3-MINUTE EMPOWERMENT

The power of words:
the art of communication may change patient outcome

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3-MINUTE EMPOWERMENT

Lifestyle changes are the cornerstone of prevention and comprehensive chronic disease management. Healthcare professionals usually use a professional-centered approach, which is more or less confrontational, to inform, convince, and prescribe actions leading to change.

This document provides professionals with a UNIVERSAL intervention tool (a single technique that applies to all behaviours, all professionals, and touches upon all CanMEDs competencies). The intervention must be brief (3 minutes) and must have the objective of accelerating and reinforcing the natural process involved in the stages of behaviour change.

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THIS IS A TWO-STEP TOOL:

1) EVALUATION:

A) Stages of change (Prochaska)

B) Intervention target: Conviction and Confidence (Miller and Rollnick)

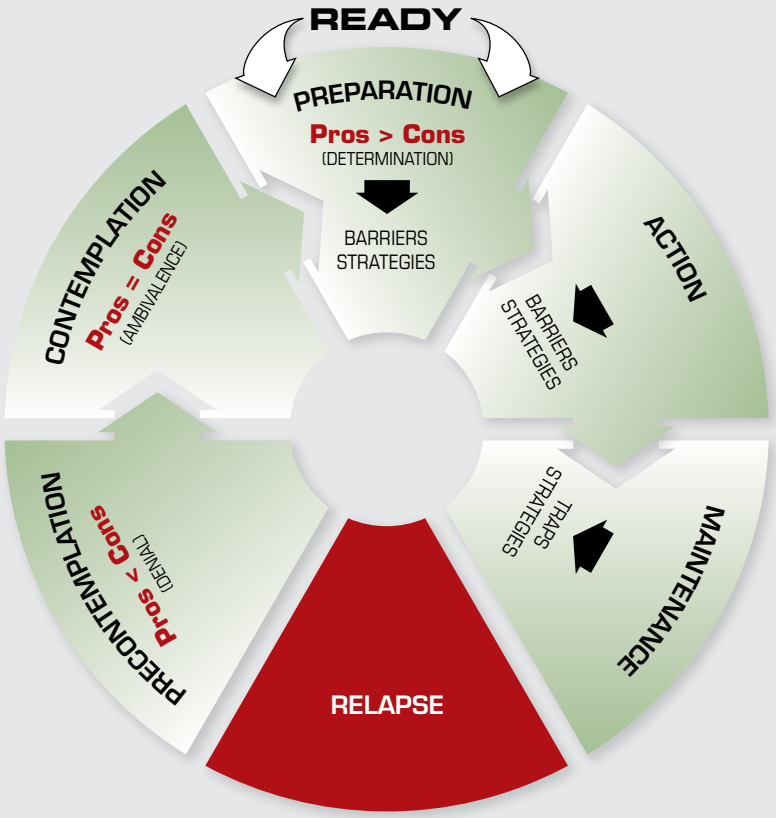
2) INTERVENTION:

Motivational interviewing

1A) EVALUATION – STAGES OF CHANGE

The decision to make a lifestyle change is the result of a NATURAL process (identical for all behaviours) which occurs in STAGES over a certain period of time. Each stage serves as the foundation for the next stage. The role of the healthcare professional, alone or as part of a team, consists essentially of recognizing, reinforcing and accelerating the natural process throughout these stages.

The following chart illustrates the stages (Prochaska's transtheoretical model), moving clockwise from the Precontemplation stage (bottom left).



PROCHASKA'S STAGES

According to Prochaska, change occurs in six stages:

1) PRECONTEMPLATION
Denial of the problem behaviour. The individual does not see the benefits of changing the behaviour (pros < cons) (50% of patients).

2) CONTEMPLATION
Ambivalence based on the perception that the behaviour change presents as many advantages as disadvantages (pros = cons) (20–30% of patients).

3) PREPARATION
Conviction that the advantages related to the change outweigh the drawbacks (pros < cons). The individual tries to define the obstacles and devise strategies that will help them take action (10–20 % of patients).

4) ACTION
Behaviour change (5–10% of patients).

5) MAINTENANCE
Behaviour change sustained for six months following action.

6) RELAPSE
This is not a failure, but rather an integral part of the process. The healthcare professional should use the replase as a learning opportunity to implement protective measures (anticipation of obstacles) to increase the probability that the next passage to the Action stage will be final.

Stages are evaluated by asking open-ended questions:

"What do you think about…quitting smoking? Getting more exercise? Changing your diet? Changing the way you take your medication?"

The answers to these questions may APPEAR to resemble a particular stage. However, they may not reflect the REAL stage, as the patient may claim that they intend to change only to please or out of fear of confrontation. In the past, certain patients may have been given ultimatums which negatively affected them ("Come back to see me only once you've quit smoking.") It is incumbent upon the healthcare professional to determine the REAL stage by a match with the conviction level (refer to section: "Determination of the real stage: Merging the two concepts").

Before any intervention, systematically determining the REAL stage with confirmation of Conviction level is essential in order to:

1) Ensure a patient-centered approach by choosing an intervention scenario specific to the patient's stage.
2) Fix a realistic goal for each intervention (one intervention = one stage).
3) Evaluate the success or failure of the intervention by measuring stage progression at each appointment. If there has been no change, a different strategy may be required.
4) Determine the optimal moment for utilization of pharmacological resources (e.g., nicotine patches for smokers) or to enlist the help of other professionals in the team (doctors, pharmacists, nurses, nutritionists, kinesiologists) by first bringing the patient to the Preparation stage (motivated to change).

If the patient is at the Precontemplation or Contemplation stage, it is completely futile to prescribe nicotine patches to a smoker or to refer a patient for consultation with a nutritionist for a diet or a kinesiologist for coaching physical activity.

1B) EVALUATION – INTERVENTION TARGET

Conviction or Confidence

CONVICTION: PERCEIVING the benefits of a behaviour change.

CONFIDENCE: FEELING capable of changing a behaviour.

As with the Prochaska model, open-ended questions should be asked to evaluate Conviction and Confidence:

CONVICTION: "If you decided to…how would that benefit you?"

CONFIDENCE: "If you decided to…do you think you could do it?"

Conviction can be…

1) LOW (0 to 3/10): Patient perceives no advantages or abstract advantages; use of doubt-expressing words such as "maybe" or "possibly" indicate that little importance is attributed to the perceived advantages. When the patient uses such words, the healthcare professional must divide the level of Conviction by 2 (e.g. "If I ate better, maybe I could lower my blood glucose level." "Blood glucose level" (abstract advantage) = moderate Conviction of 4/10, but addition of the word "maybe" requires that we divide by 2, which equals 2/10. Consequently, Conviction is LOW.

2) MODERATE (4 to 6/10): Patient is aware of the abstract or theoretical advantages. In practice, MODERATE Conviction is defined as the unequivocal awareness of the abstract advantages of a behaviour change. The patient might say, "If I quit smoking, I would be in better health; if I took my medication, I would have lower cholesterol; if I quit drinking, I would have lower blood pressure; if I ate healthier, I could better control my blood glucose," etc.

Knowledge of the advantages of these changes is derived from reading, browsing the Internet, conversations with healthcare professionals, etc., and corresponds with what we will call COGNITIVE CONVICTION.

Therefore, MODERATE CONVICTION (4 to 6/10) = COGNITIVE CONVICTION.

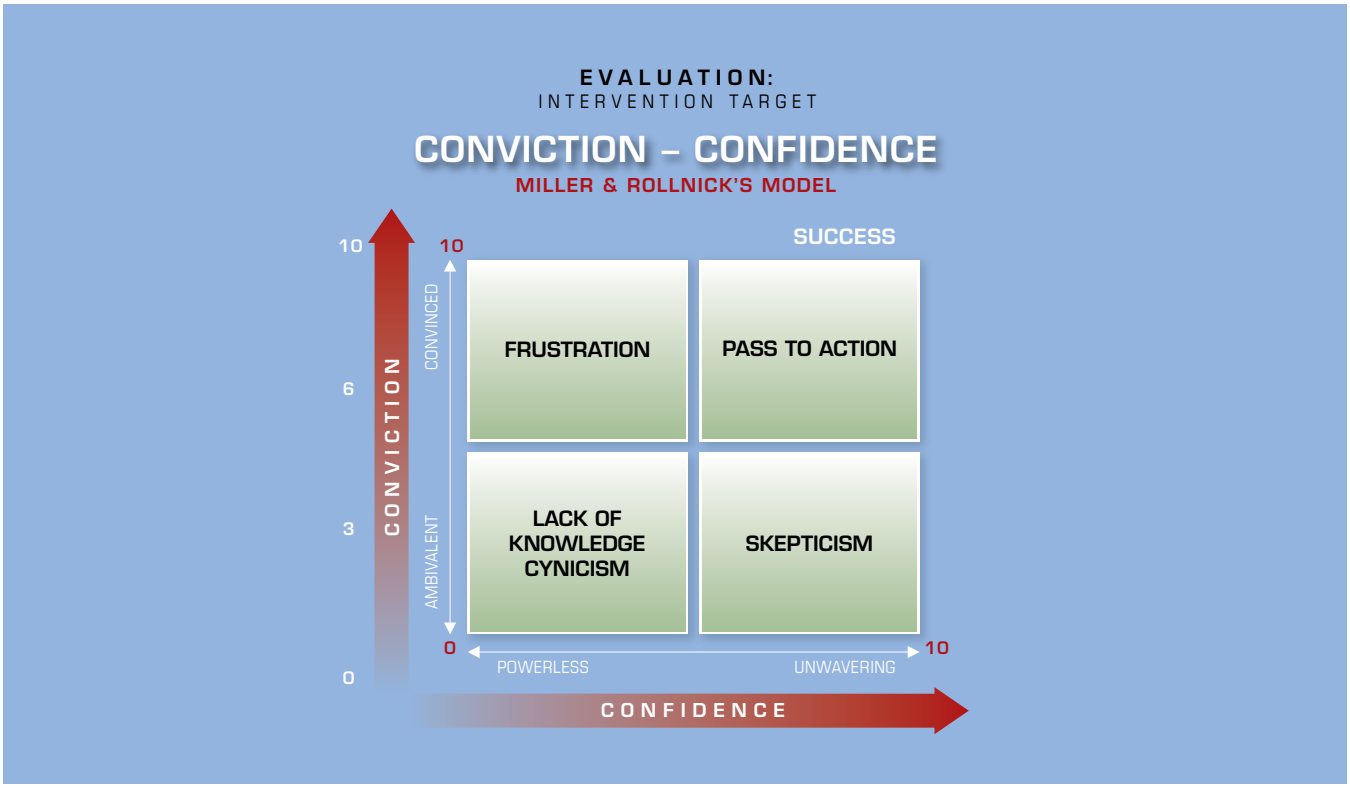
3) HIGH (7 to 10/10): Patient perceives advantages not only on a cognitive level (abstract advantages), but also (IN ADDITION) on a personal, highly emotional level (e.g. "If I quit smoking, I will be less short of breath. I will enjoy life and, most importantly, I will be able to play with my grandchildren. My life will be wonderful!"). We call this Conviction AFFECTIVE CONVICTION.

Therefore, HIGH CONVICTION = AFFECTIVE CONVICTION.

Similarly, Confidence can be low (feeling powerless) or high (unshakeable Confidence).

The evaluation process that leads to a targeted intervention strategy must always start with open-ended questions, asked in sequence, in order to determine the following points: Stage – Conviction – Confidence (which will take approx. 30 seconds). It is impossible to perform a patient-centered intervention without these three elements. Without them, the healthcare professional resorts to the inefficient directive approach (the same for all) in which we only provide information and instructions (healthcare professional-centered intervention).

Conviction and Confidence can be measured on a scale of 1 to 10 and can be illustrated as follows:



A patient will always correspond to one of the four boxes above:

> **skeptical** (low Conviction – high Confidence)
> **frustrated** (high Conviction – low Confidence)
> **cynical** or **ignorant** (low Conviction – low Confidence)
> **pass to action** (high Conviction – high Confidence)

The purpose of a targeted intervention is to first increase Conviction and then boost Confidence in order to get the patient to take ACTION when BOTH (Conviction and Confidence) are high.

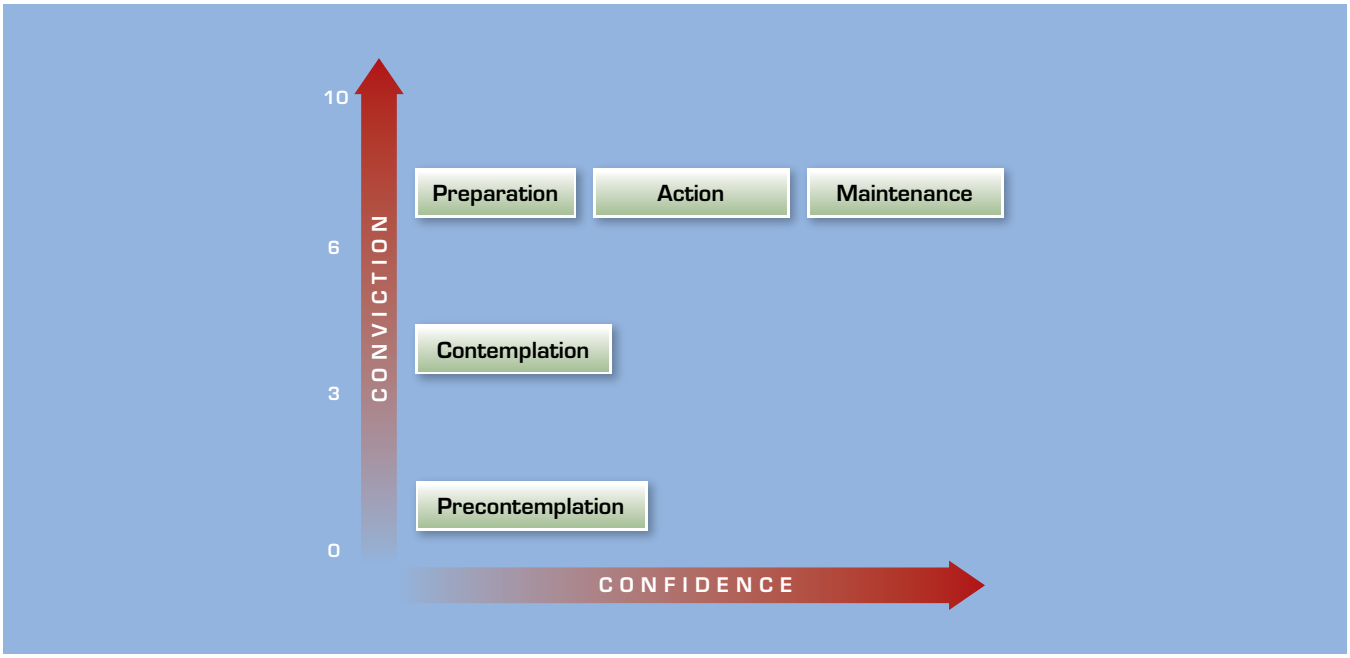
In a skeptical patient (low Conviction – high Confidence), the intervention first aims to increase Conviction to a moderate level (4 to 6/10) first, essentially by improving the patient's perception of the cognitive ADVANTAGES, and then improving their perception of personal, positive and emotional affective ADVANTAGES, leading to high Conviction (7 to 10/10).

In a frustrated patient (high Conviction – low Confidence), the intervention aims to increase Confidence by getting the patient to detect obstacles and solutions (strategies) leading to Action.

In a cynical or ignorant patient (low Conviction – low Confidence), the intervention prioritizes an increase in Conviction so that the patient is motivated and prepared for change. Only at this point do you tackle Confidence (barriers and strategies).

DETERMINATION OF THE REAL STAGE: MERGING THE TWO CONCEPTS

The first three stages of behaviour change according to the Prochaska model (Precontemplation, Contemplation and Preparation) are essentially identical to the three levels of Conviction according to the Miller and Rollnick model (Low 0–3/10 – Moderate 4–6/10 – High 7–10/10).

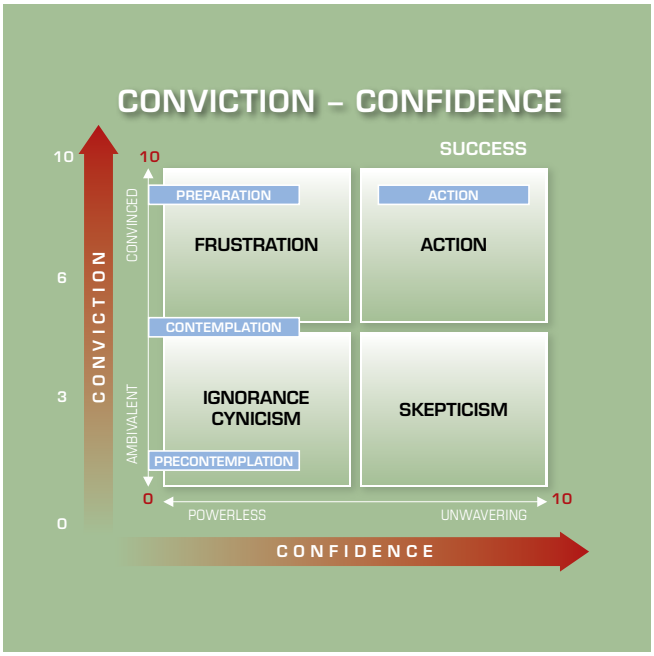


Low Conviction (1 to 3/10) = Precontemplation
Patient perceives no advantages or abstract advantages (use of the word "maybe").

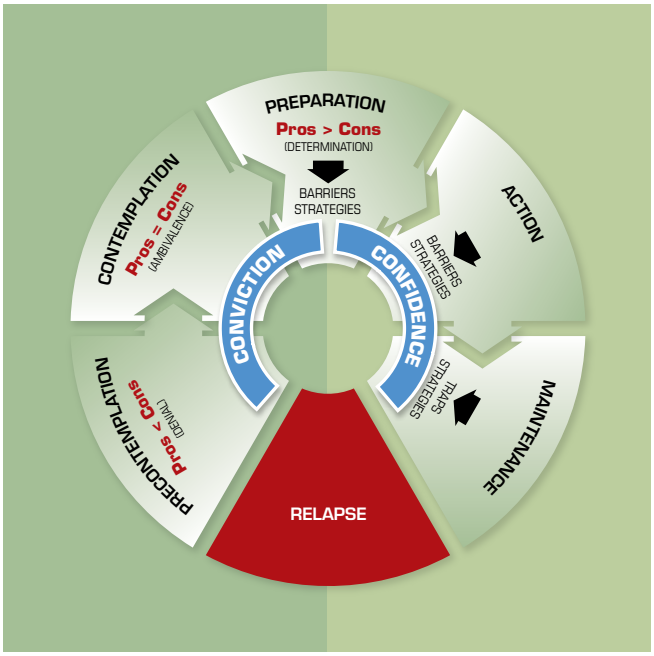
Moderate Conviction (4 to 6/10) = Contemplation
Patient perceives abstract advantages or theoretical knowledge: **cognitive Conviction**.

High Conviction (7 to 10/10) = Preparation
Patient perceives abstract advantages **+** personal, positive, emotional advantages: **affective Conviction**.

The following illustration integrates the Prochaska model into the Miller and Rollnick model, in relation to the Conviction scale.



The following illustration integrates the Miller and Rollnick model into the Prochaska model.



This finding (merging the two concepts) provides us with a formidable new tool to ensure that we always identify the patient's REAL stage, which permits us to appropriately intervene according to the stage, even if the patient attempts to conceal it.

If there is discordance between the APPARENT stage determined by the first question, "What do you think about the idea of quitting smoking?…of exercising?, etc." and the Conviction level determined by the second question, "What would the advantages be for you if you quit smoking?…if you exercised?", the REAL stage is always determined by the level of Conviction (e.g. low Conviction (1 to 3/10) corresponds to the Precontemplation REAL stage, moderate Conviction (4 to 6/10) corresponds to the Contemplation REAL stage, high Conviction (7 to 10/10) corresponds to the Preparation REAL stage).

The target intervention should always be individualized and modulated according to the REAL stage.

2) INTERVENTION:

Motivational interviewing

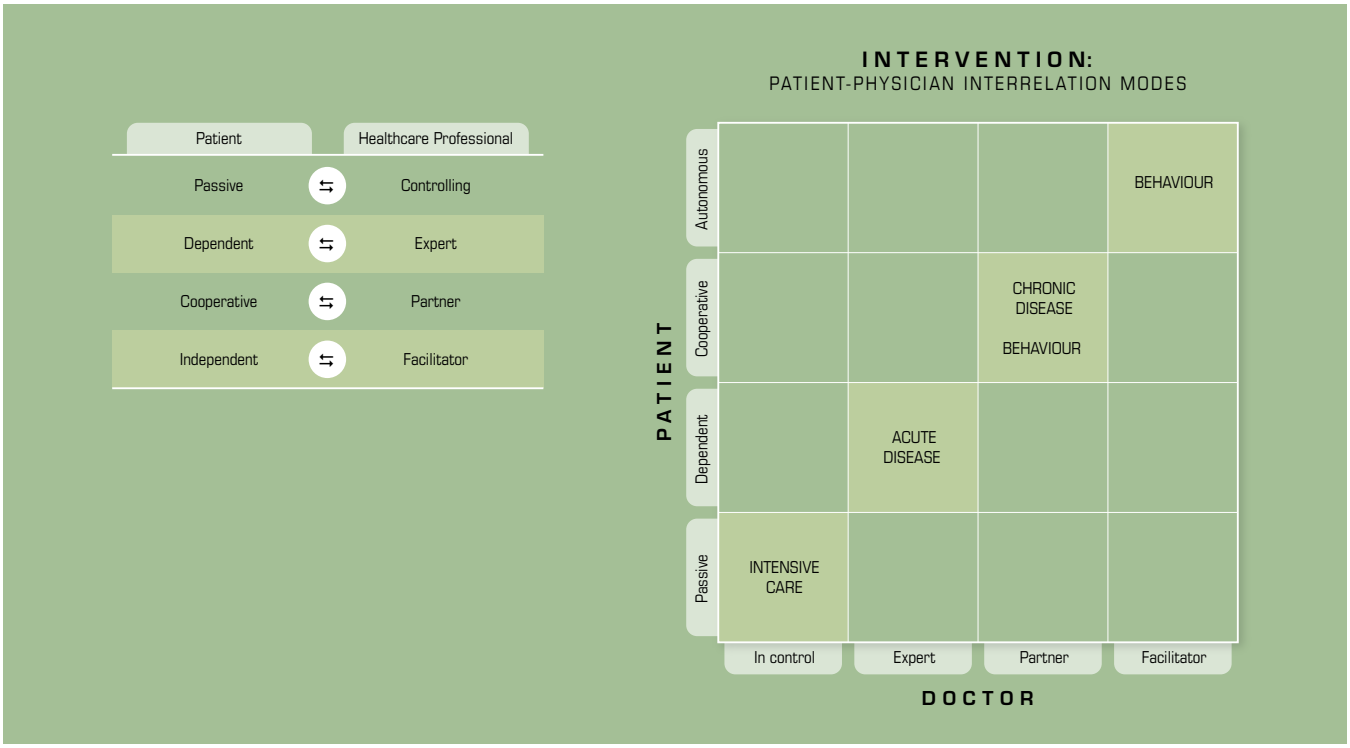
The traditional (health professional-centered) approach is directive, often confrontational, and unfortunately, ineffective. It often results in the patient responding, "Yes, but…", which leads us to recognize that our intervention is directive and will probably not yield the desired effect. In fact, when patients express arguments to justify their objections, they convince themselves that the desired goal is unattainable (since we feel only what we express).

It is not surprising that the majority of healthcare professionals have the impression that, despite their interventions, their patients fail to modify their problem behaviour. Indeed, the traditional directive approach often has the contrary effect: regression instead of progression.

On the other hand, the patient-centered, negotiated approach characteristic of the motivational interview leverages the power of OPEN-ENDED QUESTIONS to first raise awareness of the benefits (increased Conviction; firstly cognitive, secondly emotional) in the early stages (Precontemplation, Contemplation, Preparation), followed by an evaluation of the obstacles and solutions (increased Confidence) in the advanced stages (Action, Maintenance).

The effectiveness of this intervention is based on the fact that it reinforces INTRINSIC MOTIVATION so that the patient wills and implements the change (it is not imposed externally).

Let's see where this type of intervention is situated in the general context of communication profiles between healthcare professionals and patients.



Each communication profile corresponds to a specific clinical situation and must be used under the right circumstances.

The passive patient – controlling healthcare professional mode (healthcare professional-centered) would be appropriate with a patient in intensive care who is unconscious or uncommunicative. Decisions are thus unilaterally taken by the healthcare professional.

In the dependent patient – expert healthcare professional mode (disease-centered), the patient temporarily renounces some of their autonomy and accepts the professional's expertise in treating an acute disease. For a physician, the characteristic intervention is prescription.

In the cooperative patient – partner healthcare professional mode (patient-centered), the patient retains their autonomy and plays a predominant and active role in the decision to initiate or pursue treatment. This mode of communication should be used in the treatment of chronic diseases and in interventions targeting behaviour change. The characteristic intervention is negotiation, not prescription.

Ultimately, the independent patient – facilitator professional mode should be used to reinforce patients who have reached the Action and Maintenance stages after a behaviour change.

Knowing how to shift from one means of communication to another, according to the clinical situation, is characteristic of a clinician who is an expert in four of the six overlapping roles of the CanMEDs program (professional, communicator, collaborator, health advocate).

There are three intervention scenarios possible to change a behaviour:

Scenario 1: Increase cognitive Conviction to move patient from Precontemplation to Contemplation

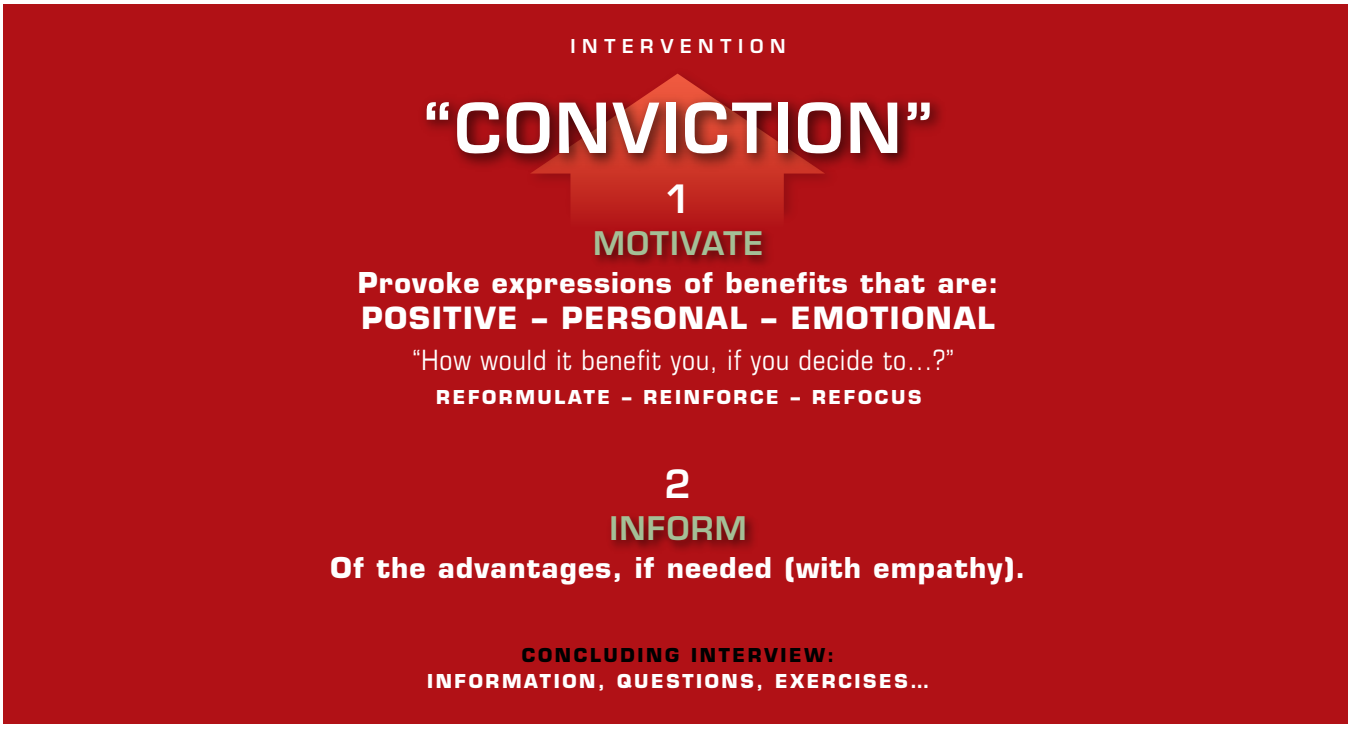
Scenario 2: Increase affective Conviction in order to motivate the patient and move from Contemplation to Preparation

Scenario 3: Increase Confidence, addressing barriers and strategies once the patient is motivated, in order to move from Preparation stage to ACTION.

Increasing Conviction

An intervention intended to increase Conviction is the most common (regardless of the targeted behaviour), as 50% of patients are in Precontemplation, 20 to 30% are in Contemplation, and 10 to 20% are in Preparation.

The folllowing graphic illustrates the GENERAL principles of this intervention:



The CONTENT of an intervention is centered on motivation and, as needed, on information.

The OBJECTIVE of each intervention is movement from one stage to the next.

The BENCHMARK to measure whether an intervention has been successful or has failed is one stage of progress per intervention (100% success).

The TOOL used is OPEN QUESTIONS which encourage rather than impose progress.
The intervention technique used to increase Conviction includes scenario 1 (cognitive Conviction, from Precontemplation to Contemplation) and scenario 2 (affective Conviction, from Contemplation to Preparation).

Each of these scenarios include a specific interview closing technique (CLOSING) which consolidates the new stage for the patient and initiates progression towards the next stage (scenario 1 = questions and information, scenario 2 = questions or progression towards scenario 3).

INTERVENTION INTENDED TO PROVOKE PROGRESS FROM PRECONTEMPLATION TO CONTEMPLATION (50% of cases) Scenario 1: Cognitive Conviction or perception of abstract advantages (my health will improve…my diabetes will be better controlled…I'll have lower blood pressure…etc.).

The objective is to move from weak Conviction (0–3/10: corresponds to Precontemplation) to moderate Conviction (4–6/10 "abstract advantages:" corresponds to Contemplation stage).

The intervention technique (motivational interview) consists of re-framing and rephrasing the open-ended questions by always linking to the advantages of the desired behaviour. By doing so, the healthcare professional encourages the patient to gradually express the advantages on their own to the point that they are convinced of the advantages of behaviour change.

In the rare case that a patient isn't aware of any advantages, the professional can return to the traditional intervention method and provide information (with empathy) that will help lead the patient to the Contemplation stage with some knowledge of abstract advantages.

How can a patient in Precontemplation who has established inflexible barriers and refuses to express any sense of advantages be reoriented? This situation may arise in patients in the Precontemplation stage who were traumatized by an earlier directive intervention they perceived as aggressive.

If the response to the first question in an intervention is negative, with complete non-verbal shutdown, the technique consists of rephrasing the question in the conditional form. That is to say, asking "What could the advantages be…?" instead of "What are the advantages of…?". The conditional form offers far less threatening phrasing when the patient dreads confrontation.

In the hypothetical case of total inflexbility, a "BYPASS" is necessary – something that depersonalizes the question: "I understand that you see no advantages, but theoretically, what might the advantages be for SOMEBODY ELSE if…?". When the patient starts to propose advantages, we continue asking questions about these advantages but rephrase by omitting the "somebody else" from the sentence. This way, we return to naming advantages for the patient. In practice, the majority of patients have the capacity to start from the Precontemplation stage and move to Contemplation.

INTERVIEW CLOSING (once Contemplation is reached) (Scenario 1):

Questions and/or information:

To consolidate this new stage, information can be provided (reading material, Internet links, brochures, etc.) for later consultation, if needed. A patient action must also be negotiated so that they will continue to ask themselves questions until the next session ("How will better health, obtained by…, help my life become more enjoyable?"). By bringing in the emotional aspect, the patient establishes links between the desired behaviour and better quality of life. This process, which extends far beyond the short interview, results in patients continuing to increasingly convince themselves of the benefits of change, thereby consolidating the Contemplation stage and moving towards the next stage – Preparation.

INTERVENTION INTENDED TO PROVOKE PROGRESS FROM CONTEMPLATION to PREPARATION (20–30% of cases) Scenario 2: affective Conviction or perception of personal, positive advantages (carrot, not the stick) with high emotional content.

The objective is to move from cognitive moderate Conviction (4–6/10: corresponding to Contemplation stage) to high affective Conviction (7–10/10: corresponding to the Preparation stage).

Even if the patient is aware of a number of abstract advantages (e.g. "My cholesterol would be lower," "My health would be better," etc.) (cognitive Conviction = Contemplation stage), the Conviction level will never exceed the moderate level (6/10). We can continue to provide information until the patient becomes an EXPERT on the advantages, which still may not motivate a change. To be motivated, there has to be MORE than only abstract advantages – there must be personal, positive benefits with very high emotional content.

At the start of the intervention, in response to the first question, the patient expresses one or more advantages (e.g. "What do you think about the idea of quitting smoking?" Response: "My health would improve and I would save money!"). The healthcare professional then chooses certain benefits that seem to have potential to lead the patient to express positive, emotional and personal advantages, then REPHRASES the question specifically to express these advantages, always repeating the link to the behaviour to change to create an automatic neuro-association (e.g. "You say your health would improve if you quit smoking, but what does better health represent for you? [bring up personal advantages]" Response: "If I quit smoking, I'll be less out of breath and will cough less.") A first stage has been broached: the patient now expresses personal advantages (coughing, shortness of breath), but they are negative (pain related to the cough and shortness of breath) and devoid of any emotional charge.

The healthcare professional then chooses an expressed advantage and rephrases the question, associating the advantage with the behaviour change, to encourage the expression of positive advantages with a high emotional charge, e.g. "You tell me that by quitting smoking, you would be less short of breath. How would this improve your quality of life? What are the good things in life that you will be able to continue enjoying if you remain in better health by quitting smoking?" Response: "The other day, for example, I tried to play with my grandchildren and I had to stop after two minutes because I was short of breath. If I was less short of breath, I'd be able to better enjoy their company…play with them…take them to the park…They would also be very happy because they love their grandfather."). The crucial step has been taken: the patient has expressed very positive benefits that are extremely emotional.

At this moment, the clinician has associated "quitting smoking – grandchildren" and asks a question so that the patient will continue to convince and motivate themselves to change (e.g. "You tell me that quitting smoking would help you become closer to your grandchildren – what else do you enjoy doing with them?"…). The more the patient describes activities they would like to do with their grandchildren, the more they'll be motivated to modify their deleterious behaviour. The more the patient talks, the more convinced they'll become, moving on to the Preparation stage (high affective Conviction, 10/10).

See Appendix 1 (Mr. Martin)

This technique is the opposite of the traditional technique, in which the clinician tries to convince the patient of advantages, but the patient replies with "Yes, but…!" and instead convinces themselves of the opposite and regresses.

This example is but an illustration of a general principle that is the same regardless of the type of intervention or behaviour. An increase in Conviction is always achieved by rephrasing open-ended questions that relate to the desired behaviour change in a way that brings the patient to themselves express and deeply feel positive, emotional and personal advantages.

INTERVIEW CLOSING once Preparation is reached (Scenario 2):

There are two possible interview conclusions (CLOSING) with Scenario 2:

1) If the perception of advantages is not charged with high emotional content, propose open-ended questions that the patient can ask themselves for a few minutes each day. They will identify more personal, positive and highly emotionally charged advantages, thereby increasing their motivation and consolidating their new stage of Preparation.

2) If the perception of advantages is highly emotionally charged, it is possible to pass to Scenario 3 (exploring barriers and strategies) and to do the Closing with passage to Action (striking while the iron is hot).

INTERVENTION INTENDED TO INCREASE CONFIDENCE (10–15% of cases) Scenario 3: Increasing Confidence

Any intervention which aims to boost the patient's Confidence can only start once the patient is convinced and motivated, i.e., has reached the key PREPARATION stage.

In practice, the healthcare professional uses 3 questions, in sequence, in order to bring the patient to identify and express their own perception of the barriers and their strategies to finally decide to pass to Action. The Closing of scenario 3 is thus movement, even partial, towards Action.

The following visual illustrates the steps:
This process is realistic, as it rests on the fact that the patient establishes their own course (initiated by the healthcare professional's questions) and identifies their own solutions, which is very different from the traditional directive approach in which the professonial projects their barriers and solutions, which are most often different from the patient's. An Action, even a partial Action, constitutes the first success which will reinforce Confidence and serve as a foundation for consolidation.

See Appendix 2 (Ms. Richards)

INTERVIEW CLOSING to increase Confidence

Negotiating an **ACTION** (even partial) constitutes the conclusion of the intervention on Confidence. After the patient has expressed the challenges and solutions, the concrete measures to take immediately are established.

During the Action and Maintenance stages, the healthcare professional must remain actively involved by evaluating the patient's affective Conviction level at each visit in a way that reinforces their Conviction, if needed, and to help prevent Relapse.

If the patient relapses (usually at the Contemplation or Preparation stage), as a first step the clinician must intervene to eliminate any guilt felt by the patient. Next, the pitfall responsible for the relapse must be identified and new protection mechanisms put in place. We then start the cycle all over again to move to Contemplation, Preparation, and lastly, Action. Equipped with this new defense mechanism, patients have a much better chance at making the next passage to action definitive. The same process will be repeated if the patient relapses due to a new pitfall.

What if a patient needs to change more than one behaviour?

Studies have shown that addressing more than one behaviour simultaneously is unsuccessful. There is one exception: one can simultaneously address physical activity and diet or physical activity and smoking cessation in the same intervention since physical activity catalyzes those two behaviours. Whether it be to limit the number of interventions (in order to maximize chances of success) or due to lack of time, the healthcare professional will more often than not have to choose a single behaviour on which to intervene, delaying intervention on the rest.

The first intervention should focus on the behaviour that is at the most advanced stage (Preparation, then Contemplation, and finally, Precontemplation); usually, the choice corresponds to the behaviour the patient prefers to change first.

For instance, a smoker who is overweight, sedentary, and has poor eating habits may be at the Preparation stage for physical activity, Contemplation for diet, and Precontemplation for smoking. In this case, the first intervention should focus primarily on physical activity in order to favour more rapid success (passage to Action). Building on this first success will have the effect of boosting confidence. The intervention strategy will then target diet to bring the patient to the Preparation stage, and then the Action stage. Smoking cessation will be addressed last by increasing cognitive Conviction to move towards Contemplation, then affective Conviction to move to the Preparation stage. Finally, Confidence will have to be addressed to pass to Action.

SUMMARY

The key messages are relatively simple:

1) In contrast to the inefficient, directive, healthcare professional-centered approach, a patient-centered intervention must occur by first identifying the patient's current REAL stage in order to select the proper intervention scenario specific to the patient. All clinicians must unavoidably acquire this new skill in order to target and accelerate behavioural change of all kinds in their patients.

2) By asking a question which evaluates the apparent stage (e.g. "What do you think about quitting smoking?…integrating physical activity in your daily routine?…changing your eating habits?…modifying the way you take your medication in order not to forget?"), it must be recalled that a significant number of patients will provide a politically correct response (either to please or due to fear of rejection). The answer may not match what the patient truly feels, and may in fact only represent an **apparent stage**! Prior to an intervention, the **REAL stage** must thus be confirmed through the level of Conviction, which always corresponds to the patient's true thoughts. Refer to section "Determination of **REAL stage**: Merging the two concepts."

3) The traditional directive intervention method is often met with resistance by the patient, and most often provokes stage regression (expressed by the "Yes, but…" syndrome). This type of intervention, which is spontaneous and comes naturally to many healthcare professionals, should no longer be used.

4) The communication technique called "motivational interviewing" will replace the directive approach. The skillful use of open-ended questions will prompt recognition, reinforcement and acceleration of the patient's progress from one stage to the next. Although it may appear challenging, the adoption of this communication technique can be easily developed and gradually become the spontaneous intervention technique centered on the patient.

The mode of communication between patients and healthcare professionals will improve until it corresponds to the model of cooperative patient – partner healthcare professional. This level of communication is superior to the dependent patient – expert professional mode (used in the treatment of acute disease), as the patient plays an active role in the management of their chronic illness(es) and lifestyle habits. The professional becomes a veritable partner – even an accomplice. In the absence of directive interventions, the healthcare professional is no longer frustrated by confrontation.

Clinicians need only get used to asking three key questions:

1) "What do you think about the idea of…?" (Apparent stage)

2) "If you decided to…, how would this benefit you?" (Conviction = **REAL stage**)

3) "If you decided to…, do you think you could do it?" (Confidence = Barriers and strategies)

The use of this intervention technique permits the healthcare professional to:

1) define, in every intervention, an adequate intervention scenario centered on the patient (from one of 3 possible scenarios) with a precise Closing technique for every scenario;
2) evaluate the success or failure of the interventions depending on the patient's progression or regression from one step to the next;
3) optimize the use of pharmacological tools (e.g. nicotine patch) or the help of other healthcare professionals (nutritionists, pharmacists, kinesiologists, etc.) at the appropriate time, once the patient has been motivated to reach the Preparation stage.

In the last 30 years, all clinical practice guidelines have focused on **WHY** it is important to intervene more effectively to change a patient's deleterious lifestyle habits; the time has come to center our attention on the **HOW**.

This is just the beginning of a step in the right direction!

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APPENDIX 1 – INCREASING CONVICTION

Mr. Martin
Myocardial infarction, dyslipidemia, COPD
Medication: enteric-coated ASA 81 mg, atenolol 50 mg, atorvastatin 40 mg, ipratropium bromide/salbutamol sulfate (Combivent® inhaler) PRN
Clinically stable
Has smoked since age 12 and has never tried to quit
Quit drinking 4 years ago
Goal: Quit smoking

1) EVALUATION: Conviction stage – Confidence

STAGE

Professional: *Have you ever thought about doing something about your smoking habit?*

Patient: *I'll probably quit someday, but I'm not ready now.* (Apparent stage: Contemplation)

CONVICTION

Professional: *If you were to decide to quit smoking, how do you think it would benefit you?*

Patient: *I think I'd be healthier.* (Perception of cognitive advantages = moderate Conviction, 4/10. Confirms Contemplation stage).

CONFIDENCE

Professional: *If you decided to quit smoking, do you think you could do it?*

Patient: *If I decided to quit, I wouldn't have any problem. I quit drinking four years ago and I've never fallen off the wagon.* (High Confidence)

Mr. Martin is at the Contemplation stage with moderate Conviction (cognitive) and high Confidence. The next intervention, using scenario number 2, will bring the patient to perceive positive personal advantages with high emotional content in addition to abstract knowledge in order to motivate them to reach the Preparation stage.

2) INTERVENTION

The healthcare professional will ask open-ended questions which invite the patient to express the benefits of behavioural change (without trying to answer for the patient). The questions can be rephrased (always linking to the behaviour to change) and reformulated according to the patient's answers, leading the patient to talk about personal advantages with high emotional content (the basis of motivation to change).

Professional: *If you decided to quit smoking, how would this benefit you?*

Patient: *My health would improve.* (Abstract advantage: moderate Conviction, 4/10)

Rephrase the question based on the patient's answer, linking it to the behaviour to change:

Professional: *How would quitting smoking improve your health?*

Patient: *I wouldn't cough as much and I wouldn't be as short of breath.*

(Benefits are more personal. Pain and discomfort are not abstract notions = moderate Conviction).

Rephrase the question based on the patient's answer and relate to the desired behaviour.

Professional: *If you were less short of breath by quitting smoking, how would your quality of life improve…How could you get more out of life?*

Patient: *My quality of life would definitely improve. For example, just the other day I tried to play with my grandchildren. I had to stop soon after because I was just too short of breath. If I quit smoking, I could be much closer to my grandchildren. I could go out with them more, maybe even take trips.*

(The benefits are now very personal and highly emotionally charged. "Play with grandchildren:" high Conviction – 10/10 = patient highly motivated).

Reinforcement by associating benefits to desired behaviour

Professional: *So, by quitting smoking you could spend quality time with your grandchildren, that's wonderful. Tell me more: What activities do you plan on doing with your grandkids?*

The more that the patient expresses the activities they would like to do with their grandchildren, the more they will profoundly desire to see them realized, which in turn increases motivation to quit smoking. We only feel what we express; as such, the patient must be prompted to express the advantages on their own rather than have the healthcare professional outline the advantages for them.

Interview closing: 2 possibilities

1) If the patient is not motivated enough, leave them with questions which they can mull over at home to identify more personal, positive and emotional advantages;

   OR

2) If the patient is highly motivated (as in the Mr. Martin example), move to scenario #3: barriers and strategies.

Closing: Since the patient is already highly motivated, we choose the second closing possibility by passing to scenario #3: barriers and strategies.

Professional: *I see that spending time with your grandchildren and being less short of breath as a result of quitting smoking is very important to you. What is preventing you from quitting? Do you think that you could do something to start heading in this direction?*

Patient: *Actually, I think that I could start by cutting back from a pack a day to half-a-pack a day.*

Professional: *I agree completely, this would be a great start. Are you ready to take the decision to start now, and when you come in for your next visit we'll see how it goes?*

Patient: *Okay. I will start today.*

The final closing thus becomes scenario #3: passage to Action (even partial).

APPENDIX 2 – INCREASING CONFIDENCE

Ms. Richards
Married 31-year-old female
Full-time customer service representative at a bank
Consults due to pregnancy-related weight gain
1.65 m; 79.5 kg; BMI 29
Tries to eat healthy, but lacks time for regular exercise (prior to marriage, she enjoyed sports)
Objective: Lose weight by resuming physical activity

1) EVALUATION: STAGE – CONVICTION-CONFIDENCE

STAGE

Professional: *What do you think about increasing your level of daily physical activity?*

Patient: *I'd love to be more active and I hopefully will be in a few months when I have found someone to help out with the housework.* (Apparent stage: Preparation, since she seems to be looking for strategies to pass to Action).

CONVICTION

Professional: *If you decide to become physically active again, what would the advantages be for you?*

Patient: *I used to be really active and I'd like to get back in shape. I wouldn't feel exhausted at the end of the day anymore. I could finally lose weight, feel better and have more energy. Life was beautiful back then!* (high Conviction with high emotional content – Conviction 10/10 = motivated = confirmation of the **REAL stage** of Preparation).

CONFIDENCE

Professional: *If you decided to get into shape now, do you think you could do it?*

Patient: *Right now I wake up early for the kids, work all day and collapse after I get them into bed. I don't see how I could do it right now.* (Very low Confidence).

Ms. Richards is at the Preparation stage with high Conviction and low Confidence. The target of the intervention should be to increase her Confidence.

2) INTERVENTION

Similar to the intervention scenario that increases Conviction, the healthcare professional will use open-ended questions so that the patient can express her own perception of the barriers ("What is preventing you from…?") and her own solutions ("How do you think you can overcome this obstacle?").

The meeting concludes with some negotiation which incites the patient to take concrete steps before her next appointment. This marks the beginning of the Action stage.

Identification of barriers:

Professional: If you decided to do more exercise, do you think you could manage it?

Patient: *Probably, but it would be pretty hard.*

Professional: *What would prevent you from getting more exercise?*

Patient: *I don't have enough time.*

Professional: *Are there any other barriers preventing you from resuming physical activity?*

Patient: *No, it's only a question of time.*

The obstacle is time.

Identification of solutions by relating to advantages

Professional: *To get back to the way you used to be and to feel full of energy, do you think that you could do something that would help you head in the right direction?*

Patient: *Taking the kids for a walk at the end of my work day would probably be a good place to start.*

Professional: *From a practical point of view, do you know how you could start doing this?*

Patient: *Yes, I think that I could start walking about 20 minutes every day, between the end of the work day and supper, when the kids get back from school.*

Professional: *This is certainly an excellent start. When would you like to begin?*

Patient: *I will start next Monday.*

Professional: *Good. Would you also agree to reflect on other things you might do to get back in touch with the feeling you used to have? We can discuss this further during our next visit.*

Patient: *Yes, I can do that, and we can discuss it next time we meet.*

Closing: negotiating concrete action

In this example, the closing is the passage to Action to start walking again.

Progress starts as a result of a realistic strategy (small step: 20 minutes of daily physical activity). It is probable that the patient will succeed in her plan, as she was the one to propose the solution. At the next appointment, her Confidence will be increased by this partial success and improved well-being. It will then be time to explore other actions she may take to fully realize her goal of increasing the intensity of her daily physical activity, losing weight and feeling good again.

Notes

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Dr. Jacques Bédard has been a specialist in internal medicine since 1976.

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