A structural framework for health behaviour change interviews

Task	Objectives	Skills/tools
Stage one		
Establish rapport	Develop supportive environment Establish trust	Non-verbal behaviour Acceptance and empathy
Set an agenda	What we might address How we might address it	Either patient starts with a wish to address a health behaviour or doctor seeks permission to address Signpost approach to be taken in interview and rationale
Assess importance confidence	Confirm understanding of patients level of motivation Reinforce to the patient their feelings about change Provides a repeatable measure Establish whether to move to exploring ambivalence or confidence scale	**Signpost use of scale** **Anchor scale** **Explore importance scale** **Depending on result use confidence scale**
Assess ambivalence	Understand patient's views, experience and beliefs Explore ambivalence Analyse cost-benefit	Open questions Reflection Empathy Affirm Summary Elicit and reinforce change-talk and commitments
Provide information	Give information that answers the patient's needs	Explore, explain, explore

Continuous thread
Minimising and working with resistance
reflection (single or double sided)
shifting focus
reframing
rolling with resistance

In this teaching module, we concentrate on stage one, together with the continuous thread of minimising resistance. The second stage involves goal setting, this uses further advanced skills and would often be the responsibility of other members of the multi-disciplinary team (see appendix).

Possible phrases to put this framework into action

Set an agenda	
Objectives	**Skills/tools**

Using a partnership approach to introduce the review of chronic condition What we might address How we might address it	Either the patient starts with a wish to address a health behaviour or doctor seeks permission to address Signpost approach to be taken in interview and rationale

Useful phrases here might be
"What's been going well with your diabetes?"

"You mentioned one of the things you would like to do is to stop smoking. Shall we take some time to discuss that now?"

"I was wondering about discussing your smoking and thinking about whether there was anything you wanted to do about that. Would you be interested in spending a few moments talking about it?"

"

Why did you leave this last piece out Sally - I thought that was rather good!

Assess importance/confidence	
Objectives	**Skills/tools**
Confirm understanding of patients level of motivation **Reinforce to the patient their feelings about change** **Provides a repeatable measure** **Establish whether to move to exploring ambivalence or confidence scale**	**Signpost use of scale** **Anchor scale** **Explore importance scale** **Depending on result use confidence scale**

Useful phrases here might be:
"Would it be alright if I checked how important it is today for you to give up smoking"
"On a scale of 0-10, where 0 is not important at all and 10 is top priority, how important is it for you to give up smoking"
"What makes you say 3 and not 1?"
Be careful here to avoid "why is it 3 and not 1" as this risks sounding judgemental
It is very important to this approach to ask "what makes it x and not x-2 (or any lower number)? " and not "why not 10?". This is in order to encourage the patient to explore what strategies they have developed so far rather than to dwell negatively on why they haven't been able to do something so far (seeing the cup half empty rather than half full). Then having elicited all the positive reasons fro change "What would need to change to move that from 3 to a 5?"
"How confident would you feel that you would succeed once you decided to change? And what makes you say x and not x - 2?"
(NB: Always start with importance; if both very low, explore whether some other issue might be more important).

Assess ambivalence	
Objectives	**Skills/tools**

Understand patient's views, experience, beliefs	Open questions Reflection Empathy Affirm
Explore ambivalence	Summary Importance-confidence scales
Analyse cost-benefit	Elicit and reinforce change-talk and commitments

Useful phrases here might be

<u>open questions</u>

"What do you think about your ….?"

"So what makes you feel that it might be time for a change?"

"What would be the reasons to continue….?" (good things of current behaviour, costs of change)

"What would change in your life for the better if you changed that issue?" (not so good things of current behaviour, gains of change)

<u>reflection</u>

"So, it's really hard for you to get more exercise but if you could find something you could do in your lunch hour you might be able to incorporate it into your busy day."

Empathy

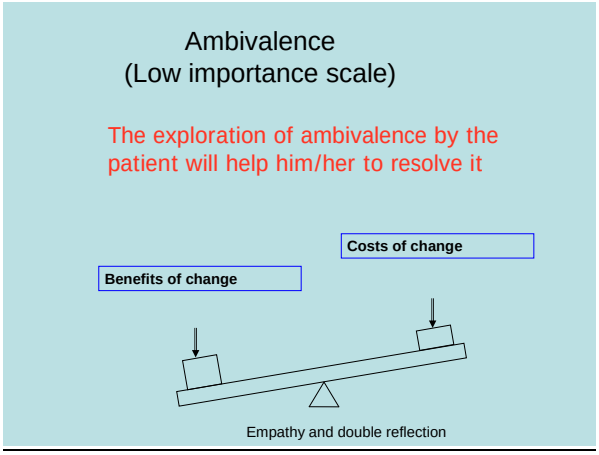
I can see that the mornings are really stressful for you and that you are very worried about the long term consequences for your health

<u>affirm</u>

"So you have managed to stop smoking for long periods in the past - you must have considerable strength of character to have been successful before."

<u>summary</u>

"Let me stop and summarize what we've just talked about. You're not sure that you want to be here today and you really only came because your partner insisted. At the same time, you've had some nagging thoughts of your own about your lifestyle, including how much you've been putting on weight recently, the change in your physical health and your missed work. Did I miss anything?"



(NB: ambivalence is normal, often taken for resistance and must be explored not confronted)

Elicit and reinforce change-talk and commitments
The goal in all of the above is to move the person forward by eliciting change talk, or self-motivational statements. Change talk involves statements or affective communications that indicate the client may be favouring the possibility of change. Essentially, any statement oriented towards change in the present or future, either in the cognitive or emotional realm, may represent a self-motivational statement. For example: "I think that my smoking may be causing problems", "I'm kind of worried that I really need to stop"; "I'm definitely going to do something about that"; "You know, I'm starting to feel like this just might be possible."

Helping the client to develop and verbalize his/her positive thoughts on change increases the likelihood of change. The strength of committing language has been shown to predict behaviour change. Therefore elicit and reinforce change talk, not resistance:

Desire	-I would like to stop smoking -I would like to breathe more easily
Ability	-I know that I'm able to... -It won't be too hard to
Reasons	-I have to save money -My wife can't bear it anymore...
Needs	-With my asthma, I can't anymore.. -My wife will leave me if I don't..

Provide information	
Objectives	**Skills/tools**
Give information that answers the patient's needs	Explore, explain, explore

Useful phrases here might be
"What information do you need from me about…?"

"Would you like me to tell you what medical science says about…?"

"Is there anything I can tell you about high blood pressure that would be helpful as we think about what to do?"

Minimising and working with resistance
reflection (single or double sided) **shifting focus** **reframing** **rolling with resistance**

Useful phrases
Throughout the conversation, be acutely aware of the need to pick up signs of resistance which may mean you are moving ahead too fast or creating a defensive environment. Use the above strategies to realign yourself with the patient.

Reflection:
The simplest approach to responding to resistance is with non resistance, by repeating the patient's statement in a neutral form. This acknowledges and validates what the patient has said, brings you alongside the patient and can elicit an opposite response.
Patient: But I can't quit drinking. I mean, all of my friends drink!
Practitioner: It sounds like quitting drinking seems nearly impossible because you spend so much time with others who drink.
Patient: Right, although maybe I should.

Double-sided reflection
With a double-sided reflection, the practitioner reflects the patients words or beliefs about both the costs and benefits and makes an empathic statement
Patient: I know drinking isn't doing me any good But I can't quit drinking. I mean, all of my friends drink!
Practitioner: You can't imagine how you could not drink with your friends, and at the same time you're worried about how it's affecting you I can see that's difficult for you...
Patient: Yes. I guess I have mixed feelings.

Shifting focus
Another way to reduce resistance is simply to shift topics. This method offers an opportunity to affirm your patient's personal choice regarding the conduct of his own life and giving control back to the patient.
Patient: You see it's been so busy, it's hard to always think about my food and I do break the rules all the time.
Practitioner: (detecting he may be going too fast and shifting focus back to agenda setting) I can understand. Can I just check, perhaps this isn't the best time to talk about this today and you'd rather be talking about something more pressing.

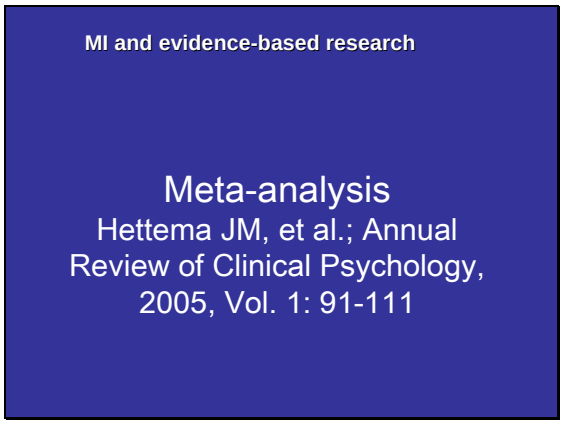
Reframing
Reframing is a strategy in which you invite clients to examine their perceptions in a new light or a reorganized form. In this way, new meaning is given to what has been said. For example, if a patient reports a spouse or loved one as saying, "You really need to deal with your weight" the patient may view this as "she's such a nag". The practitioner can reframe this as "she must care a lot about you to tell you something she feels is important to you, knowing that you will be likely get angry with her."

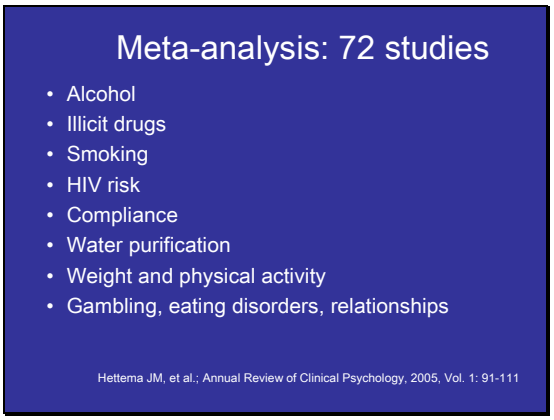
Rolling with resistance
Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this which often will bring the patient back to a balanced or opposite perspective.
Patient: But I can't quit smoking. I mean, all of my friends smoke!
Practitioner: And it may very well be that when we're through, you'll decide that it's worth it to keep on smoking as you have been. It may be too difficult to make a change. That will be up to you.
Patient: OK.

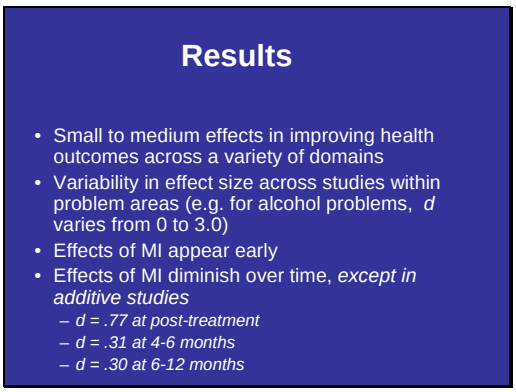
Traps to avoid

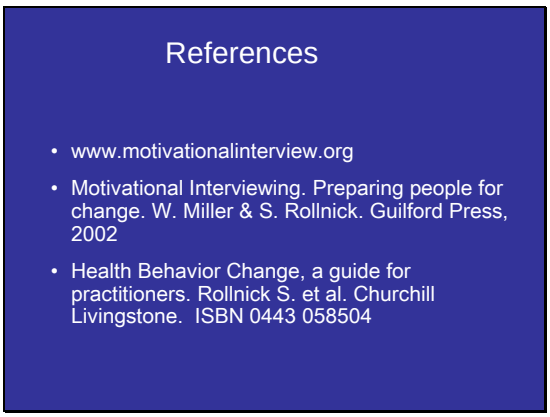
Doctor	Patient
• Question/answer trap	(> passivity, superficial exploration)
• Taking sides	(>argues for other side)
• Threatening	(>denies, argues)
• Confrontation/denial	(>arguments in response to every statement)
• Expert	(>passive acceptance but no action)
• Labelling	(>culpability, anger, low self-esteem)
• Premature focus	(>raises resistance, focus on wrong problem)
• Blaming	(>feels guilty, raises resistance)

Evidence for motivational interviewing









Plan

3 1/2 hour session from 2:00 p.m. until 5:30 p.m.

The aim of this session is to provide students with basic tools in health behaviour change and to limit the amount of teaching that we give rather than being all-inclusive.

Please note that student packs now contain the following information:

Facilitators have been asked to adhere to strict timekeeping for all CCS sessions. Therefore, you can expect this session to start and finish on time. Please ensure that you arrive at least 5 minutes before the start of the session as students arriving after the initial group introductions may not be allowed to join the group.

Verbal feedback is provided to individual students throughout the session. Students wanting to discuss/request further feedback may wish to speak to the facilitator privately. Similarly, if the

facilitator has additional feedback for individuals they may request a meeting at the end of the session. Facilitators will aim to finish 10 minutes before the end of the session to allow time for this and student evaluation/feedback.

2:00 p.m. until 3:00 p.m:

Introductions:

- Welcome, introduce yourself, ask the actor to introduce themselves, explain how this session fits in with students' overall CCS learning
- Introductions as a round - perhaps discover how they are all enjoying stage three and their new responsibilities
- Explain the rationale behind the session: to help students
  - to help students further develop their explanation and planning and shared decision-making skills and continue to build on rapport & relationship building with a partnership approach.
  - to understand a model for health behaviour change consultations and how this differs from a more traditional model
  - to have considered the benefits and challenges of using importance and confidence scaling
  - to be able to use importance and confidence scaling appropriately and effectively
  - to understand the concept that there is always a cost and a benefit to the individual with regard to a behaviour change and that feelings of ambivalence are a normal part of this process
  - to understand that sensitive and structured support for the patient to explore their ambivalence will minimise resistance and help the patient come to a decision
- Outline plan for the session

1:

- Ask each student in turn to think about an interaction they have been involved with or observed between a patient living with a long term condition and a clinician, regarding a health behaviour change. Be explicit here about what you mean by health behaviour change.
- Ask each to talk briefly about a patient on the ward or in the community who had a long term condition and with whom they have experienced issues around health behaviour change
- Flipchart responses
- Be careful in this section not to counter students' views but accept and acknowledge in the spirit of working with resistance to model what we will be doing later

2:

Experiencing two different counselling styles (persuasion and motivation)

Method: You are seated in two lines opposite each other (one line is A and the other B)

Part 1: <u>Persuasion - five minutes</u>

A : Consider a health behaviour that you would like to change and about which you are ambivalent. Such as doing more exercise, buying organic food, eating more healthily, stop smoking, losing weight, stopping risky sex (!) etc…

B : Imagine yourself as this person's healthcare provider. You want your patient to change.

(1) Listen carefully to the situation first

(2) Then try to convince him/her by following steps 1 to 5 faithfully - **do this by telling patient rather than having a dialogue:**

a Explain why the client should make this change.

b Give at least three specific <u>benefits</u> that would result from making the change.

c Emphasize how important it is for the client to change.
d Tell the client how to change and
e Tell the client to do it.

These questions will be available for each student on paper. Don't run through them, just give them out to the B students so the A students don't hear.

While B is trying to persuade A, A can react to Bs proposals. Ask the A's to remember how they are feeling for the debrief.

Part 2 : Motivation - five minutes

The As stand up and move one chair along the line: you have a different partner to continue the exercise.
B : this time, you think of a situation that you would like to change : *see above*

A : you are the health-care provider, and you want to explore your partner's ambivalence: listen carefully with a goal of understanding the dilemma. Give no advice. Ask these four questions and then follow point 5 to 7:

(1) What change are you considering making
would you want to make this change?
(2) Ask your partner on a scale from 0 – 10 (ensuring that you use anchors at either end), how important is it for them to make this change.
(3) Using equipoise explore what makes it the number they give rather than one to two below (E.g. what makes it a 6 rather than a 4 or 5).
(4) Ask them what would need to happen to increase it to the next number e.g. What would need to happen to take it to a 7?
(5) Then move to a confidence scaling and repeat the process as for importance.
(6) Exploring with the patient what will increase their confidence starts them on the journey of independent problem solving.
(5) Give a short summary/reflection of the speaker's motivations for change.
(6) Then ask, "So what do you think you'll do?" and just listen with interest.
(7) How might you go about it, in order to succeed?

These questions again will be available for each student on paper.

3: 10 minutes only

- Debrief the exercise above
- Discuss in some way the material they should have read as homework on the ER Web
- Introduce theory and plan, possibly watch videos - here, just concentrate on the concepts of ambivalence and resistance - emphasise that these signals from the patient are useful rather than to be avoided, that they need to be recognized and used
    - it's about assessing ambivalence
    - talking about the importance of change to pt
    - discovering the patient's confidence of being able to
    - the aim is to motivate people to change, not just tell them to

This will already have been posted on the ER Web for students to read and watch before the session. Assuming they have done this, this element should be brief and a recap of this material. It is more important to get the ethos over rather than the detail and we should make sure not to overload students with theory. This whole component should only last 10 minutes.

We will make available overheads of the overall diagram we are teaching to and some of the slides

Break 15 minutes only to be negotiated with group.
Simulated patient will remain with the group throughout the session and so when you move from first to second role can also be negotiated.

Approx timings
3:00 p.m. - 4:00p.m. - First role
4:15 p.m. - 5:15 p.m. - Second role
5:15p.m. - 5:20p.m. Review learning
5:20p.m. – 5:30p.m. Evaluation and Feedback

Practise health behaviour change interviews with an actor in a motivational style. Both the following interviews relate to chronic diseases which are most suitable for the students to engage with.

In the first session the actors will play the part without much resistance (i.e. high importance scaling) to overcome so that students can practise the use of reflection, summary and importance/confidence scales. We start with concentrating on importance rather than confidence as firstly we should not assume a shared understanding in this regard without checking with the patient and secondly misunderstanding at this point may well lead to poor goal setting and attainment later on. This first run through with the actor is very much to get the structure in students' minds - be overt about this with the students. We can progress this as the afternoon continues in whichever way we wish Because the actor remains with you they can listen to the discussion about where the group wishes to go next and at what level to pitch this. The actors will be able to play the second role similarly to the first or move on into more resistance and defensiveness as you wish.

By the end of the afternoon we need to have covered agenda setting, importance confidence scales plus some elements of exploring ambivalence in a patient whose importance is low. It is more important that the students get the overall message and spirit of this rather than the detail

With Charles/Christine Chilvers
who is a married patient of 61 years, who works as an accountant. You have met him/her several times before about his/her diabetes. S/he has two grown-up sons of 25 and 29, 3 grand-children, is overweight (BMI 27), has high blood pressure and type II diabetes. S/He is on maximal oral hypoglycaemic medication and you have discussed before the next step in medication, to be avoided if possible, would be insulin. With medication, the blood pressure is more or less under control, and the blood sugar levels are variable. Recently has not been a good period and the blood sugar is consistently too high.

Subject of the interview: review of the medication (high blood pressure and diabetes tablets, no insulin at this stage, but it could become necessary). Since arriving the patient has had their urine tested and, blood pressure checked by the nurse (140/80). She has also tested their feet for sensation as she always does and tested his/her eyesight. Blood tests were done a week ago and you have the results and blood samples taken and. Everything Ok except random BS of 10.2 and HbA1c of 8.0. The nurse has popped in before him/her and said that s/he is much the same, sugars are still a little high and do you think you could discuss weight and exercise with Mr/Mrs Chilvers.
You are concerned with the high blood sugar and really would like your patient to discuss increasing exercise or losing weight.

With Gillian/Gordon Freeman

A divorced person of 53 years, who lives alone and who has brought up 3 children (now 15-18-20) who still live at home.
S/he is a heavy smoker (20-30 cigarettes/d) and had heart attack 2 years before. At the hospital, s/he was told that s/he absolutely had to stop smoking and that s/he should keep an eye on her/his cholesterol which was borderline high. S/he stopped smoking for 3 months and stupidly started again when current boy/girlfriend left. S/he hasn't had any more heart problems. However their lifestyle at the moment makes it hard to prioritise giving up smoking.

Subject of the consultation : The patient visits the GP for a six monthly check-up. You look at the results and tell her that her/his cholesterol is fine. S/he mentions that a brother, also a heavy smoker, has just had a heart attack and that the doctors are seriously discussing a heart transplant! You really want to see if the patient is prepared to discuss smoking.

Be motivational: the reasons and solutions are within the patient more than on your side
Use reflections rather than questioning

5:15: Ending

- Brief round of how the students are feeling and what they have learnt
- Facilitator sums up and relates to the literature or to the Calgary-Cambridge guides.

5:20: Evaluation and Feedback

Health Behaviour Change: patient role 1 **Name: Charles Chilvers** **Age: 61**

Setting
You are visiting your GP for **a six monthly check for diabetes** and blood pressure. You are an accountant of many years standing. From your point of view, you are happy enough to come for your regular review and also need a repeat prescription for your medication as you haven't been organised enough to get your monthly prescription (high blood pressure and diabetes tablets – no insulin at this stage, but you know it could become necessary).

Since arriving you have had your blood pressure checked by the nurse **(140/80)** and urine tested; you attended a week ago for blood tests. She has also tested your feet for sensation as she always does and tested your eyesight, all fine. You are now waiting to see the GP you have met before and get on with reasonably well. You suspect the doctor will discuss the results of your blood tests and wish to discuss losing weight and increasing exercise again.

Clinical details
You are overweight (Body Mass Index 27). You were diagnosed as type II diabetes about 10 years ago. Since then your blood sugar levels have been variable (up and down). Lately, your blood sugar levels have been raised (you check them at home – by pricking your finger and using a test strip in a machine – they average about 8).

The diabetic nurse in the practice noted that your blood pressure (BP) was raised when you came for your regular check-up a year ago. Since then you, and your GP, have been striving to get the blood pressure under control. It is more or less under control, with medication.

Recently you have been under a lot of stress: work has been heavy (government red tape!) and your grandchildren come and stay rather a lot…

Past medical history
Any previous illnesses:
cholecystectomy 5 years ago
not a lot else - piles, a bit of eczema, indigestion occasionally

Medication
Any medication taken for this:
Diabetes tablets: gliclazide 80mg one twice a day, and metformin 500mg one three times a day
BP medication: enalapril 20mg one daily

Family history
Any family history of
heart disease: father died aged 63 after heart attack
mental: your brother (55) has schizophrenia and lives in Linton with your parents
Smoking: no
Alcohol: probably drink more than you should

Charles: *You are married to Jane.* Things are a little difficult at the moment as your wife is going through the change and seems intent on spending more time with the grand-children than with you….
Jane: You are married to John. Things are a little difficult at the moment as your husband is going through a mid-life crisis and seems intent on spending more time with his sports car ….
Children: 2 (son aged 25 and daughter aged 29); 3 grandchildren all belonging to daughter
Occupation: Accountant (head up a small firm) in Cambridge
Where do you live: in Abington
Type of housing: large detached *Social class:* upper middle

You go to your parents' house once in a while to give your mother a break. Your elderly mother doesn't like leaving your brother alone, even for a few hours.

Temperament
Well balanced; socially integrated. You are in charge of the local choir which takes up two evenings a week; you enjoy gardening and eating out. You like Southern France and French food. You are quite chatty and engaging.

Patient's framework

- **feelings**

how are you feeling about it all: a little stressed as you know you should take more exercise but how can you when you have so many pressures from work and family

- **effect on life**

what effect is this having on your life: under stress at work because your partner is hardly ever there (spends more time on golf course than in the office)

Behaviour
Psychosocial: You live in your own house (mortgage) with a small garden. Heavy workload at work as colleague spends a lot of time away from office. Worry about staying in job as the company is not doing very well. There is a lot of pressure to please the clients.

Health perspective: You are very conscious of the ins and outs of diabetes. An aunt who took insulin had her foot amputated and later died of a heart attack at the age of 60. You are worried about the recent high blood sugar levels and really wouldn't want to go on insulin. You would like to find a way to loose weight as the blood sugar was a lot better 5 years before when you had to lose weight before a cholecystectomy operation which you did by walking more. You don't really at the moment want to consider diets. You have been to special courses organized for diabetics and you know all the theory. In practice, you often eat out with clients and don't have time (or your wife/husband doesn't have time) to prepare healthy food. You enjoy eating and it helps dealing with the stresses and disappointments during the day. The dietician said it was important to continue enjoying food and diabetics are supposed to eat snacks to keep the blood sugar at a regular level.

Possible change: You don't want to discuss changing diet. You enjoy your food and you have tried so many different diets without success, in fact your weight has increased over the years. ***You are however prepared to discuss being more active physically***.

Pros: you enjoy gardening and your schizophrenic brother likes walking and is enthusiastic about Nordic walking. You could do that with him. You have noticed that exercise has an immediate effect on the blood sugar and you like to see immediate results. You go to work by car and have thought many times that it would be quicker by bicycle (8 miles with only one hill).

Cons: your time is limited and you don't see your wife/husband very much as it is. Your bicycle needs repair and you haven't got a helmet. You are concerned by pollution and the lack of safety on the roads. This isn't Holland (yet). What happens when it rains (even with global warming it still rains a lot!)? Also, what about carrying your laptop to work. Also, what would the clients think if you turned up on a bicycle? (one of your younger colleagues has started to do it, so at least there is a precedent.)

How to work with the students:
Please start without much too much resistance to overcome so that students can practise health behaviour change more easily at first. If the student explores your thoughts about what you want to work on suggest that you don't want to discuss diet, but are keen to increase your exercise. In response to further questions from the students if they ask you about the importance of increasing your exercise say 7. When questioned further about what makes it 7 rather than 5 or 6 state that you'd like to feel fitter, you're worried

about consequences of sugar not being controlled and you've worked hard to get blood pressure under control. If the students then explores with you what would increase the importance e.g. to an 8 you can tell them if you definitely told me that if my sugars weren't controlled I'd have to start insulin. Please don't introduce resistance at this point.

If not asked you will be clearly resistant to diet but agree reluctantly to discuss exercise.

So initially play this so that you already understand and buy into the importance of increasing your exercise so that you can lose weight; the main problem is not having the confidence that you would actually be able to do this. If asked, on a scale of 0 to 10, how confident you are that you would succeed once you decided to change, say '3'. And if asked why 3 and not 1, talk about your success in losing weight before the gallbladder operation − you know you can do it but it is difficult to put good intentions into practice and then talk about what might cause you problems e.g. finding time to bike etc.
For this to work for *you*, the students will need to develop some rapport with you and set an agenda about talking about this issue by asking permission to enter this area. We hope then that they will explore your thoughts on your importance and confidence through the use of open questions, reflection, summary and importance/confidence scales.

If the doctor tries to convince you or decides what is good for you: you say "yes, but…" "that seems like a good idea, but…" then state the reasons why exercise is too difficult to fit into your busy schedule: gradually introduce work, grandchildren, choir-work, schizophrenic brother, tiredness at end of day, lack of safety on roads with a bicycle, as well as risk of having the bicycle stolen, a friend who was knocked over by a rubbish-lorry, difficult to wear a suit/carry the laptop, you get sweaty, takes more time…

However, if the doctor is empathic, reformulates, asks open questions about <u>your</u> feelings, ideas and experience, summarises and affirms your position….then you are open to discuss ways of fitting more exercise into your busy schedule with less resistance.

<u>Ambivalence</u>
If the doctor tries to explore with you the advantages and disadvantages of the status-quo and of change, these are the things you might say:

	Advantages	**Disadvantages**
Status quo	It is easier to continue in routine lifestyle It is legitimate to leave gardening and bicycling to a later period of my life when I have more time! You like your food and it stops you being stressed	Don't feel fit Bad blood sugar control Future consequences of uncontrolled diabetes Overweight Easily out of breath Feel flabby Garden not very interesting; not many vegetables for the family
Change	<u>bicycle</u> -better blood sugar control No need for insulin -feel fit -satisfaction of achieving goal -good example for children -new ideas for activities with children -reduce pollution with bicycle <u>walking with brother</u> -good thing to do with him	<u>bicycle</u> -effort to repair bicycle -effort to buy helmet - worry about rainy days - worry about time-factor - problem about suit at work - problem about arriving on bicycle to clients - fear of accidents <u>walking with brother</u> -don't see him so often so not very regular

	-easy to achieve <u>garden</u> - have own vegetables - relaxing activity - pleasure to watch plants grow - enjoy doing gardening with the grandchildren <u>In general</u> - like the idea of being healthy - hope for better stress control? - better sleep?	<u>garden</u> -time-factor -spend more money on garden

If this was handled really well, what you would agree to would be to start by weeding the garden and walking with your brother and then possibly to repair the bicycle and buy a helmet. Also, to return some time later to discuss how you are getting on. What will help is if the doctor agrees to reasonably small steps at first, rather than wholesale change and if the doctor legitimises your problems or provides information that will help.

Setting
You are visiting your GP for a six-monthly check-up. The doctor will want to see if you are prepared to discuss smoking and maybe alcohol.

Clinical details
You are a heavy smoker (20–30 a day). Two years ago (roughly) you had a heart attack. At the hospital, you were told that you must stop smoking – or else. Also, you should look after your cholesterol level which was high with both drugs and diet. You stopped smoking for 3 months but stupidly started again when your partner at the time left you.

No current partner, although an ex-work colleague rings you up from time to time and you might be interested if….

No more heart problems since. You are conscious that smoking is really bad for you and you feel very annoyed with yourself for starting again.

Past medical history
Any previous illnesses: none

Medication
Any medication taken for this: simvastatin 20mg one daily for cholesterol, aspirin 75mg daily

Family history
Any family history of heart disease: Your brother (aged 58, also a heavy smoker) has just had a heart attack and not doing so well – they called it heart failure!
Smoking: 20−30 cigarettes a day since a teenager (but only 15 on a good day!) Your eldest son, Tom, nags you about your smoking when home from uni.
Alcohol: yes, particularly when feeling low. You have drunk more since losing your job (see below). You meet up with old work colleagues at least once a week and at the pub you lose count of the amount you drink when down the pub. You also drink whilst at home, watching tv. This can amount to half a bottle a night; probably more when out socially.

Social history
You are divorced (husband/wife walked out 10 years ago). Succession of partners since, but they never seem to stay for long!
Children: 3 (Tom 20, Dan 18 and Lucy 15). Basically, you have brought them up single-handedly. Lucy has recently been diagnosed with asthma and deep down you're worried this might be related to you smoking
Occupation: Mother/father
Where do you live: Fulbourn
Type of housing: ex-council house
Social class: You have been on unemployment benefit for a year since your company was bought out by Nestlé of Switzerland, and you were among 15 workers who were told that you weren't needed any more. You are trained in computer programming and were always led to believe that you would never have a problem in finding a job in that field.
Hobbies: gardening and going to the cinema
Constraints: you can't afford to run a car whilst on unemployment benefit. This makes it difficult to get to see your mother (78) who lives about 100 miles away. She is getting forgetful and you are annoyed with your younger brother (51) who lives closer to her. He hardly ever visits and won't go round to take your mother to her GP about a nagging leg pain that she is always going on about.

Temperament

Easy going but still bitter about the way you were treated by your company where you worked for 20 years, with very few days off (despite being a parent and running a family).

Patient's framework

- **ideas and thoughts**

You wonder if you are drinking too much. On the other hand, everyone needs to find a way to relax after a difficult day. Also, alcohol is supposed to be good for the arteries, isn't it?

- **concerns**

what are you concerned about: You are worried about having a heart attack. Your grandfather had a heart problem and died early (50). You have tried on your own to reduce the cigarettes (from 30 to around 20), but invariably, when you get stressed ... you increase the amount.

- **feelings**

how are you feeling about it all: bitter about the way you were treated by your company where you worked for 20 years with very few days off sick. Worried about finding another job quickly, since your financial situation is dire. Your relationship with ex is made difficult by the fact that s/he doesn't pay the money for the children regularly. You have to find a way to pay their university fees.

Possible change: You would like to find an easy way to stop smoking. You would also consider reducing your alcohol intake if the subject was broached sensitively.

SMOKING

Pros for change: this is a good time as you are very concerned about your brother's heart attack; you also spend a lot of precious money on your habit. You never smoke in the house, but your clothes (especially after a long evening sat out on pub patio under the heater) really smell; you would like to set a good example for your children, you know your arteries are in a bad condition, on top of it cholesterol is high which makes matters worse.

Cons: very hard to stop, all your friends smoke, don't want to put on weight, get very irritable when you try to stop, enjoy the first cigarette and cigarettes with beer. Also, you have to die of something − pollution is such a problem anyway. Last time you stopped, you didn't stop coughing and catching colds, you are sure the cigarettes kept the infection away.

How to work with the students: This role can either be played as before with high importance and low confidence so that students can practise health behaviour change more easily at first *or* with low importance so that students can practise exploring ambivalence.

With high importance if the student asks if it would be ok to discuss smoking and asks you about the importance of stopping smoking on a scale of 0-10 say 8. When questioned further about what makes it an 8 rather than 6 or 7 state that you're really worried about your brother and don't want to end up like him. If the students then explores with you what would increase the importance e.g. to a 9 you can tell them if you thought your children were developing asthma because of your smoking. So initially play this so that you already understand and buy into the importance of stopping smoking; the main problem is not having the confidence that you would actually be able to do this. If asked, on a scale of 0 to 10, how confident you are that you would succeed once you decided to change, say '3'. And if asked why 3 and not 1, talk about your success in giving up after your first MI but immediately follow that but I've been well since. If asked what would have to happen to improve your confidence talk about perhaps feeling like I wasn't trying to do it on my own. If handled well, what you would eventually agree to is you will reduce number of cigarettes over the next few days, if medication is given; you give a quit date in about three weeks, after your next job interview which is planned in two weeks' time. If asked about potential obstacles: discuss how to manage to not smoke during sessions with ex-colleagues, weight gain. Look encouraged if the doctor legitimises your problems or provides information that will help you in the change (internet address, leaflets, possibility of phoning the practice nurse about withdrawal, etc.)

Starting with low importance and low confidence.

The role is designed to help the students explore ambivalence. Please start with saying it's only a 3 or 4 because it's just not on my agenda right now. I'm out of work, struggling to b ring up the kids and it's my only pleasure it helps me cope with stress and the loneliness. What makes it a 3 and not a 1 well I am worried about having a heart attack. What would have to happen to increase the importance, if I thought it was affecting other people and if I couldn't afford them? If the student carefully explores the importance and manages your ambivalence then this will become more important to you. If these issues aren't explored sensitively and fully then you will remain with low confidence. If the doctor tries to convince or decide what is good for you: you say "yes, but…" "That seems like a good idea, but…" you have to die of something; you've never felt short of breath and you are never ill (at least while you smoke; when you stop, you get colds).

For this to work for *you*, the students will need to develop some rapport with you and empathise you're your situation. We hope then that they will explore your ambivalence about whether to change through the use of open questions, reflection, summary and importance scales. If you do now feel it's more important you will then move to saying, yes well I've tried loads of times and it just hasn't worked. You will then be expressing low confidence in giving up (confidence would only be discussed when the importance is higher). if the student then begins to explore this further with you is empathic, reformulates, asks open questions about your feelings, solutions, ideas …. Then you are open to discuss ways of trying to stop with smoking aids and agree to go away and think about whether you would like another appointment to discuss practical strategies that might be used to support your attempt to give up.

<u>Ambivalence</u>

If the doctor tries to explore with you the advantages and disadvantages of the status-quo and of change, these are the things you might say:

	Advantages	Disadvantages
Status quo	Pleasure smoking Associated with having a good time Helps keep weight down Something to look forward to when going is hard and feel lonely	Fear of heart attack¨ Worried about high cholesterol as well Expensive Don't like the smell Bad example for children Might make Lucy's asthma worse
Change	Doing good to health Money to spend on weekend outings (Paris, Brussels) You are a good mother/father, concerned with children's welfare Coherent message to the children Avoid the smell of smoke on clothes	Irritability during withdrawal Worry about gaining weight Can't think of what can do to replace the pleasure of smoking

Appendix 2 **Stage two**			Continuous thread
Negotiate plan	Define an objective	Specific Measurable Achievable Relevant Timely	Reacting to resistance **reflection (single or double side**
	Agree on action plan (first step)	Negotiate	
	Anticipate difficulties or rewards		**shifting focus**
Provide support	Affirm (reinforce patient's strengths, successes) Practical information (social resources)	Support self-efficacy	**reframing** **rolling with resistance**
Forward planning	Organise follow-up, evaluation (when and how)		