

Behavioural changes ie smoking cessation



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This essay will discuss the Behaviour Change Model of Health education or The Trans-theoretical Model, (TTM) in relation to smoking cessation.

As G. K. Chesterton

once said, “ It isn’t that they can’t see the solution. It is that they can’t see the problem.” Families, friends, neighbours, or employees, however, are often well aware that the pre-contemplators have problems.

Stages of Change

Prochaska & DiClement`s transtheoretical model (1984, 1986; Prochaska et al 1992) is important in describing the process of change. The model derived from their work on encouraging change in addiction behaviours, although it can be used to show that most people go through stages when trying to change or acquire behaviours.

American psychologists, Jim Prochaska and Carlo Di Clement,

Termination.

Process of change.

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In our studies using the discrete categorization

measurement of stages of change, we ask whether

the individual is seriously intending to change the

problem behavior in the near future, typically within

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the next six months. If not, he or she is classified as a precontemplator. Even precontemplators can wish to change, but this seems to be quite different from intending or seriously considering change in the next six months. Items that are used to identify precontemplation on the continuous stage of change measure include “ As far as I’m concerned, I don’t have any problems that need changing” and “ I guess I have faults, but there’s nothing that I really need to change.” Resistance to recognizing or modifying a problem is the hallmark of precontemplation .

Spiral Pattern of Change.

Many New Year’s resolvers

report five or more years of consecutive pledges

before maintaining the behavioral goal for at least six

months (Norcross & Vangarelli, 1989). Relapse and

recycling through the stages occur quite frequently

as individuals attempt to modify or cease addictive

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behaviors. Variations of the stage model are being used increasingly by behavior change specialists to investigate the dynamics of relapse (e. g., Brownell et al., 1986; Donovan & Marlatt, 1988).

Because relapse is the rule rather than the exception with addictions, we found that we needed to modify our original stage model. Initially we conceptualized change as a linear progression through the stages; people were supposed to progress simply and discretely through each step. Linear progression is a possible but relatively rare phenomenon with addictive behaviors.

Figure 1 presents a spiral pattern that illustrates how most people actually move through the stages of change. In this spiral pattern, people can progress from contemplation to preparation to action to maintenance, but most individuals will relapse. During

relapse, individuals regress to an earlier stage. Some

TERMINATION a MAINTENANCE

PRECONTEMPLATION CONTEMPLATION PREPARATION

relapsers feel like failures-embarrassed, ashamed,

and guilty. These individuals become demoralized

and resist thinking about behavior change. As a result,

they return to the precontemplation stage and

can remain there for various periods of time. Approximately

15% of smokers who relapsed in our

self-change research regressed back to the precontemplation

stage (Prochaska & DiClemente, 1986).

Fortunately, this research indicates that the vast

majority of relapsers-85% of smokers, for example-

recycle back to the contemplation or preparation

stages (Prochaska & DiClemente, 1984). They

begin to consider plans for their next action attempt

while trying to learn from their recent efforts. To

take another example, fully 60% of unsuccessful

New Year's resolvers make the same pledge the next year (Norcross, Ratzin, & Payne, 1989; Norcross & Vangarelli, 1989). The spiral model suggests that most relapsers do not resolve endlessly in circles and that they do not regress all the way back to where they began. Instead, each time relapsers recycle through the stages, they potentially learn from their mistakes and can try something different the next time around (DiClemente et al., 1991).

On any one trial, successful behavior change is limited in the absolute numbers of individuals who are able to achieve maintenance (Cohen et al., 1989; Schachter, 1982). Nevertheless, in a cohort of individuals, the number of successes continues to increase gradually over time. However, a large number of individuals remain in contemplation and precontemplation stages. Ordinarily, the more action

taken, the better the prognosis. Much more research is needed to better distinguish those who benefit from recycling from those who end up spinning their wheels.

Arguments for and against

Conclusion

Influencing the people to change behaviours such as how they eat, exercise, drink, smoke requires a long term commitment but it is a process that they can succeed. Nurses have a key role to play in influencing behaviour of their patients, and health promotion should be embedded

MAINTENANCE:

practice required for the

new behaviour to be consistently maintained,

incorporated into the repertoire of behaviours

available to a person at any one time.

ACTION: people make changes, acting on previous decisions, experience, information, new skills, and motivations for making the change.

PREPARATION:

person prepares to

undertake the desired change – requires

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gathering information, finding out how to achieve the change, ascertaining skills necessary, deciding when change should take place – may include talking with others to see how they feel about the likely change, considering impact change will have and who will be affected.

CONTEMPLATION:

something happens to prompt the person to start thinking about change – perhaps hearing that someone has made changes – or something else has changed – resulting in the need for further change.

PRECONTEMPLATION:

changing a behaviour has not been considered; person might not realise that change is possible or

that it might be of interest to them.

Source:

The Behavior Change spiral from “ What do they want us to do now?” AFAO
1996

ded in daily practice. E

following review explores and considers some of the major theories of
behaviour

and behaviour change that may be pertinent to the development of effective
interventions in travel behaviour, including theories and concepts from
mainstream

psychology, and the associated sub-disciplines of health, leisure, recreation,
physical

activity and exercise psychology.

For many years conceptual models of behaviour change, such as Bandura’s
Social

Cognitive Learning Theory (1986), Becker’s Health Belief Model (1974), Azjen
and

Fishbein’s Theory of Reasoned Action (1975); have been applied across a
wide

variety of disciplines, including travel and road user behaviour.

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Considerable attention has been given in the literature to models of individual

behaviour change per se – but much less attention has been given to models or

theories that attempt to understand behaviour change within groups, organisations and

whole communities. The design of programs to reach populations requires an understanding of how those communities work, their barriers and enablers to change,

and what influences their behaviours in general.

Stage Theories of Behaviour Change

Mounting evidence suggests that behaviour change occurs in stages or steps and that

movement through these stages is neither unitary or linear, but rather, cyclical,

involving a pattern of adoption, maintenance, relapse, and readoption over time.

The work of Prochaska and DiClemente (1986) and their colleagues have formally

identified the dynamics and structure of staged behaviour change. In attempting to

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explain these patterns of behaviour, Prochaska and DiClemente developed a transtheoretical model of behavioural change, which proposes that behaviour change

occurs in five distinct stages through which people move in a cyclical or spiral

pattern.

The first of these stages is termed precontemplation. In this stage, there is no intent

on the part of the individual to change his or her behaviour in the foreseeable future.

The second stage is called contemplation, where people are aware that a problem

exists and are seriously considering taking some action to address the problem.

However, at this stage, they have not made a commitment to undertake action. The

third stage is described as preparation, and involves both intention to change and

some behaviour, usually minor, and often meeting with limited success.

Action is the fourth stage where individuals actually modify their behaviour,

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experiences, or environment in order to overcome their problems or to meet their

goals. The fifth and final stage, maintenance, is where people work to prevent relapse

and consolidate the gains attained in the action stage. The stabilization of behaviour

change and the avoidance of relapse are characteristic of the maintenance stage.

Prochaska and DiClemente further suggest that behavioural change occurs in a

cyclical process that involves both progress and periodic relapse. That is, even with

successful behaviour change, people likely will move back and forth between the five

stages for some time, experiencing one or more periods of relapse to earlier stages,

before moving once again through the stages of contemplation, preparation, action

and eventually, maintenance. In successful behavioural change, while relapses to

earlier stages inevitably occur, individuals never remain within the earlier stage to

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practice required for the

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available to a person at any one time.

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Source:

The Behavior Change spiral from “ What do they want us to do now?” AFAO
1996

which they have regressed, but rather, spiral upwards, until eventually they reach a

state where most of their time is spent in the maintenance stage.

Further work undertaken and reported by Prochaska et al (1992) suggests that

behaviour change can only take place in the context of an enabling or supportive

environment.

Prochaska's and DiClemente's model has received considerable support in the

research literature. Their model has also been shown to have relevance for understanding, among other things, patterns of physical activity participation and

adherence and would have relevance in bringing about change in travel behaviours.

Consistent with the above perspective, Sallis and Nader (1988) also have suggested a

stage approach to explaining movement behaviour, particularly in family groups, with

research aimed at understanding better the cyclical patterns of movement activity

SOCIAL FEATURES

– nature of personal relationships; expectations of class, position, age, gender; access to knowledge, information.

CULTURAL FEATURES

– the behaviours and attitudes considered acceptable in given contexts – eg. relating to sex, gender, drugs, leisure, participation.

ETHICAL & SPIRITUAL FEATURES

– influence of personal and shared values and discussion about moral systems from which those are derived – can include rituals, religion and rights of passage.

LEGAL FEATURES

– laws determining what people can do and activities to encourage observance of those laws .

POLITICAL FEATURES

– systems of governance in which change will have to take place – can, for example, limit access to information and involvement in social action.

RESOURCE FEATURES

– affect what is required to make things happen – covers human, financial and material resources;

community knowledge and skills; and items for exchange

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Source:

The Behavior Change spiral from “ What do they want us to do now?” AFAO
1996

involvement, including adoption, maintenance, and relapse, and
interventions aimed

at minimizing the amount of time individuals spend in the relapse stage as
well as

maximizing time spent in action or maintenance.

This stage approach is contrasted to the “ all or none” approach to physical
activity

participation that often characterized early research on exercise adherence.

Such a staged approach sits well with any school based program that is
focussed on

travel behaviour change – given that the context in which the program is to
be applied

would see fluctuations in the positive and negative influences according to
such things

as work and time demands of family members, weather, events or incidents
in the

local neighbourhood that may influence perceptions of safety.

Parallel with the work of Prochaska and DiClemente, Rogers, (1983) also developed a

stage-based theory to explain how new ideas or innovations are disseminated and

adopted at the community and population levels. Rogers identified five distinct stages

in the process of diffusion of any new initiative or innovation. These are knowledge,

persuasion, decision, implementation, and confirmation. Rogers argued that the

diffusion of an innovation is enhanced when the perceived superiority of an innovation is high compared to existing practice (i. e. the relative advantage), and

when the compatibility of the innovation with the existing social system is perceived

to be high (i. e. compatibility).

Other important influences on the diffusion process are said to be complexity,

trialability, and observability, with innovations which are of low complexity, easily

observed, and that are able to be adopted on a trial basis, being associated with greater

adoption and swifter diffusion. Building success and comfort during the early stages

of the implementation of the TravelSMART Schools program will be paramount to its

success.

Rogers classifies individuals as innovators, early adopters, early majority, late

majority, late adopters, and laggards, dependent upon when during the overall

diffusion process they adopt a new idea or behaviour. While this model has not been

tested empirically to date, it has been adapted and applied in health promotion settings

usually in conjunction with social learning theory and/or self-efficacy theory, with

some success. It certainly warrants attention in the development of the

TravelSMART Schools program.

In summarizing the various stage models of behaviour change that have been

proposed over the past two decades, Owen and Lee (1984) highlighted a number of

commonalties they share.

These authors propose an integrated stage-based model in which behaviour change is

viewed as a cyclical process that involves five stages of:

1. awareness of the problem and a need to change
2. motivation to make a change
3. skill development to prepare for the change
4. initial adoption of the new activity or behaviour, and
5. maintenance of the new activity and integration into the lifestyle.

In terms of a TravelSMART program this may mean:

Five stages of behaviour change Examples of content and processes

- Awareness of the problem and a need to change
Provision of, or ways to seek information on the dependence on motorised travel;
evidence of the greenhouse effect; issues relation to building relationships and

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fitness

- Motivation to make a change Benefits of increased personal fitness;

benefits of leaving the car at home – eg.

environmental and social

- Skill development to prepare for the

change

Mapping of the local area to identify

alternative forms of travel, ways to

negotiate with reluctant family members

or peers to manage the need to carry;

strategies for trip chaining and travel

blending

- Initial adoption of the new activity or

behaviour

Self monitoring of newly adopted

behaviours to, opportunities for

reflections and comparisons

- Maintenance of the new activity and

integration into the lifestyle

Provision of feedback on how the change

is going, and an injection of new ideas or strategy

An important aspect of both Prochaska's and DiClemente's approach and that

suggested by Owen and Lee is that each of the five stages of behaviour change is said

to involve different cognitive processes and require different treatments or

intervention strategies for the overall change process to be successful.

Prochaska and

DiClemente (1992) outlined a number of cognitive change processes that have been

found to be associated with each stage.

Other researchers also propose that different stages in the change process require

different intervention strategies, and generally recommend a multifaceted,

community-based approach to intervention in which all stages are addressed so that

individuals at all stages of "readiness for change" can potentially be influenced. This

sits well with the overall TravelSMART programs – TravelSMART Communities,

TravelSMART Workplaces and TravelSMART Schools.

A major insight offered by stage theories of behaviour change, then, is the emphasis

they place on matching interventions to the stage of readiness of the individual. This

kind of approach provides an excellent framework for understanding and examining

individual differences in motivation for, and involvement in, change in travel behaviours over time, including patterns of initiation, maintenance, relapse, and

resumption.

In summary, theories that conceptualise behaviour change in terms of a cyclical

process through which individuals move in stages, have received empirical support in

the research, and appear to offer much promise for understanding travel behaviours

and curricula to bring about changes in travel behaviour.

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A major strength of the Stages of Change model is that it has also been used in

conjunction with a variety of other theories and models that are relevant to different

levels of influence at an intrapersonal, interpersonal, institutional, community or

public policy level. (Glanz and Rimer (1995) as reported by Oldenberg et al (1999))

Social Cognitive-Behavioural Theories and Similar Theories

Social Cognitive Theory explains human behaviour in terms of a triadic, dynamic and

reciprocal model in which behaviour, personal factors, and environmental influences

interact. It addresses both the psychological dynamics underlying behaviour and their

methods for promoting behaviour change. It is a very complex theory and includes

many key constructs. Self-efficacy is one of the key concepts.

Self-efficacy refers to one's confidence in the ability to take action and persist in

action. It is seen by Bandura (1986) as perhaps the single most important factor in

promoting changes in behaviour. Measures of self-efficacy and some of the other key

concepts from Social Cognitive Theory have also been identified as key determinants

of movement through the stages of change, (Oldenburg, 1999).

Self-efficacy expectations have been found repeatedly to be important determinants

of:

1. the choice of activities in which people engage
2. how much energy they will expend on such activities and
3. the degree of persistence they demonstrate in the face of failure
and/or
adversity.

In general, higher levels of self-efficacy for a given activity are associated with higher

participation in that activity.

Similarly, and closely aligned to Social Cognitive Theory, Attribution Theory proposes that individuals generally view their performance (and thus, their successes

and failures) as dependent upon ability, effort, task difficulty, and luck. In addition,

causal influences are seen as either internal to the individual (e. g. personal ability), or

external (e. g. barriers to community safety, lack of convenient and attractive travel

alternatives).

The distinction between internal and external attributions is an important one, in that

how we attribute our personal successes and failures has been shown to be related to

not only our behaviour, but our self-esteem, our perceptions of personal control, our

self-efficacy for different tasks and/or performance situations, and our ongoing

involvement in different activities.

For example, a person who attributes their failure to change their dependence on

motorised travel to their inherent lack of ability to identify and use alternatives will be

less likely to continue with the alternative modes of travel after the educational

program has ceased.

A person's attributions for personal success and failure in a given situation, then,

determines how that person feels about the task, as well as the amount of effort he or

she is likely to invest in the task the next time around. When failure is attributed to

low personal ability and a difficult task, individuals are more likely to give up sooner,

select easier alternatives, such as using personal motorised travel, and lower their

goals. Conversely, when failure is attributed to external factors such as bad luck,

individuals are likely to have higher motivations to continue and to try again for

success.

Attitudes and their potential relationship to behaviour also have been studied

extensively. In general, attitudes have not generally been found to be consistently

related to behaviour. This failure to demonstrate a consistent relationship between

attitudes and behaviour may be because situational factors also exert a powerful

influence on behaviour. In addition, how attitudes have been defined and measured in

different studies varies considerably.

Research has demonstrated consistently that an attitude is likely to predict behaviour

when:

- the attitude includes a specific behavioural intention
- when both the attitude and the intention are very specific and
- when the attitude is based on first-hand experience .

These aspects of the behaviour-attitude relationship have been addressed in the

Theory of Reasoned Action, which focuses on the role of context-specific attitudes in

defining behaviour. In this model, behaviour is seen as a function of a person's

intention, which in turn is comprised of the individual's attitudes towards performing

the behaviour and the influence of perceived social norms concerning the performance of the behaviour. Attitudes are affected by the person's beliefs about the

perceived consequences of performing a given action, and his or her subjective

evaluation of each of the consequences.

Drawing this together, any published individually focused and community based

health behaviour change and health promotion programs have generally been based

on Social Cognitive theories utilising techniques that emphasise the cognitive and

social mediators of behaviour. Interventions based on cognitive learning theory

emphasize self-management principles and strategies.

Other Theories to Consider

Personality Theories

Personality theories explain behaviour largely in terms of stable traits or patterns of

behaviour which are viewed as resistant to change and inalterable. Rogers', (1985),

classification of individuals into the five categories of innovators, early adopters,

early majority, late majority, late adopters, and laggards is an example of this kind of

approach to understanding behaviour.

A major limitation of personality theories is that they do not take account of important

aspects of the physical, social and economic environments, or the previous experiences of the individual, which also are known to strongly influence behaviour.

For this reason, personality theories alone now are generally considered inadequate to

explain behaviour change.

Learning and Behaviour Theories

Learning theorists have demonstrated that behaviour can be changed by providing

appropriate rewards, incentives, and/or disincentives. In learning or behaviourist

approaches, these rewards and incentives are typically incorporated into structured

reinforcement schedules, and the process of behaviour changes is often termed

behaviour modification.

While effective in bringing about behaviour change, such approaches require a high

level of external control over both the physical and social environment, and the

incentives (or disincentives) used to reinforce certain behaviours and discourage

others. This kind of control is hard to maintain in real life settings, and thus, strict

behaviourist approaches are subject to a number of limitations.

Social Learning Theory

Social learning theory is similar to learning and behaviour theories in that it focuses

on specific, measurable aspects of behaviour. Learning theories, however, view

behaviour as being shaped primarily by events within the environment, whereas social

learning theory views the individual as an active participant in his or her behaviour,

interpreting events and selecting courses of action based on past experience.

Again, one important theory deriving from social learning theory which has had a

major impact on many current models of behaviour change is that of self-efficacy. As

stated earlier, self-efficacy expectations have to do with a person's beliefs in his or her

abilities to successfully execute the actions necessary to meet specific situational

demands. Such expectations have been found to be consistently related to behaviour

across a wide range of situations and populations sub-groups.

Social Psychological Theories

Social psychological theories are concerned with understanding how events and

experiences external to a person (i. e. aspects of the social situation and physical

environment) influence his or her behaviour.

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Emphasis is placed on aspects of the social context in which behaviour occurs,

including social norms and expectations, cultural mores, social stereotypes, group

dynamics, cohesion, attitudes and beliefs. A number of useful concepts have emerged

from social psychological theories, including attribution, locus of control, and cognitive dissonance, to name a few.

Social Cognitive Approaches

Social cognitive approaches combine aspects of social psychological theories with

components of both social learning theory and cognitive behavioural approaches.

Social-cognitive approaches emphasize the person's subjective perceptions and

interpretations of a given situation or set of events, and argue that these need to be

taken into account if we are to understand adequately both behaviour and the

processes of behaviour change.

A number of social psychological concepts have been found to be consistently related

to behaviour change across a wide range of situations. For example, the social reality

of a the group (e. g. peer group, school group, family group etc.) will affect an

individual's behaviour. All groups are characterized by certain group norms, beliefs

and ways of behaving, and these can strongly affect the behaviour of the group

members.

Expectations of significant or respected others can also have a strong influence on a

person's behaviour. This phenomenon has been most consistently demonstrated in the

early research on self-fulfilling prophecies, which showed that teachers' expectations

of their students were consistently related to the students' subsequent performance,

even when these expectations were based on falsified information. Thus, support and

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encouragement, or conversely, low expectations from significant or respected others,

can affect and bring about, (or not), changes in individual behaviour.

Health Belief Model

The Health Belief Model attempts to explain health-behaviour in terms of individual

decision-making, and proposes that the likelihood of a person adopting a given healthrelated

behaviour is a function of that individual's perception of a threat to their

personal health, and their belief that the recommended behaviour will reduce this

threat.

Thus, a person would be more likely to adopt a given behaviour (e. g. walk or cycle

regularly) if non-adoption of that behaviour (e. g. unclean air or confused traffic

situations) is perceived as a health threat and adoption is seen as reducing that threat.

To date, the Health Belief Model has not received consistent or strong support in

explaining behaviour change. When the concept of self-efficacy is added to the

model, however, prediction of behaviour increases.

Social Marketing

Another approach that has been used to bring about behaviour change is that of social

marketing. The concept of social marketing is based on marketing principles and

focuses on four key elements, including:

1. development of a product
2. the promotion of the product
3. the place
4. the price.

As such, this approach is not so much a theory of behaviour change but a proposed

framework, which situates people as “ consumer” who will potentially “ buy into” a

certain idea or argument, given the appropriate selling techniques are applied. It is

then assumed that the “ buying in” to that idea by individuals will result in behaviour

change.

Theory of Interpersonal Behaviour

Habit strength is another concept that has been found to be important in predicting or

changing behaviour. Habit is an important element of the theory of interpersonal

behaviour, which proposes that the likelihood of engaging in a given behaviour is a

function of:

1. the habit of performing the behaviour
2. the intention to perform the behaviour
3. conditions which act to facilitate or inhibit performance of the behaviour.

In turn, intentions are said to be shaped by a cognitive component, an affective

component, a social component, and a personal normative belief. The theory of

i