Topic: Treatment Adherence and Behaviour Change
Required Reading: Text Chapter 16 (150-154)

- *so far we have been focused on us (as the doctor) figuring out what the patient's problem is; now we are shifting our focus to the treatment of patients – what do you do that gets them well?*
- *treatment adherence refers to when or why the patient does not get better (non-compliance)*

<u>Objective 1:</u> Demonstrate an understanding of how to assess non-compliance in treatment, and know five strategies one can use to improve treatment adherence

- studies of treatment effectiveness routinely show that almost 20% of patients so not come for scheduled appointments, and of those who do, about a third fail to follow their therapists' recommendations
- these phenomena are referred to as patient non-cooperation or non-compliance
- more recently, it has been argued that the term compliance implies a passive role for the patient and often presumes that failure to comply solely the fault of the patient
- in contrast, the term adherence conveys a more active, voluntary and collaborative involvement of the patient in a mutually accepted treatment plan
- whatever terms one uses, this phenomenon is one of the more important factors that the chiropractor must consider, in order to provide their patient with the most effective treatment possible
- *what do you do to find out if you've got a non-compliant patient?*

<u>Question...</u>

- **What characterizes patients who respond best to your treatments?** *(some examples given by the class were: highly motivated patients, patients who are not working while they are ill and therefore need the money for their families, or athletes that want to get back into training)*
- Why should **any** patient listen to you? *(Dr. R asked us if we have ever been to a health care professional and decided not to follow the treatment that they suggested – about half of the people who were in class said that they had – this is just human nature)*
- Do patients usually **assume** that they will get better? Why? *(some patients do assume that they will get better for the wrong reasons – the best motivated aren't always that way; you can't assume that the patient just wants to get better, they struggle with recommendations)*

<u>Quote of the Day...</u>

"Your education has been a failure no matter how much it has done for your mind, if it has failed to open your heart." - J.A. Rosenkranz

- *we must remember that when dealing with patients, if we fail to connect with the patient, all the education we have, will not help us if that connection is not made in the first place*

Responsibility for Adherence is **Shared**

- “Health should be, for the patient and physician alike, one element within the overall goal of attaining a human, free, and dignified manner of life.” - Eraker et al, 1984
- *the idea of shared adherence refers to what you do, and what the patient does*
- *health is not a separate goal; health is one part of an overall picture*

Dr. R's prediction of the most important Adherence Factors:

- there are a number of things that the doctor can do to reduce the impact of factors interfering with treatment
- although the number of factors that studies have shown to be involved in non-adherence are numerous, Turk and Rudy (1991) suggest the principle elements include:
  (a) complexity of the treatment regimen (extent of lifestyle changes required)
  (b) trust in the doctor-patient relationship
  (c) communication of the nature of the condition and the nature of the treatment regimen
  (d) competing environmental demands
  (e) the availability of social supports

How to Assess Adherence?

1. recognize, and accept that the patient is **autonomous** *(the patient makes their own decisions)*
2. the patient will make the personal choices to maximize their quality of life, **as they see it** *(this could involve taking drugs for pain, etc., not everyone's idea of quality of life is the same, and we must respect the decision of the patient even if it goes against our ways of dealing with the situation, or what we think is best for their quality of life)*
3. patients are the **experts** on their own values, preferences and capabilities *(they know themselves a lot better than we do)*

- *do you think a quiet patient who just sits there and nods at your every suggestion, never asks questions, is a good candidate for adherence? - the facts is, they probably aren't because they are not engaged or active about their recovery*
- *the most important thing is to respect the autonomy of the patient*

Factors that Influence Adherence:

1. communication *(this is the key factor – if you communicate well, the patient will disclose more important details about their condition, they will trust you more, and they will be more committed to their treatment)*

2. trust in the doctor-patient relationship
3. patient commitment to treatment
4. doctor's anticipating / overcoming barriers
   - complexity of treatment
   - managing competing demands
   - enlisting available social supports

Communication

- **two essential elements of communication:**
  1. accurate transmittal of information from patient to practitioner and from practitioner to patient, and
  2. emotional support and understanding of the patient as a unique person, and of his or her emotional needs and personal experience in medical care

Communication

- **half of patients leave doctors not knowing what to do, or why. Improve this by:**

1. introduce one treatment element at a time *(don't overwhelm the patient, go one step at a time)*
2. avoid jargon
3. link every element of treatment to outcome *(if the patient has back pain for example, and as a result, they have trouble climbing stairs, you might want to explain to them how each element of the treatment plan will help them to improve and be able to climb stairs again – link the treatment outcomes to some element of functionality)*
4. write down all essential instructions *(write down any complex instructions or technical terms so the patient can understand them)*
5. encourage questions

- strong **COMMUNICATION** skills are probably the most important ingredient in managing non-compliance

Provide a Course of Action *(report of findings)*

1. outline choices clearly
2. discuss disadvantages and adversities prior to undertaking a course of action
3. help the patient understand what they are committing to
4. set realistic goals *(go step by step – you can always change the treatment plan by adding something or taking something away; make sure your treatment plan is reasonable enough to allow for a 90 -100% chance of being successful in the first two weeks – remember, if you can't do your treatment plan easily, chances are, your patient can't either, and won't)*

- *patients do better if you're clear on your course of action*

- **MOTIVATION** of the patient is nurtured by communicating effectively and by making efforts to foster increased self-control

- helping the patient to set realistic goals, to concentrate on pleasant environmental stimuli when doing exercises, and of recognizing and valuing their efforts
- self-efficacy expectation is defined as a personal conviction that one can successfully perform certain required (treatment) behaviours (Turk and Rudy, 1991)

Increasing Patient Motivation

- *motivation is constantly changing*

1. reinforce all efforts the patient reports
2. problem solve with the patient about barriers
3. help the patient identify and acknowledge their positive efforts *(this can go unnoticed to the patient sometimes)*
4. help the patient develop strategies for handling interfering factors

- *remember, how the patient is motivated has a lot to do with how they are working and interacting with you*

Education

"Real education consists of drawing the best out of yourself" - Mahatma Mohandas Ghandi

- **PATIENT EDUCATION** is most effective if it follows certain principles (Jette, 1982):

1. education is individualized
2. takes the person's quality of life goals into account *(you can't just let them know that their muscles will function better after treatment, you have to link this to something tangible to their own goals and needs - for instance, you may tell them that they will be able to pick up their children, or play with them again without pain after treatment)*
3. feedback is immediate
4. expectations are explicit and repeated
5. motivation is increased *(when the patient knows what they are doing and why they are doing it)*
6. the link between what is done **and why** is repeatedly emphasized *(your patient should understand your treatment plan so well, that they can relate it to someone else – so you need to be certain you use language and goals specific to each patient's needs)*

- **SOCIAL SUPPORTS:** an often-overlooked intervention is to fail to involve the patient's family or other supports
- Has the patient discussed their goals with significant others?
- Are there key people who would be very supportive of the efforts of the patient?
- How can you review this issue with the patient?

<u>Social Supports</u>

1. do you know who could help your patient *(there must be someone that they are connected to that can help them – for example, a married person might bring their spouse to the appointment, and you should be able to tell them what they can do to help with the treatment at home)*
2. whenever possible involve the supports
3. encourage the patient to discuss their treatment goals with their supports
4. help the patient understand that their social supports are part of their overall quality of life *(involving the supports will help your patient to make changes that will continue)*

- **PREVENTING RELAPSE** of the patient's condition, after discharge from active treatment is another important aspect of discharge planning
- it is important to understand that how well the patient continues to adhere to his treatment regimen after discharge will depend largely on how well you have involved the patient during the treatment process
- for example, how much attention have you paid?
- Have you discussed with the patient about how to recognize and deal with “back sliding” prior to a full-blown relapse?

<u>Relapse Planning</u>

1. start early *(discuss the possibility that they might not get better right away, and that the process of healing sometimes includes set backs)*
2. set out possible negative outcomes *(tell them what may aggravate their condition so that they don't do it)*
3. discuss how the patient can defect “back sliding” *(start this early)*
4. emphasize early action
5. at termination of active treatment review their understanding of their options *(tell the patient “I am so proud of how well you've done, and the proof is in how well you feel; however, things can happen that can set you back, so what will you do if something like that happens? What are your choices?” Knowing how the patient's thought process works and what they would do in this situation (problem solving) before it happens can enable you to educate the patient on the proper way to go about dealing with a set back)*

<u>Psychology and Adherence</u>

1. psychological factors are especially important in ongoing treatment *(it is important to remember that we are treating a person, not a condition; and people have attitudes, opinions, etc. - everyday we will be dealing with psychology, even as a chiropractor)*
2. they *(psychological factors)* **most often** disrupt the patient's recovery
3. the earlier these factors are addressed, the better the outcome
4. knowledge of **how psychological factors are involved in ALL change** is key *(any change – health related or otherwise)*

<u>Objective 2: Recognize that there are a variety of psychological and behavioural “factors” that can come to interfere with treatment adherence and successful resolution of the physical condition you are treating: DSM-IV recognizes six main problems</u>

Topic: BEHAVIOUR CHANGE
Required Reading: Text Chapter 15 (135-141)

- *Dr. R. referred back to our good old optic lens model to illustrate that how the person sees the world has an impact on the person's illness outcomes*

<u>Diagnostic Criteria – Psych Factors</u>
- (a) a medical / physical condition is present
- (b) psychological factors **adversely affect** the physical condition in one of the following ways:
  - 1. they influence the course of the condition
  - **2. they interfere with its treatment**
  - 3. the factors constitute additional health risk for the person
  - 4. stress-related physiological responses precipitate the medical condition

<u>Five Types of Psychological Factors</u>
1. maladaptive health behaviours affecting...
2. personality traits / coping style affecting...
3. stress-related physiological responses affecting... [SI Syndrome]
4. psychological symptoms affecting [Sciatica]
5. mental disorder affecting [Prostate Disease]
- *numbers 1 and 2 are patterns of behaviour*
- *numbers 3-5 deal with the level of symptoms or distress within the person*

<u>Objective 3: Recognize that any change in Perception and Coping Patterns will create ambivalence that must be understood and considered by the clinician when formulating their treatment plan</u>

- *this refers to changing the way that the person functions*
- the perceptions of the patient are critical to all efforts at creating any meaningful changes in lifestyle, or day to day behavioural patterns
- the doctor should make efforts to evaluate the patient's perception of the seriousness of their problem of change as key elements of working with patients who are ready to undertake such changes in lifestyle
- the clinical information obtained is best understood within the framework of the Stages of Change model of behaviour change

- *remember, as the stress level goes up – coping strategies start to change – firstly the patient will use what they always use and as the stress builds, they*

will use patterns familiar to them until they eventually break down and can't cope anymore – so by learning how our patients deal with stress and what patterns are familiar to them, we can help them cope with the treatment plan

Objective 4: Demonstrate the ability to help patients make successful changes in their health related behaviour, by the clinician's use of strategies from the six stages in the Stages of Change Model

- the six stages involved in creating meaningful behaviour change provide a useful and easy to use approach to assessing and managing the patient's ambivalence about change
- the steps are outlined in Chapter 15, Table 15-2 (p. 140)
- students should familiarize themselves with the key characteristics of each stage as well as how you as a doctor can use this understanding to focus your interventions with your patient

- *each person goes through very specific stages to bring about change and make it a part of their life*

Think of an Example...
- take a moment...think of an example of a behaviour you wanted to change in the past year
- *keep this struggle in mind as we go through the Stages of Change model, to see what stage you're in*

Stages of Change Model
1. precontemplation
2. contemplation
3. preparation / determination
4. action
5. maintenance
6. relapse

- *you must complete one stage before moving on to the next, or you will be stuck in that phase*
- *there is no actual change until stage 4 (action)*

Precontemplation
- *many people are in this stage in health situations*
- **little thought about the problem or its solution** *(e.g., the patient is overweight and has low back pain – you know that the weight is aggravating the low back pain and so you ask them if they think it could be an issue, if this patient was in the precontemplation stage, he would not think the weight was an issue and would dismiss it as unimportant)*
- **patient characteristics:**
  1. denies problem and its importance

2. reluctant to discuss / admit problem
3. shows reluctance when pressured
4. high risk of argument *(these patients are very defensive – they will say something like "I know I'm overweight, but it's fine." - they don't want to talk about it)*

Contemplation

- *patients in this stage realize that there is a problem, and they are starting to think about a solution*
- **the problem and its solution are being considered**
- **patient characteristics:**
  1. shows an openness to talk *(they will ask you questions pertaining to the issue that they want to change – for example, a patient may ask "What is a BMI?"*
  2. weighs the pros and cons *(this might be something like the pros and cons of changing their lifestyle)*
  3. dabbles in action *(they might have already started to do something about it)*
  4. obsessive about the problem *(this is typical – they think about it, but they don't get to the next stage)*

Preparation / Determination

- **focus on specific courses of action and timetables for committing energy to change** *(they are telling you their plans for change)*
- **patient characteristics:**
  1. understands that change is needed *(you don't need to discuss the possibility of change with them, they already know and accept that change is needed)*
  2. can picture overcoming obstacles *(for example, if they plan to join a health club, you might ask them what they might do if they can't afford to join – they will have an answer thought out already)*
  3. may procrastinate about start date *(there is still some ambivalence)*
  4. begins to commit to specific goals, etc. *(they are clearly starting to move forward)*

Action

- **steps are taken on a regular basis to make the change in behaviour** *(it must be on a regular basis – so if they have joined a health club but skipped a few weeks, then went back, this will not do – it has to be consistent)*
- **patient characteristics:**
  1. following a plan of regular activity
  2. can describe the plan in detail *(there is no hesitancy, no vagueness, no generalization)*
  3. shows commitment in facing obstacles *(they understand that part of change is struggling with failure)*

4. still vulnerable to abandoning effort *(due to stress, etc.)*

- *most of our work will be with people who are in one of these 4 stages, but there are still 2 more stages after the action stage*

<u>Maintenance</u>

- **successful changes incorporate new behaviours into "new normal"** *("new normal" refers to setting up a system that takes into account certain needs)*
- **patient characteristics:**
  1. has accomplished tangible results
  2. awareness of importance of vigilance
  3. has experienced set backs
  4. developing lifestyle that precludes relapse *(they are planning time in a way that prevents them from falling back)*
- *an interesting thing Dr. R. brought up was the fact that the mean number of times a person tries to quit smoking is 7 – so every person struggles with set backs and relapses*

<u>Relapse</u>

- **any return to an earlier stage** *(failure is built into the model, it is just part of human nature)*
- **patient characteristics:**
  1. begins as slips that are not resisted
  2. marked by a consistent return to problem behaviours
  3. goal is to decrease the time spent in this stage, and fully integrate long-term change *(this must be done early – this is how change happens)*
- *change is an <u>on-going, never ending process</u>*

<u>Clinical Strategies</u>

- each stage mandates the use of specific clinical interventions
- your goal is to assist the patient in moving on to the next stage
- see text page 140 for a review
- *we must know the stage the patient is at, and for each stage, we must know what to say and to do (pg. 140) to help them move on to the next stage*

<u>...remember?</u>

"Your education has been a failure no matter how much it has done for your mind, if it has failed to open your heart" - J.A. Rosenkranz

- *we must connect with the patient – this is the number one goal!*