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National HIV Nurses Association

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Central and North West London NHS Foundation Trust

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Chelsea and Westminster Hospital NHS Foundation Trust

Psychological models to promote behaviour change: *what do HIV nurses need to know & why?*

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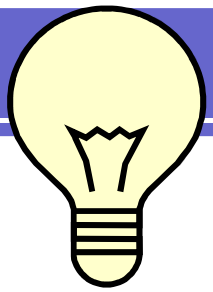


Q. How many psychologists does it take to change a light-bulb?

A. One… but the light-bulb has to **want** to change!

Talk outline

- Common issues in behaviour change
- CBT model of 'Permission Giving Thoughts'
- Motivational Interviewing (MI) theory and case study
- Transferable Relapse Management ideas
- Resources & Q&A

Practical issues in behaviour change

- Who's the behaviour a problem for: **staff or patient**?
- '**Willpower**' & responsibility: where does client put *loci* of control?
- Reason for lack of change may not be due to motivation, but concurrent **mood difficulty**. E.g.
  - *Depression*: reduced motivation across board
  - *Needle phobia*: avoiding having blood taken
  - *Social anxiety*: anxious at meeting others in clinic
  - *Paranoia*: feel unable to trust advice
  - *Panic attacks:* feel unable to leave the house
  - *Adult ADHD*: self medicating using club drugs
  - *Swallowing phobia*: unable to swallow ARTs

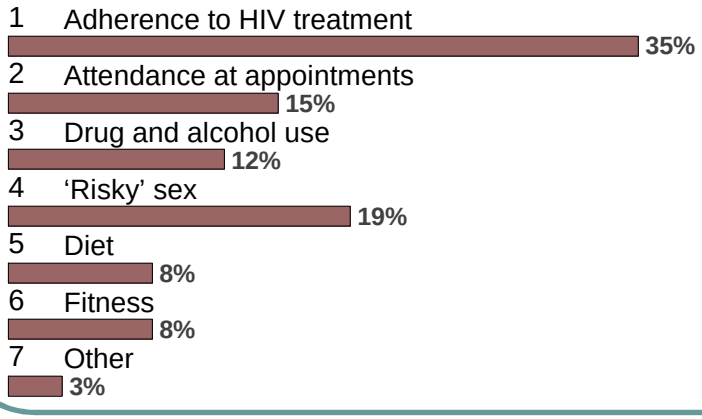
Interactive voting! What behaviours do you want to help patients change?

Please select the behaviours you're commonly asked to help clients change (select all that apply).

- Adherence to HIV treatment
- Attendance at appointments
- Drug and alcohol use
- 'Risky' sex
- Diet
- Fitness
- Other

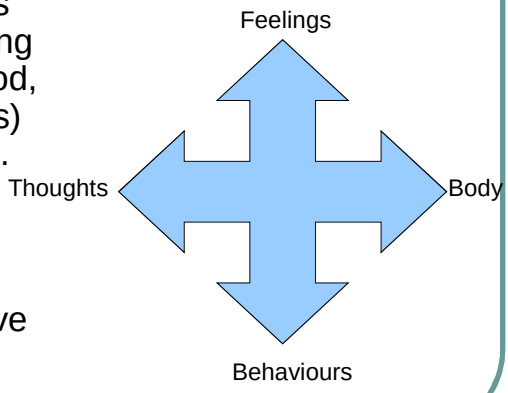
Interactive voting! What behaviours do you want to help patients change?

Please select the behaviours you're commonly asked to help clients change (select all that apply).



CBT Model: 'Hot Cross Bun'

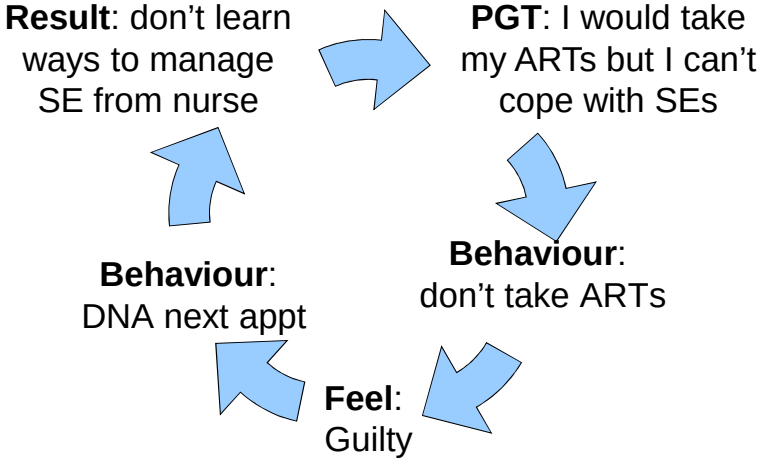
- Hot cross bun – link between behaviours (which we are looking to change) and mood, thoughts (cognitions) and body (physical).
- Thoughts can be images, words, speaking to self etc
- Mood can be positive or negative



Role of 'Permission Giving Thoughts' (PGTs)

- PGTs are a special kind of thought that excuse us from something we don't want to do, but keep the intention. They can be (re)framed as 'Yes, *but*…'
  - "I would take my ARVs *but* can't stand the SEs"
  - "I've had a bad day, I deserve to let my hair down and have a bit of coke"
  - "He's not said anything about condoms, so let's just have bareback"
  - "I want to attend clinic *but* I can't get time off work"
  - "Of course I'll cut down drinking… tomorrow"

Example: Adherence & DNAs



Steps in working with PGTs

1. Recognise PGTs are happening in the room (is there "Yes, but…" to every suggestion you make?)
2. Reflect process back to patient, do they recognise and agree with pattern of PGTs you've noticed?
3. Help client to identify and note when having PGTs
4. Discuss with client ways to test out and challenge their PGTs (with supervision from a Psychologist!).

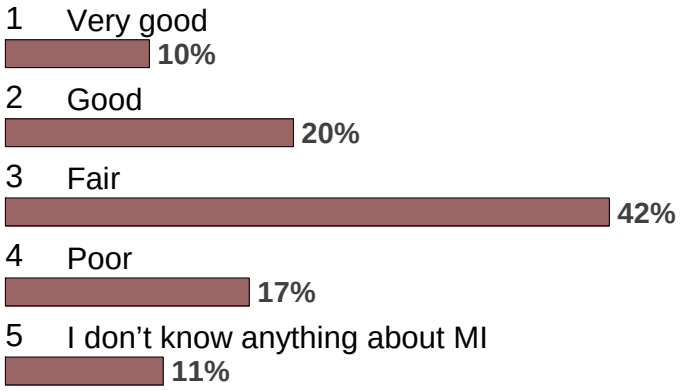
- *Pros/Cons of PGTs*
- *Evidence for/against PGTs*
- *Sentence reversal of PGTs*
- *10, 10, 10 rule*
- *Mindfulness & PGTs*
- *Imagery & PGTs*
- *What would they say to a friend?*

MI Quiz

- Please vote: Select only one option
- My knowledge of MI is:
- Very good
- Good
- Fair
- poor
- I don't know anything about MI

MI Quiz! Please rate your knowledge of MI.

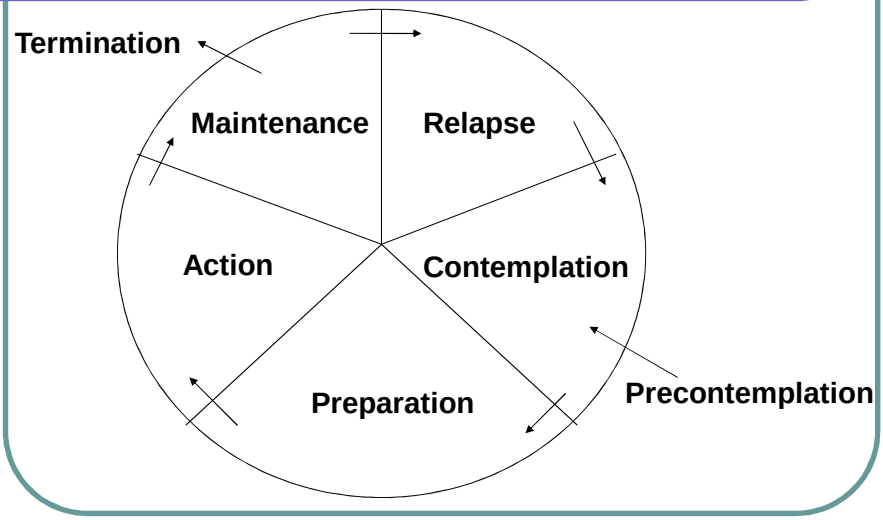
Please vote: Select only one option



Key Ideas in Motivational Interviewing (MI)

- MI is **goal directed**: focus on specific behaviour change
- **Motivation:**
  - inherent in client, change comes from the client – goal setting
  - may fluctuate over time. It is open to influence in either direction
- Spirit of MI – not just techniques
- **Self-efficacy**: build on client's confidence in their ability to make change. Use of scaling Q's. Build on past successes in making change.

Prochaska and DiClemente's Wheel of Change; Transtheoretical Model



From Contemplation….

To Action!

Using MI in HIV nursing

- Role for *all* nurses in facilitating behaviour change, not just specialist staff
- What can you do in 10 mins?
- Change talk/sustain talk - Patients will flip flop between **change talk** (I really don't want to become HIV+) and **sustain talk** (**but** I can't see myself never having bareback sex again).
- **Role – build on change talk! Using:**
- Reflections e.g. simple reflection – "It's very important to you to stay HIV negative."
- Purpose of reflections – patient hears their own reasons for change twice

Using summaries in MI

- *'You came today for an STI screen because it's important to you to look after your health. You find it uncomfortable to use condoms and at the same time you really want to stay negative, and you are thinking about the ways that you can build on this in the future.'*
- Timing of summaries
- Used to round up an appointment
- May include double sided reflections – to acknowledge reasons for current behaviour but
- **end with change talk! NB word order**

MI case study in HIV setting: from textbook to clinic room

- **Patient**: LT HIV+ gay man, 40s, LT unemployed
- **Presenting difficulties**:
  - **Multiple STIs** in past
  - Long history **casual UPAI**, x5 p/wk, Group sex
  - **1yr Chemsex** - Cocaine; Crystal, GHB.
  - **Mood:** low mood and passive suicidal ideation.
  - **Chaotic lifestyle**: lack of routine, poor diet, poor sleep, poor adherence to ARVs.
  - **Social**: No rlshp since diagnosed (HIV adjustment difficulties, hopelessness re relationship)

Intervention: 5 sessions MI

- **Sustain talk**: lots of reasons he kept having risky chemsex - his whole social life revolved around sex & drugs, only chance to have sexual relationships, no job, stopped all hobbies. Way of combating loneliness and boredom.
- **Change talk**: But ultimately he was unhappy with his sex life – not fulfilling, felt used – this was our starting point for the work.
- **Patient's goals/values**: Reducing chemsex was linked to his ultimate goal of finding a partner
- **Goal setting**: 'SMART' sub-goals
- **Self-efficacy**: behaviour change builds on self-efficacy

Outcome

- **Measurement tools**: Sexual Risk Indicator Tool, importance/confidence ratings, GAD-7, PHQ-9
- **Behaviour change**: ↓ UPAI, ↓ drug use, ↑ ARV
- **Mood change**: from hopeless to hopeful re relationship and his future in general
- **In his words**: 'It's a big step for me…I was taking drugs and I didn't give a flying fuck about nothing, I was up for 5 days and having sex with whoever knocked on the door…I've realised that's not what I want to do. It's a mental change, from 'I just don't give a shit' to realising that I do care about myself and my future.'

Relapse Management

- Relapse Management techniques found in addictions work may be transferable. E.g.
  - Coping with cravings
  - High risk situations
  - Problem solving
  - Increasing pleasant activities
  - Thoughts, feelings & mind traps
  - Developing an emergency lapse plan
  - Managing a lapse or a relapse
  - Building a balanced lifestyle

A final reflection

- *Ultimately, we cannot directly change anyone's behaviour but our **own**:*

  …so…
- *What behaviours do **we** want and need to change in ourselves and our practice, to help our clients?*

Resources, Reflections, Q&A

- **Books**:
1. *'Sex, Drugs, Gambling, & Chocolate'*
2. *'Motivational Interviewing in Healthcare'*
3. *'The Sex Addiction Workbook'*
4. An Introduction to Cognitive Behaviour Therapy: Skills and Applications

- **Papers***:*
1. *Downing,J., Jones,L., Cook, P.A. & Bellis, M.A. (2006). HIV prevention: a review of reviews assessing the effectiveness of interventions to reduce the risk of sexual transmission. Evidence Briefing Update* http://www.nice.org.uk/nicemedia/live/11377/43873/43873.pdf
2. *Herbst et al (2005)* A Meta-Analytic Review of HIV Behavioral Interventions for Reducing Sexual Risk Behavior of Men Who Have Sex With Men. Journal of Acquired Immune Deficiency Syndromes. 39(2), pp 228-241

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