BEHAVIOR CHANGE COMMUNICATION
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INTERVIEWING TECHNIQUES

Skillful interviewing techniques can increase patient compliance, or acceptance of advice. The interview can be made more effective by the health care professionals’ understanding of what influences a person’s behavior, and by the inclusion of explicit strategies for behavioral intervention. The Health Belief Model (1) and the process of Motivational Interviewing (2) provide the theoretical basis for the health education process.

THE HEALTH BELIEF MODEL

Interviewing methods based on the Health Belief Model aim to promote health-related behavioral changes by understanding the patients’ own beliefs about their health. The Health Belief Model originated as an attempt to understand why individuals do or do not engage in a variety of health-related behaviors. It was argued that behavioral motivation and goal-setting are governed by two main factors.

1. The individual’s perception of the value of the goal
2. The belief that a specific health action will result in the relief or prevention of ill health (i.e. the desired outcome).

These factors are divided into four specific aspects:

Perceived Susceptibility:
Vulnerability to a given condition, and perception of its risks: ‘Is it likely to happen to me?’ Therefore individuals who have a family history of hypertension are more likely to make changes in lifestyle to prevent hypertension than those who have no family history.

Perceived Severity:
Feeling the seriousness of the threat of illness, and the potential risk of not doing something about it. Here the individual evaluates the medical consequences and their social implications: ‘How seriously is it likely to affect me?’ Individuals who understand that hypertension is a major cause of stroke or ‘falij’ are more likely to make changes in lifestyle to prevent/control hypertension.

Perceived Benefits:
This is dependent upon the individual’s estimate of health risk, and his perception of the efficacy of the health advice. ‘How much will my health improve? Will I live longer, be able to do what I want to do, and improve the quality of my life generally?’ In the Islamic context prolonging life is not a great motivator as most Muslims believe that the hour of death is appointed and humans do not have the power to influence that. Therefore the emphasis should be more on improving the quality of life. If you can delay the onset of hypertension by making lifestyle changes you can avoid taking medication. Or if you take your medication regularly and keep your BP under control you can decrease your risk of getting a stroke.
Another benefit may be ‘social approval’, i.e. the ‘person’s beliefs that specific individuals or groups think he should or should not perform the behavior’ If regular exercise is seen by the community as something individuals should do the individual is more likely to comply with the health care professionals’ suggestion to exercise regularly.

**Perceived Barriers:**
This is the cost-benefit analysis in which the individual weighs the balance between the perceived advantages of better health against the disadvantage of personal efforts and inconvenience, etc. ‘If I go through this discomfort of ‘self-denial’ to make change, how much benefit will I reap? Is it worth the price of giving up something I really like doing?’

Can I afford to make the suggested changes in my diet? What would I have to give up in order diverting the money towards fruits and milk? Do I have the time and energy to exercise?

Social disapproval on the other hand can act as a barrier to change. In communities where it is not acceptable for women to be outside their homes the recommendation to go for a walk in the park will get poor compliance. Similarly if the norm in the community is to serve fried snacks and ‘salans’ (curries) that have a layer of oil on top, cooking foods low in oil may meet with social disapproval.

The Health Belief Model states that certain cues act as a trigger for an individual to make a decision to do something positive about his health. This ‘cue to action’, can be internal, for example, concern about own health or a relative’s illness, or external, for example, from outside influences such as the media, family or friends, prevailing social climate, or suggestion from health care providers.

The Health Belief Model only really applies where ‘health’ is a highly valued concern or goal for most people, and where ‘cues to action’ (particularly external, e.g. media, information, or advice, etc.) are widely available and effective. The aim of our health education should therefore be to get the community to value health as an end in its self and to provide the external cues to motivating changes in life style to achieve and maintain health.

**Self-Efficacy**
Individuals may believe that a particular course of action will produce certain outcomes, but if they are doubtful that they can perform the necessary activities the health education will not influence their behavior. This belief in one’s abilities or self-efficacy is influential in determining whether individuals will change their health behavior. An individual’s strength of conviction in their own effectiveness will also affect whether they even attempt to change. Those who believe they do not have the skills to change would have a low sense of self-efficacy and may not even try. For example a person who sees himself as having no will power is not likely to try and give up smoking. Thus, recognizing that outcomes are personally determined does not necessarily make it more likely that change will be attempted. An individual with a high sense of self-efficacy might easily overcome perceived barriers, whereas a person with a weak sense of self-efficacy might be overwhelmed by them.

Successes increase a person’s sense of mastery of a particular behavior which raises their feelings of self-efficacy, and gives confidence to continue. By setting achievable goals for
change and ensuring each is mastered before moving to the next goal, builds the expectation of performance by raising feelings of self-efficacy. Suggesting small changes in graduated steps is more likely to lead to success. For example instead of telling a person who has never exercised regularly to walk for 45 minutes daily may seem unrealistic to him/her. It would be better to suggest that the individual start with walking at least 3 times a week for 10-15 minutes and then building it up gradually to the target duration. This gradual build up strategy may achieve more success. Personal and social change relies extensively on methods of empowerment, by enabling people to alter aspects of their lives over which they have some control with the requisite knowledge, skills and belief in their self-efficacy.

INTERVENTION PROCESS USING THE HEALTH BELIEF MODEL

Health Care Practitioners should:
- ‘Elicit patients’ health beliefs
- Reinforce positive attitudes to health
- Counter myths and negative attitudes
- Inform the patient about the cause and prognosis.

Plan with the individual an appropriate course of action to suit his/her needs and life-style. Essentially this type of structured approach to health education is supportive, and it can be summarized as a flow chart (Figure 1.1). Here the practitioner starts by exploring the individual’s health beliefs and then goes on to provide what would seem to be the most appropriate information and advice. The individual can then make a choice about changing his behavior; if he agrees to change, a plan is made, targets are agreed, and appropriate support is provided.

This may be a stepwise procedure where new targets are agreed as previous ones are achieved. Insufficient change, no change, or a decision not to change takes the practitioner back to exploring health beliefs, and perhaps to looking at the barriers to change in more detail. There is no doubt that this approach is preferable to a punitive or censorious one. However, it does not take into account the patient’s motivational level, his readiness for change (Figure 1.2).

The goal of this type of consultation is to achieve change, and anything less can be construed as failure. In a motivational approach to interviewing, the goal becomes one of motivating the individual to desire change. It provides an essential bridge between eliciting health beliefs and planning action for changes. It also builds on the patient’s self-esteem and by this empowerment strengthens his sense of self-efficacy, which is essential to increasing the likelihood of success.
Figure 1.1 Intervention Process using the Health Belief Model
MOTIVATIONAL INTERVIEWING

Motivational interviewing is an approach to behavioral counseling especially aimed at fostering the individual’s desire to change. It begins with the premise that when people deliberately make changes in their behavior, they go through a natural series of stages of change with each stage having a different frame of mind about the behavior concerned and each prompting a different kind of motivation.

Its principle is to empower individuals to take responsibility for their own decisions and actions by increasing their self-esteem and self-efficacy. The locus of control lies with the individual. The practitioner respects the patient’s views and concerns. Targets are negotiated and jointly agreed.

Figure 1.2 Prochaska and DiClemente’s Stages of Change Model
Most people who make changes in their lives do so by themselves, without professional help. Professionals are more likely to be effective in engendering change by going with the grain of the patient rather than strictly following a professional agenda.

Studies of the processes of change suggest that people go through five natural stages when they consciously make changes to their lives. Each stage has a different frame of mind about the behavior concerned, and a different kind of motivation. Stages of Change Model (Transtheoretical Model) have become one of the most influential models in health psychology (3, 4). The model describes stages of change as:

**Pre-contemplation:**
People in this stage feel little concern about their behavior. This may be because they have no recognition of the need to change, such as people who do not see themselves as overweight, therefore would not be thinking about changing their eating or activity patterns to bring about a decrease in their weight. On the other hand other people may be very concerned but the individuals’ attitude is “What’s the problem? No-one’s perfect.”

**Contemplation:**
In the contemplation stage people experience conflict about the behavior: they are drawn to it but unhappy about it; they are not sure whether they really want to or can change it. I want to but I don’t want to’. It is helpful to see motivation as a pair of scales with reasons for change on one side and reasons for not changing on the other. In contemplation the two are fairly evenly balanced: hence motivation can shift and sway dramatically over a short period of time. Example a person would really like to look better by losing some weight but also feels that making changes in their eating patterns requires too much effort or that they really don’t know how to go about making those changes. At this stage the persons are likely to listen when the health care professionals tells them how to bring about changes.

Motivational interviewing is most appropriate for people at the contemplation stage when they are in conflict with the behavior and weighing the balance of ‘to change or not to change’.

It recognizes that motivation belongs to the individual, but can be influenced by discussion between the health professional and the individual.

It acknowledges that health professionals cannot force or manipulate change, but rather, that they can help their patients in the process of making decisions – decisions that belong to the individual. That helping motivate patients involves supporting their decision making.

It starts with the individual’s concerns – getting him to talk about them and helping him to express them as clearly as he can. The more clearly individual describe in detail all the reasons why they believe they should change, the more weights they are putting on the ‘change’ side of the balance. The aim is to enable them to come to a position where they are persuading you (the professional) that they should change. How far a person can come will depend on where they are
to start with. For some people, your interaction will be a success if they end up considering the possibility of change, for others it may lead to a decision to do something.

The process of motivational interviewing consists of three distinct stages or phases:

**Eliciting phase:**
This is the beginning of the interview. The goal of this phase is to get the individual to state as clearly as possible his concerns about particular area(s) of his life and to lead him to convince you that change is necessary.

In this phase, the practitioner uses open questions, reflections and summarizing / structuring to elicit statements of concern from the individual.

The technique for dealing with statements of non-concern is also employed here using restructuring and devil’s advocate to elicit more positive statements and to move the individual forward in the process of making the desired decision.

**Information phase:**
In this phase, the practitioner and the individual are mutually engaged in an active quest for information. The individual is now actively interested in his health.

Here, the goal is to help the individual to gather and assimilate relevant information and look at its implications for change.

**Negotiating phase:**
The focus of this phase is on what (if anything) the patient wants to change – the goal of change, the means of achieving it, and where to begin.

By the end of the information phase, the individual will have become more aware of what needs changing and what choices are before him. He may have made a decision to change. If this is the case the practitioner will discuss what options are open to him, agree a realistic target and invite him back for follow up and support.

The goal of motivational interviewing is to get the individual to talk as much as possible about why he feels he should change. There are several ways of doing these using existing communication skills. They include:

- **Open questions**
- **Reflection**
- **Summarizing**

**OPEN QUESTIONS:**

Here the practitioner asks question that cannot be answered by one or two words. Open questions can provoke a wide range of answers: How do you feel about your weight? How difficult will it be for your family to give up eating foods cooked in ghee?
**REFLECTION:**

Reflections are statements which play back to the individual what he has just said. It can be a mere literal repetition or a reflection of the individual’s feeling. It is a response to statements of concern by the individual, reinforces his positive contemplation and helps him towards making a decision.

**Community member:** I could switch to using oil for cooking but my family may not like the taste of food cooked in oil.

**CHW:**
You are OK with using oil for cooking but are worried about your family not liking the food.

**SUMMARIZING:**
This brings structure to the information the individual is giving by reorganizing what has been said and repeating it, presenting the facts in a non-moralizing and non-confrontation way. One way of structure is to summarize or give feedback to the individual about what he has said and check that you have understood correctly.

**Family member:** I could switch to using oil for cooking but my family may not like the taste of food cooked in oil. Maybe I should start with using oil for vegetables but continue using ghee for ‘parathas’ and frying e.g. My in-laws have always used ghee for cooking. Isn’t oil more expensive than ghee?

**CHW:** So, even though you are fine with using oil for cooking you are worried about the reaction of your in-laws if you switching to oil, your family do not like the taste of food cooked in oil, also, you are concerned about costs. Is that right?

Another way of structure can be by making a list with the individual based on the information he is giving, like a list of how many times per week desserts are cooked for the family. You should try and summarize what the individual has said every four or five minutes to show that it’s important to you to get things right and to check that you understand what the individual is saying.

**RESTRUCTURING:**
Restructuring is a method of further exploring the individual’s concerns and his feeling about particular areas of his life. Here the practitioner tries to find the most positive interpretation in expressions of one willing to change.

Positive restructuring when carried out skillfully helps to raise the individual’s self-esteem, and enables him to see himself and his ability in a more positive light and instill in him, a fresh feeling of I can do it.

**Individual:**
I have tried to lose weight several times but after a while I just can’t keep up with my diet I like sweets too much.
**Restructuring:**
I can see you really want to lose weight but giving up sweets totally is difficult for you.

**Individual:**
Twice I have given up smoking and have not smoked for months but eventually I start again. It is just too difficult to quit. I don’t know if I will ever be able to do it.

**Restructuring:**
You have really thought about giving up smoking. Recognizing that it is difficult to do so is the first step it takes more courage than to pretend that it would be easy.

**Provoking:** You know that high blood pressure can be harmful to your health but since you feel healthy now why should you give up foods you enjoy? People take risks every day walking on the road is risky but people do it all the time

**Individual:**
Twice I have given up smoking and have not smoked for months but eventually I start again. It is just too difficult to quit. I don’t think I will ever be able to do it.

**Provoking:**
You are right. It is difficult to give up smoking. You will not be able to it because I don’t think you really want to

**ACTION:**
In the action stage people are ready and committed to change their behavior. ‘I’m doing it now.’

**MAINTENANCE:**
Maintaining and consolidating changes is an active process that might need efforts for many months. Change can only be stable after the person has meet old situations associated with the behavior and responded to them in new ways. Example a person who has given up eating calorie rich foods goes to a wedding and avoids eating rich foods. Change can often be challenged by negative moods (anxiety, depression, boredom) and temptation to return to old habits.

**RELAPSE:**
Relapse means going completely back to the old ways, returning to the ways things were before any changes were made.

The stages of change model shows that people are motivated for different things at different stages and cannot be seen as simply motivated or not motivated. It recognizes that at different stages people have different needs and that professionals are more likely to be successful if their help is more closely meeting these needs. Professional help should be directed towards nudging the person along to the next stage, not trying to do too much.

In the course of making change people may go round the circle of change several times, before reaching lasting success. Previous failures may make present success more likely. A temporary success on this attempt may make the person more successful in the future.
The difference between the intervention processes is using the Health Belief Model alone, and that using the Stages of Change model, is that health care professionals establish not only the individual’s health beliefs but also their readiness for change. After determining the stage of change that the individual is at using the appropriate techniques the health care professionals then acts accordingly.

Health care professionals should start with exploring health beliefs and determining the individual’s stage of change. If they are at the pre-contemplation stage health care professionals should use the techniques described under Motivational Interviewing to help the individual, to move to the contemplation phase. In the contemplation phase health care professionals will reflect back the positive statements the individual make to enable the patients to make a decision.
about change. If the individual decides not to change, then the health care professionals can return to start the cycle again when they think is appropriate. If the individual decide to change, then the health care professionals actively support them to plan and sustain the change through the maintenance phase. Individuals who relapse can be invited back and the practitioner will then explore with them their difficulties in maintaining the change. Individual may be at any stage of change when they come for screening. They may be at different stages for different behaviors. They may proceed through some of the motivational stages during the course of the interview or over months during repeat visits. The practitioner’s goal is to move the individual towards a positive decision to change, and then to provide him with the means to make and sustain that change until it is consolidated in his everyday life.

IMPORTANT POINTS FOR HEALTH EDUCATION SESSIONS:

1. Create a warm, comfortable and relaxing atmosphere.
2. Actively listen to the patient.
3. Give clear and concrete feedback to the family about their health behavior.
4. Provide choice alternatives concerning the risk behavior and its related problems.
5. Stay in contact with the patient.

REFERENCES: