



Facilitating behavioural change and treatment adherence: theory and skills to support the success of conservative interventions for incontinence.

W13, 29 August 2011 14:00 - 17:00

| Start | End | Topic | Speakers |
|-------|-------|--|---|
| 14:00 | 14:30 | Theoretical and applied aspects of behavioural therapies | <ul style="list-style-type: none">• Kathy Burgio |
| 14:30 | 15:00 | Illness perceptions: their influence on coping and adherence | <ul style="list-style-type: none">• Jean Hay-Smith |
| 15:00 | 15:30 | The role of patient education in treatment adherence | <ul style="list-style-type: none">• Dianne Alewijnse |
| 15:30 | 16:00 | Break | None |
| 16:00 | 16:45 | Communicating for Change - Interactive Session | <ul style="list-style-type: none">• Pauline Chiarelli |
| 16:45 | 17:00 | Q&A Panel Discussion | All |

Aims of course/workshop

The aim of this workshop is to provide knowledge and skills that will improve the success of, and adherence to, conservative therapies for incontinence and pelvic organ prolapse. Specific objectives are to: briefly describe key health behaviour models with applicability in the rehabilitation setting, discuss the application of these models in clinical practice, give clinical examples of how these theories are applied and the evidence (based on clinical research, with specific reference to urinary incontinence and pelvic organ prolapse) of their effectiveness.

Educational Objectives

The content of this workshop is innovative, multi-disciplinary and interactive, and will examine the behavioural – physical therapies interface. The focus of this workshop is on how health professionals can assist patients to take up and maintain treatments that are known to be effective. Usually workshops concentrate on presenting the evidence of effectiveness of treatments such as pelvic floor muscle training or bladder training, but it is also clear that (a) we do not have good long term data about the effectiveness of these treatments, and (b) the existing data suggest treatment decreases in effectiveness over time and so does treatment adherence. Therefore, developing the skills and knowledge of health professionals in the area of health behaviour and the application of health psychology constructs in practice are a potentially important element of effective practice.

Workshop 13.

Facilitating behavioural change and treatment adherence: theory and skills to support the success of conservative interventions for incontinence.

Part 1. Theoretical and Applied Aspects of Behavioural Therapies

Kathryn L. Burgio, PhD

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Objectives

- Increase awareness of behavioural underpinnings of conservative treatment efficacy
- Describe paradigms of behaviour change in healthcare
- Explain principles of behaviour change
- Describe applied aspects of behavioural interventions to promote behaviour change and adherence

The role of behaviour change in conservative therapies for incontinence

- Conservative therapies involve changing patient behaviour and teaching new skills
- The efficacy of conservative treatments for incontinence and other pelvic floor disorders depends on the active participation of an engaged and motivated patient
- Some patients are self-motivated and adherent
- Most patients require assistance with motivation and adherence from their therapist

The interface of behaviour therapy and physical therapy

- How they differ - how they overlap and complement
- Behavioural strategies in rehabilitation programs
 - For stress incontinence: stress strategies, counterbracing, the Knack
 - For urge incontinence: urge control, urge suppression

Paradigms of behaviour change in healthcare

- Health education (health information)
- Behavioural (antecedent and operant conditioning)
- Social cognitive
 - Self-efficacy
 - Self-regulation
 - Motivational interviewing

Factors involved in promoting behaviour change

- Physical - muscle strength, neurological factors, co-morbidities
- Social - personality style, relationships
- Cognitive - readiness, illness perceptions, confidence to change, intentions
- Emotional - affective states, coping skills
- Environmental - living/working environment, ability to alter environment
- Behavioural - daily activities, habits, health behaviours, adaptive behaviours

Principles of behaviour change

- The therapeutic relationship - the foundation for change
- Tailoring treatment to the patient - everybody is different

- Shaping - getting from point A to point B
- The learning curve - its ups and downs
- Realistic expectations - impact on motivation and inoculating against failure
- Positive reinforcement and feedback - establishing new behaviours
- Integrating behaviour change into daily life - the key to long-term adherence

Applied aspects: behavioural components to promote behaviour change and adherence

- Teaching methods - adult education, learning styles
 - Verbal teaching
 - Pamphlets, written instructions
 - Visual tools
 - Hands-on teaching (performance)
- Ways to monitor progress and provide feedback
 - Patient self-report
 - Bladder diary
 - Pelvic floor muscle assessments
 - Adherence assessments
- Ways to integrate new behaviours into daily life
 - Visual, auditory, and temporal cues
 - Understanding the patient's daily life
 - Selecting specific cues
- Follow-up and the transition to independence
 - Follow-up essential to ensure adherence, identify barriers, problem solve, encourage persistence, and ensure behaviours are integrated into daily life
 - Monitoring and feedback needed to "bridge the gap" until patient experiences natural reinforcement - the results of their efforts

Part 2. Illness perceptions: their influence on coping and adherence.

Jean Hay-Smith PhD
 Physiotherapist. New Zealand . jean.hay-smith@otago.ac.nz

Jean will present Leventhal's Self-Regulation Model (or common sense model) and discuss its application in clinical practice. In particular she will consider the way in which the cognitive and affective meaning women give to their symptoms is likely to influence their choice of coping strategy and their adherence to recommended interventions.

Preliminary findings of some research about illness perceptions in women with incontinence will be presented.

Part 3. The role of patient education in treatment adherence

Dianne Alewijnse, PhD

Past: Maastricht University, Dept of Health Education & Promotion, The Netherlands

Present: Gelre hospitals, Apeldoorn/Zutphen, The Netherlands

Objectives

- Explain the Attitude-Social influence - self-Efficacy model (ASE) and the hypothesis that an individual's intentions are the best predictor of behavioural change.
- Describe the development of a theory driven patient education programme to enhance long term adherence to pelvic floor muscle training (PFMT).
- Provide evidence for the effectiveness of a patient education programme to promote long-term adherence to and outcome of PFMT among women with urinary incontinence.
- Provide recommendations for practice.

The study of behavioural determinants of adherence

- Needs assessment based on empirical and theoretical data
- Explaining behaviour with the ASE-model
- The role of intention in relation to other behavioural determinants
- The role of sex specific aspects on behaviour(al change)

Development of a health education programme

- The use of behavioural change theories in health education materials
- The use of intervention mapping to combine determinants with goals and strategies
- The design of a 3-component health education programme promoting adherence

Design of a longitudinal randomised controlled trial (RCT)

- Development of a protocol checklist for PFMT aspects ('practice guideline')
- Integrating health education (materials) in the physiotherapeutical treatment plan
- How to operationalise adherence behaviour for an RCT?
- How to assess important outcome measures?
- How to involve and randomise patients, general practitioners and physical therapists?
- Content of 1 control & 3 intervention conditions for the evaluation study

Effect evaluation of RCT

- What are predictors of long-term adherence to PFMT?
- How effective is PFMT with and without adherence promoting health education?

Process evaluation of RCT & recommendations for practice

- What is the role of the physical therapist on behavioural change?
- Explaining patient's behaviour in terms of motivational stages of change & self-efficacy
- The role of feedback during PFMT
- What are the most important elements of the physiotherapeutical treatment plan for PFMT influencing adherence behaviour

Part 4: Communicating for change

Pauline Chiarelli PhD. FACP

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Individuals are bombarded with enormous amounts of information that is interpreted through the filters of their past experiences, backgrounds, beliefs, values and attitudes. Human behaviour is complex, and understanding how to encourage behaviour change is even more complex. Many theories have been devised in an attempt to understand and promote changes in health behaviour. All such theories are based on the fact that health is mediated by some behaviour and that health behaviours have the potential to change. Behaviour is motivated by a hierarchy of needs and this helps to explain why not everyone responds to what might be seen as responsible behaviour change.

While advocating health education, all theories related to health promotion emphasise the role of individualisation – personalising the information so that it is seen by individuals as relevant and pertinent.

An excellent technique for negotiating behaviour change in a clinical setting, motivational interviewing (MI) was originally developed to enhance behaviour change related to substance abuse. However the strategy is easily adaptable to suit any behavioural intervention related to lifestyle changes and primary care clinicians have reported the method to be acceptable and effective in many clinical settings.

Motivational interviewing is a client-centred yet directive method for enhancing the patient's patients' intrinsic readiness to change, their feelings of self efficacy. The interviewing technique motivates behaviour change by exploring the patient's feelings of competency in relation to the proposed health behaviour and encouraging repeated, well supervised practice to improve self efficacy and self-esteem. In essence, the patient's talk themselves into change. Motivational interviewing is especially useful for engaging and retaining people in many different forms of treatment, and is well developed and researched.

The technique calls on healthcare professionals use their well honed communication skills such as: open questioning, summarizing, reflective listening skills and empathizing. The patient is encouraged to discuss both the relevant behaviour and its related health outcome in their own terms.

The patient is then encouraged to explore how important **they** assess **their** health behaviour to be – again **on their terms**.

Finally, the patients is asked how confident they feel in their **own abilities** to change. Throughout the interchange, relevant health information is offered by the healthcare professional – information is exchanged. In essence, the aim is to make the patient argue the reasons for change.

Motivational interviewing has been used successfully by various professions to help people work through their ambivalence to change related to such health behaviours as alcohol abuse, diabetes, smoking physical activity. Systematic review shows it to be superior to other interviewing.

The most difficult task is for healthcare professionals to learn to roll with resistance NOT try to change patients mind – patients must change their OWN minds and this is the crux of motivational interviewing. The technique offers a quick method of improving the likelihood that clients will adopt the required behaviours that are part of conservative management strategies. The principles of motivational interviewing are **READS**:

- **R**oll with resistance
- **E**xpress empathy
- **A**void arguing
- **D**evelop discrepancy

- Support Self efficacy

Key tools underpinning motivational interview include:

1. Identifying the required health behaviour and setting the agenda
2. Assessing the client's motivation for change in terms of their perceived:
 - Readiness for
 - Importance of
 - Confidence in their ability to
3. Pros and cons of adopting the health behaviour to act on client's decision balance.

The foundation of the MI technique is based upon pneumatic OARS

These skills develop rapport and provide healthcare professional with important background information.

- O** – open ended questioning: “give me a picture of how your "bladder problem" Interferes with you day to day activities ”
- A** - Affirmations - are positive r reinforcements in relation to patient behaviour that deserves. For example the patient tells you about innovative practices they use to cope with the problem, you might say something like:”that's really clever idea you've come up with” or "sounds like you go to a lot of trouble but you manage well to cope with “xx”.
- R**- Reflective listening involves rephrasing paraphrasing statements, reflecting on statements patients have made. It is a skill that seems simple but in fact requires a lot of practice to sound genuine. Some standard phrases used to demonstrate reflective listening include:
 - "So you feel....."
 - "Sounds like you..."
 - "What I hear you saying is..."
 - "This is what I'm hearing; correct me if I am wrong..."
- S**- Summarising can be helpful at transition points in a conversation or to actually end the conversation as well. Some examples are: "Let me see if I have the got this right..."
 - "Here is what I've heard so far, tell me if I have missed anything"
 - "We've covered X and Y, now let's talk about..."

Giving advice related to behaviour change

To offer advice related to the a specific health behaviour it is important to begin by finding out what the client already knows. This can be facilitated using the pneumatic PAPA :

- **P** -permission to share relevant information about..... is sought. **But then**
- **A**- Ask the client to tell you what they already know about....
- **P** -Provide relevant information tailored to what client already knows
- **A** - Ask client if the information you give is relevant. “How do you think you might use this information about.....?”

This saves you time and allows you to tailor the info you give to what the client needs. It allows you to give CORRECT information but ALWAYS in a non- judgemental way

Talking Tools used to encourage adoption of health behaviour include the five R's:

Risk, Relevance/ (Rewards), Readiness, Roadblocks, Repetition

Recommended reading /viewing

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people for change. New York: Guilford Press. www.motivationalinterview.org