

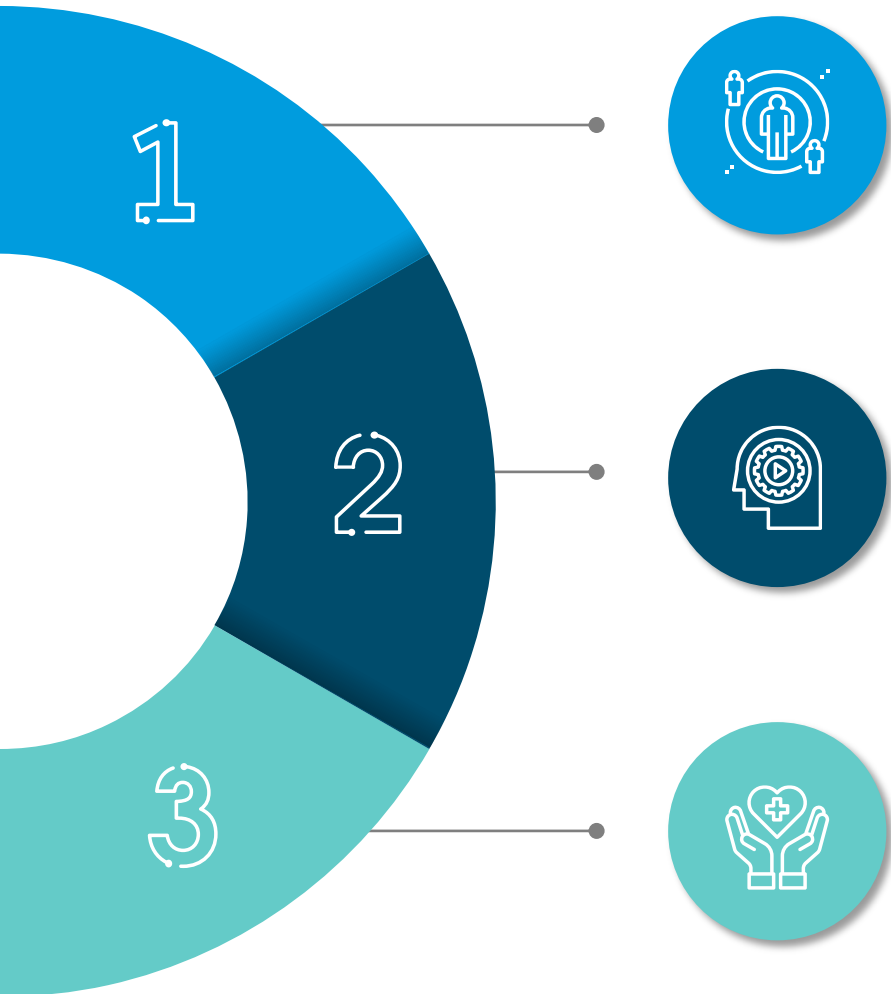
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Behavioral Science and Menopause

Prof. John Weinman
King's College London



Presentation outline



Impact of menopause on behavior & adherence

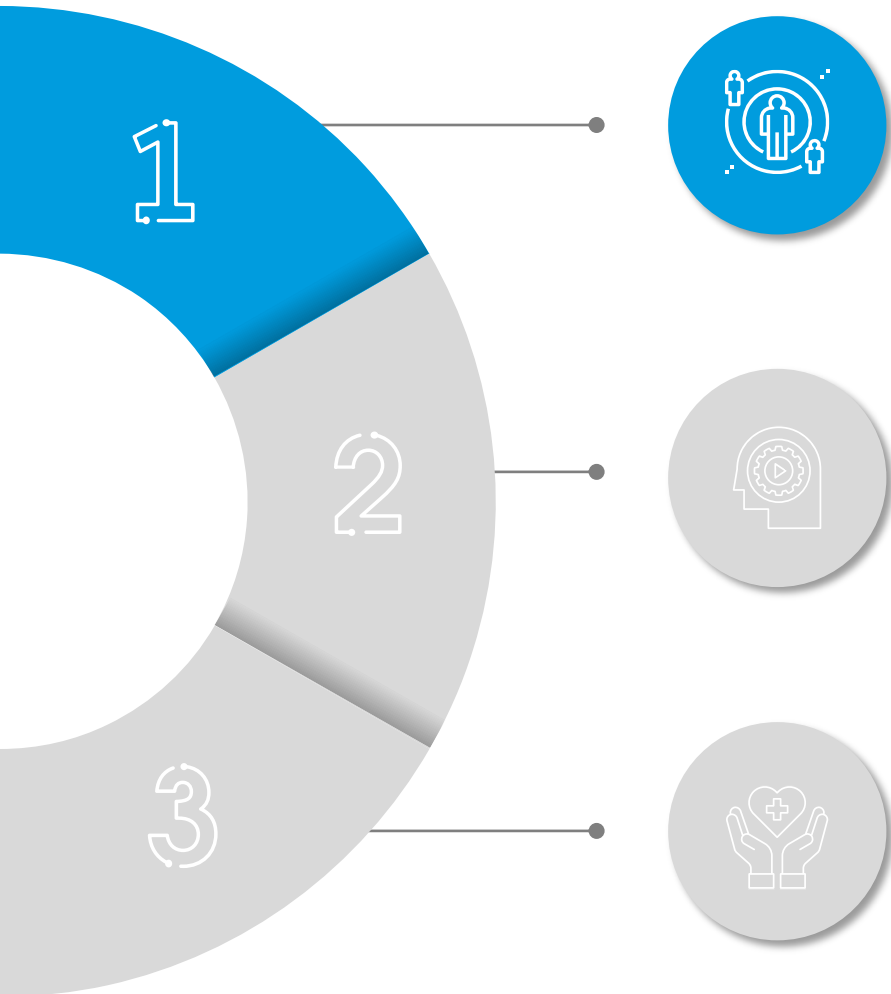


Behavioral frameworks to analyze adherence



How can healthcare professionals deal with medication adherence in menopause setup

Presentation outline



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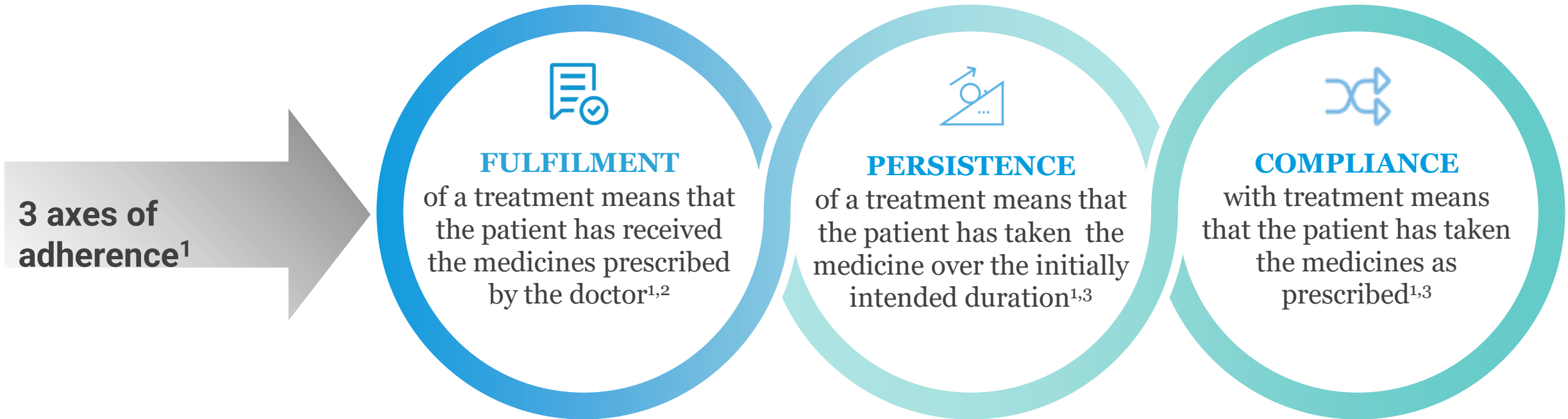


How can healthcare professionals deal with medication adherence in menopause setup



Adherence definition

Adherence – or the way patients follow and keep up with medical treatments, is an important aspect to improve the health of the overall population.



1. Jimmy, Beena, and Jimmy Jose. "Patient medication adherence: measures in daily practice." Oman Medical Journal vol. 26,3 (2011): 155-9. 2. Abhijit S. Gadkari & Colleen A. McHorney (2010) Medication nonfulfillment rates and reasons: narrative systematic review, Current Medical Research and Opinion, 26:3, 683-705. 3. Cramer JA, Roy A, Burrell A, et al. Medication compliance and persistence: terminology and definitions. Value Health. 2008;11(1):44-47.

Menopause – a crucial moment in women’s lives

Menopause occurs on average at 50⁴ y.o., – one of the most crucial age in the lives of many women, as at this age



1

Careers are usually at peak⁵

2

Children are starting their own adult life⁶

3

Parents are often aged and sick and may require attention/care⁶

After menopause, symptoms may continue for up to 10 years or longer^{7,8}

4. Johnson A, Roberts L, Elkins G. Complementary and alternative medicine for menopause. JEBIM. 2019;24. 5. Patterson J. It’s time to start talking about menopause at work. February 2020. Accessed August 19, 2020. <https://hbr.org/2020/02/its-time-to-start-talking-about-menopause-at-work> 6. Hunter M, Smith M, in collaboration with the British Menopause Society. Cognitive behavior therapy (CBT) for menopausal symptoms: Information for GPs and health professionals. Post Reprod Health. 2017;23(2):83–84. 7. Dalal PK, Agarwal M. Postmenopausal syndrome. Indian J Psychiatry. 2015;57(Suppl 2) 8. Manson JE, Kaunitz AM. Menopause Management--Getting Clinical Care Back on Track. N Engl J Med. 2016;374(9):803-806.

Menopausal symptoms and associated taboo⁹



Up to 90% of the women experience symptoms at some point during menopause transition, with approximately half of them considering their symptoms bothersome^{*25-27}



Roughly **half of women do not seek** medical advice^{*10}



The topic remains a taboo⁹ in many societies

*As per surveys in postmenopausal European women

9. British Medical Association, Challenging the culture on menopause for working doctors, <https://www.bma.org.uk/media/2913/>, Accessed August 19, 2020 10. Constantine GD et al. Behaviours and attitudes influencing treatment decisions for menopausal symptoms in five European countries. *Post Reprod Health*, 2016; 22(3):112-122. 25. Hunter MS, Gentry-Maharaj A, Ryan A, et al. Prevalence, frequency and problem rating of hot flushes persist in older postmenopausal women: Impact of age, body mass index, hysterectomy, hormone therapy use, lifestyle and mood in a cross-sectional cohort study of 10,418 British women aged 54-65. *BJOG* 2012; 119: 40-50. 26. Buhling KJ, Daniels BV, Studnitz FS, et al. The use of complementary and alternative medicine by women transitioning through menopause in Germany: Results of a survey of women aged 45-60 years. *Complement Ther Med* 2014; 22: 94-98. 27. Garton M, Reid D, Rennie E. The climacteric, osteoporosis and hormone replacement; views of women aged 45-49. *Maturitas* 1995; 21: 7-15.

Impact of untreated menopause



Cognitive and psychological problems

In addition to hot flashes, menopausal women may suffer from depression, anxiety, sleep deprivation and cognitive impairment.^{11, 12, 13}



Impact on the professional environment

Hot flashes lead to higher intention of post-menopause women to leave the work force.¹⁴

11. Gava G, Orsili I, Alvisi S, Mancini I, Seracchioli R, Meriggiola MC. Cognition, Mood and Sleep in Menopausal Transition: The Role of Menopause Hormone Therapy. *Medicina (Kaunas)*. 2019;55(10):668. Published 2019 Oct 1. 12. Amy J-J. (1996) Femoston®: Effects on bone and quality-of-life, *Gynecological Endocrinology*, 10:sup4, 13. Manson JE, Kaunitz AM. Menopause Management--Getting Clinical Care Back on Track. *N Engl J Med*. 2016;374(9):803-806.14. Hardy C, Thorne E, Griffiths A, & Hunter M. Work outcomes in midlife women: The impact of menopause, work stress and working environment. *Women's Midlife Health*; 2018; 4.

Adherence and menopause



The proportion of women discontinuing the originally prescribed hormone regimen at 1 year ¹⁵



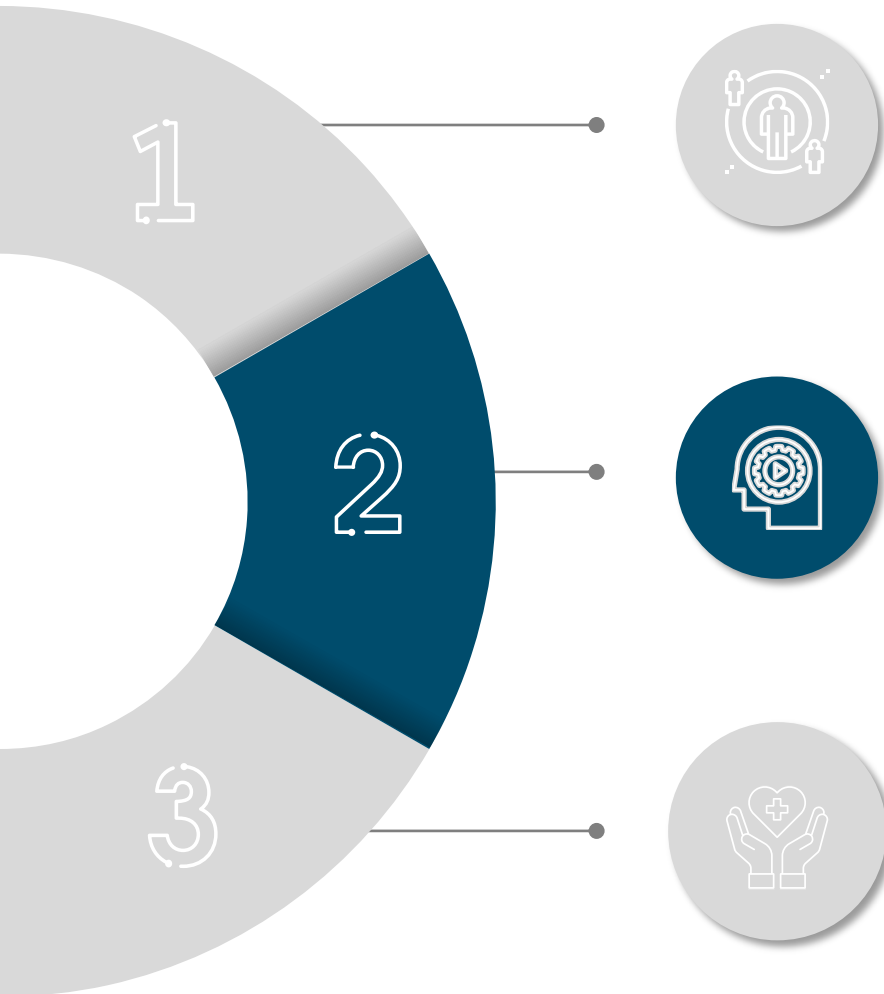
Menopause impacts adherence rates to treatments to other diseases**16,17,18

* Based on an indirect calculation where proportion of adherence to continuous combined therapy users was (68.9%, 62/90) and sequential therapy users was (54.4%, 62/114)

**Conditions presented in the cited studies: breast cancer and HIV

15. Hill DA, Weiss NS, LaCroix AZ. Adherence to postmenopausal hormone therapy during the year after the initial prescription: A population-based study. Am J Obstet Gynecol. 2000;182(2):270-276. 16. Cutimanco-Pacheco V, Arriola-Montenegro J, Mezones-Holguin E, Niño-García R, Bonifacio-Morales N, Lucchetti-Rodríguez A, Ticona-Chávez E, Blümel JE, Pérez-López FR, & Chedraui, P. Menopausal symptoms are associated with non-adherence to highly active antiretroviral therapy in human immunodeficiency virus-infected middle-aged women. Climacteric; 2020; 23(3): 17: Duff PK, Money DM, Ogilvie GS, et al. Severe menopausal symptoms associated with reduced adherence to antiretroviral therapy among perimenopausal and menopausal women living with HIV in Metro Vancouver. Menopause; 2018; 25(5): 531-537. 18 : Miller L. Menopause symptoms affect treatment adherence in breast cancer survivors. Cure Today website. <https://www.curetoday.com/articles/menopause-symptoms-affect-treatment-adherence-in-breast-cancer-survivors>, December 10, 2016, Accessed August 19, 2020.

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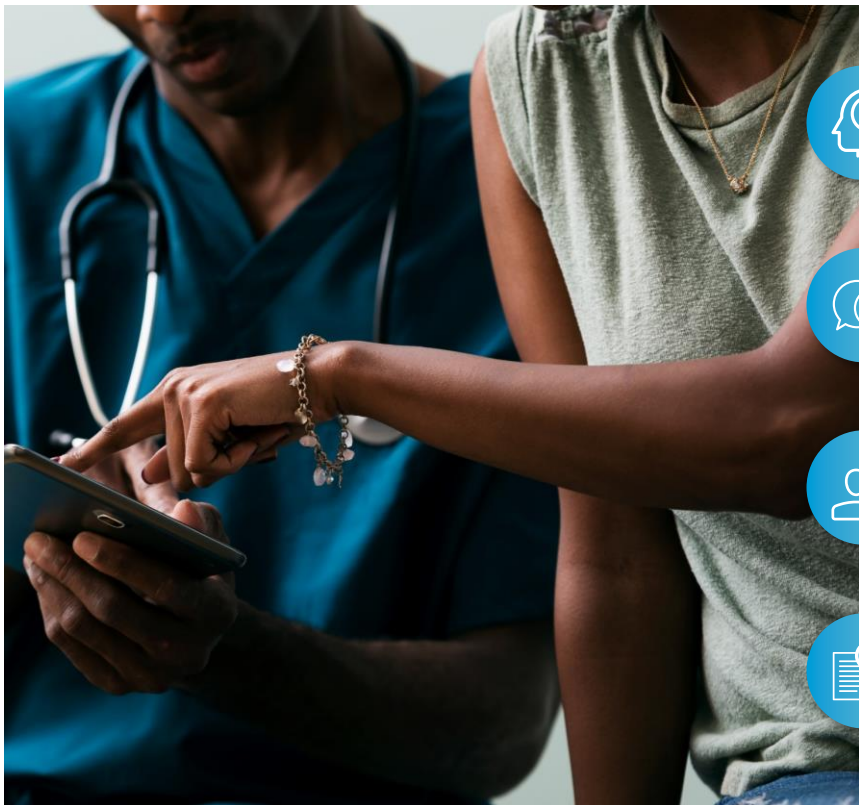


Behavioral frameworks to analyze adherence



How can healthcare professionals deal with medication adherence in menopause setup

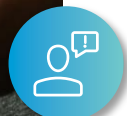
What are the reasons for non-adherence?



Early explanations for non-adherence focused on lack of understanding or forgetting



These still form the basis of many interventions



But interventions which provide information or reminders are not effective for those who are non-adherent¹⁹ (e.g. Choudhry et al, 2017)

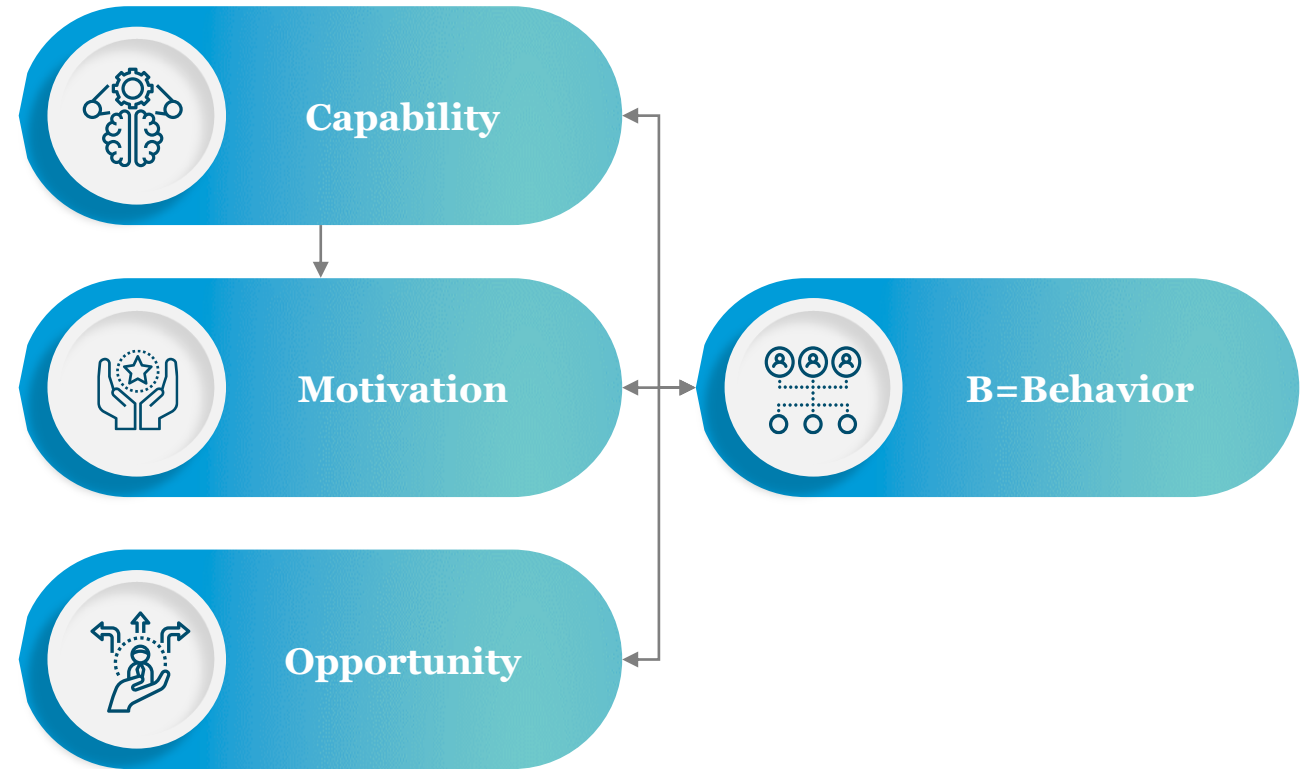


Now many other reasons have been found, and these can vary between individuals

19. .K. Choudhry, A.A. Krumme, P.M. Ercole, C. Girdish, A.Y. Tong, N.F. Khan, T.A. Brennan, O.S. Matlin, W.H. Shrank J.M. Franklin, The effect of reminder devices on medication adherence : the REMIND randomised clinical trial, JAMA Intern. Med. (2017),.

Current state of knowledge regarding determinants of health-related behavior: The COM-B framework

- How to classify the modifiable factors: the COM-B framework²⁰
- **Incorporates all the factors which have been found to influence health-related behaviors, and puts them into 3 broad groups**
 - **Capability**
 - **Opportunity**
 - **Motivation**
 - **(B= Behavior)**
- A general framework which has now been applied to adherence



20.. Susan Michie, Maartje M. van Stralen and Robert West: The behavior change wheel: A new method for characterising and designing behavior change interventions. Implementation Science 6, 42, Apr 2011

A new approach to classifying causes of non-adherence: COM-B²¹

ehp.s.nhbjp applying COM-B to medication adherence

original article

Applying COM-B to medication adherence

A suggested framework for research and interventions

On average only fifty percent of people with long term conditions are adherent to their treatment across diverse disease and patient groups (Holloway & van Dijk, 2011; Sabaath, 2003). Medication non-adherence leads to reduced clinical benefit, avoidable morbidity and mortality and medication wastage (DiMatteo, Giordano, Leggat, & Coughan, 2002). With increases in life expectancies as well as the number of patients managing chronic illnesses, this problem may well become worse in the next few years. Consequently, policy makers have called for successful interventions to address the causes of non-adherence and improve the population's use of medicines (Holloway & van Dijk, 2011; Horne, Weinman, Barber, Elliott, & Morgan, 2006; Nunes et al., 2009; Sabaath, 2003). Indeed, it has been estimated that \$269 billion worldwide could be saved by improving patient medication adherence (IMS Institute for Healthcare Informatics, 2012).

Unfortunately, many adherence interventions to date have not been effective (Haynes, Ackloo, Sahota, McDonald, & Yao, 2008). Medical Research Council guidelines recommend that appropriate theory and evidence should be identified to inform the development of an intervention (Craig et al., 2008). However, most adherence interventions are developed without a sound theoretical base, which may be one of the reasons they have not been effective (Horne et al., 2006). Successful interventions have often involved a level of complexity that would be too difficult and expensive to implement in practice (Haynes et al., 2008).

Explanations and models of medication

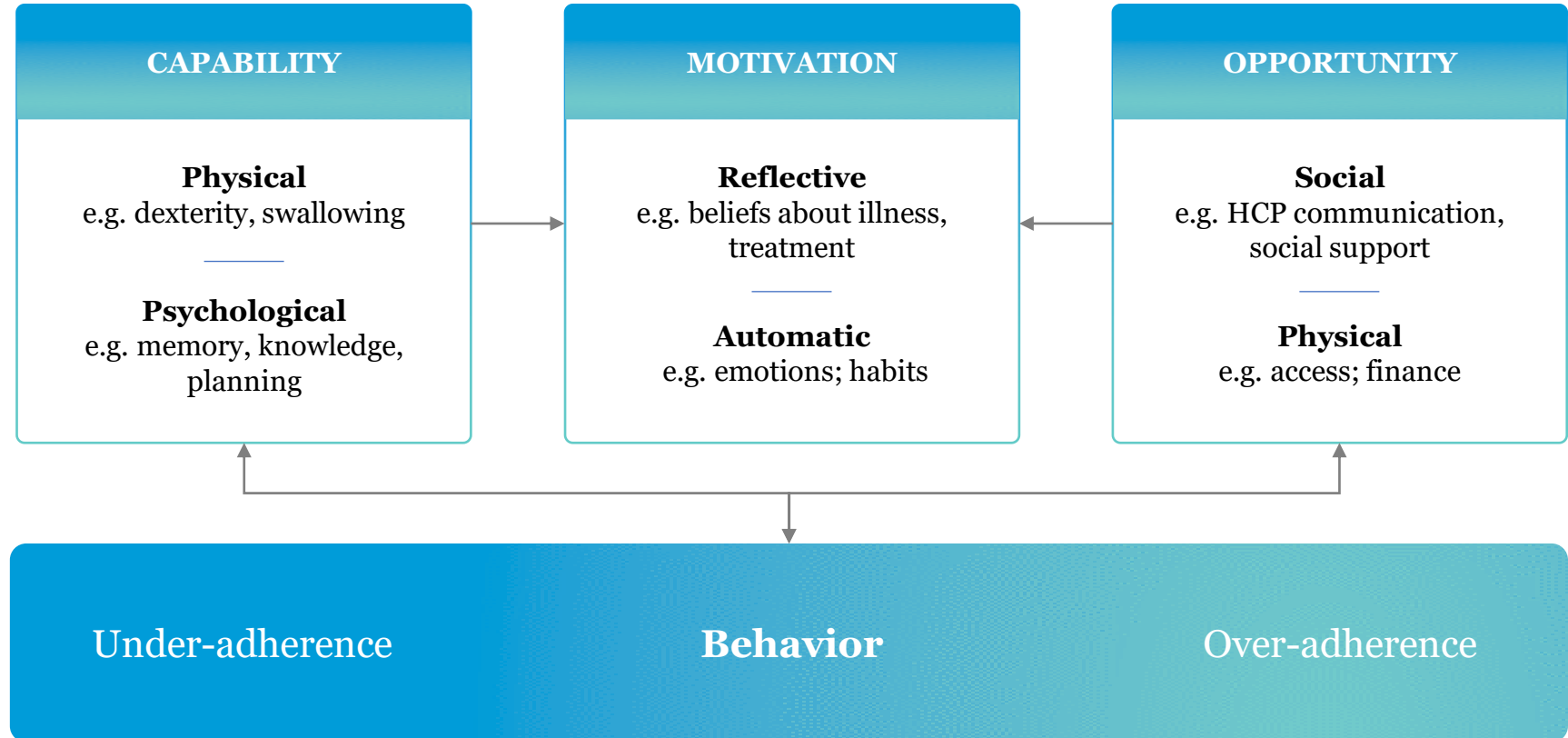
adherence/non-adherence have changed over the years. Early work tended to focus on the role of doctor-patient communication and its effects on patient satisfaction, understanding and forgetting as key determinants of subsequent treatment adherence (Lay, 1984). However, health behaviour research has consistently demonstrated that the provision of information alone is not an effective way to change behaviour, and so research has now moved onto approaches and models which focus on patients' beliefs, motivation and planning abilities as the core explanatory variables. Many of these are social cognition or self-regulatory models which emphasize the importance of the beliefs which individuals have about their illness and treatment as well as their own ability to follow the treatment and advice which they are given (see Conner & Norman, 2005). Existing models and frameworks are not comprehensive since they neglect automatic processes such as habit (for example, Ajzen, 1985; Bandura, 1977, 1986; Horne, 1997, 2003; Leventhal, Nerenz, & Steele, 1984; Pound et al., 2005; Rosenstock, 1974), do not describe dynamic behaviour whereby the experience of adherence/non-adherence can alter predisposing factors such as beliefs about medication (for example, Ajzen, 1985; Bandura, 1977, 1986; Horne, 2003; Pound et al., 2005; Rosenstock, 1974) and neglect factors at a systems level (for example, Horne, 2000, 2003; Leventhal et al., 1984; Pound et al., 2005; Rosenstock, 1974). In addition, the often used

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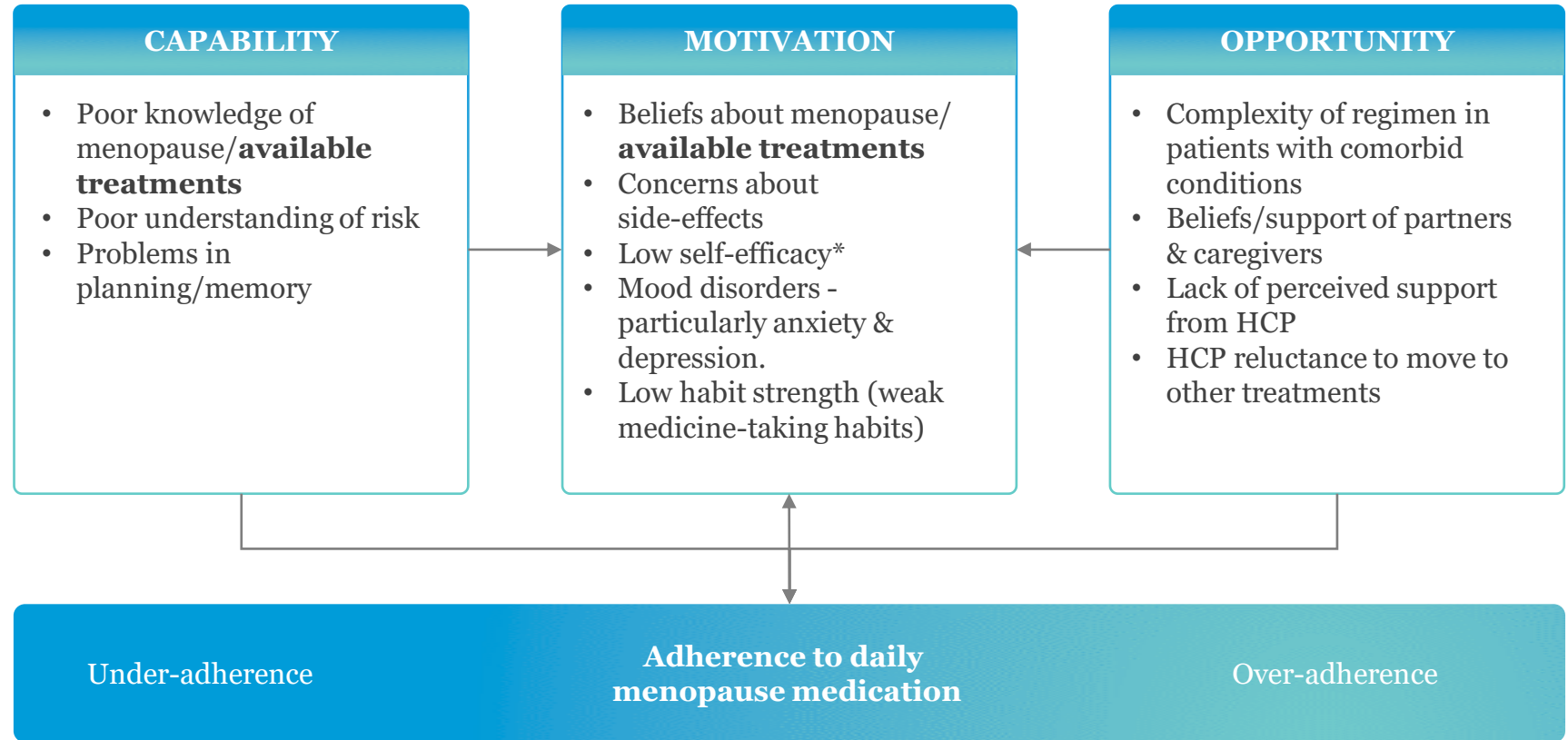
21. Christina Jackson, Lina Eliasson, Nick Barber and John Weinman: Applying COM-B to medication adherence: a suggested framework for research and interventions, The European Health Psychologist, Jan 2014 [Accessed 26 June 2020], <https://pdfs.semanticscholar.org/bfdb/62f5430b90243959e8a989abf5ddb12ee32b.pdf>



Applying COM-B framework to medication adherence in menopause



*confidence in one's own ability to do something



Implications for changing adherence behavior



Importance of
understanding
drivers/barriers for EACH
PATIENT over time



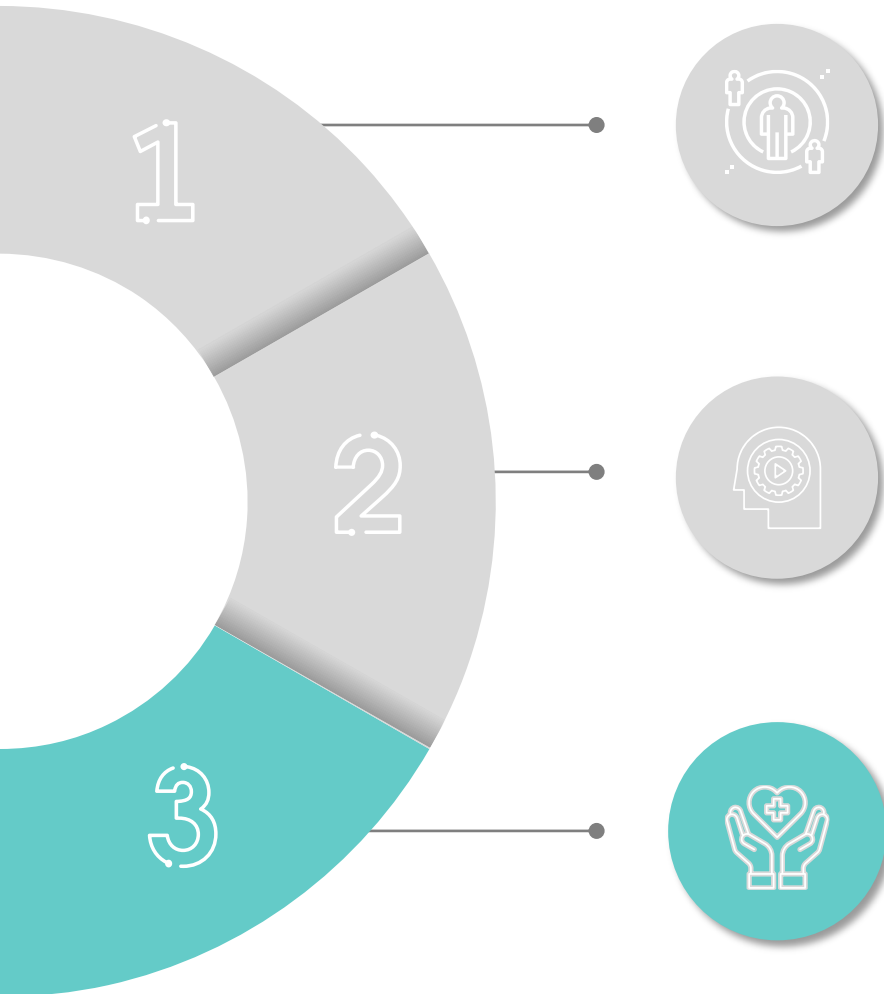
Need to find out
INDIVIDUAL DRIVERS/
BARRIERS for each
patient (C, O or M?)



Address
these with
APPROPRIATE
INTERVENTION²²

22. Samuel S. Allemann, Robby Nieuwlaat, Bart J.F. van den Bemt, Kurt E. Hersberger and Isabelle Arnet: Matching Adherence Interventions to Patient Determinants Using the Theoretical Domains Framework, Nov 2014, [Accessed 26 June 2020], <https://pubmed.ncbi.nlm.nih.gov/27895583/>

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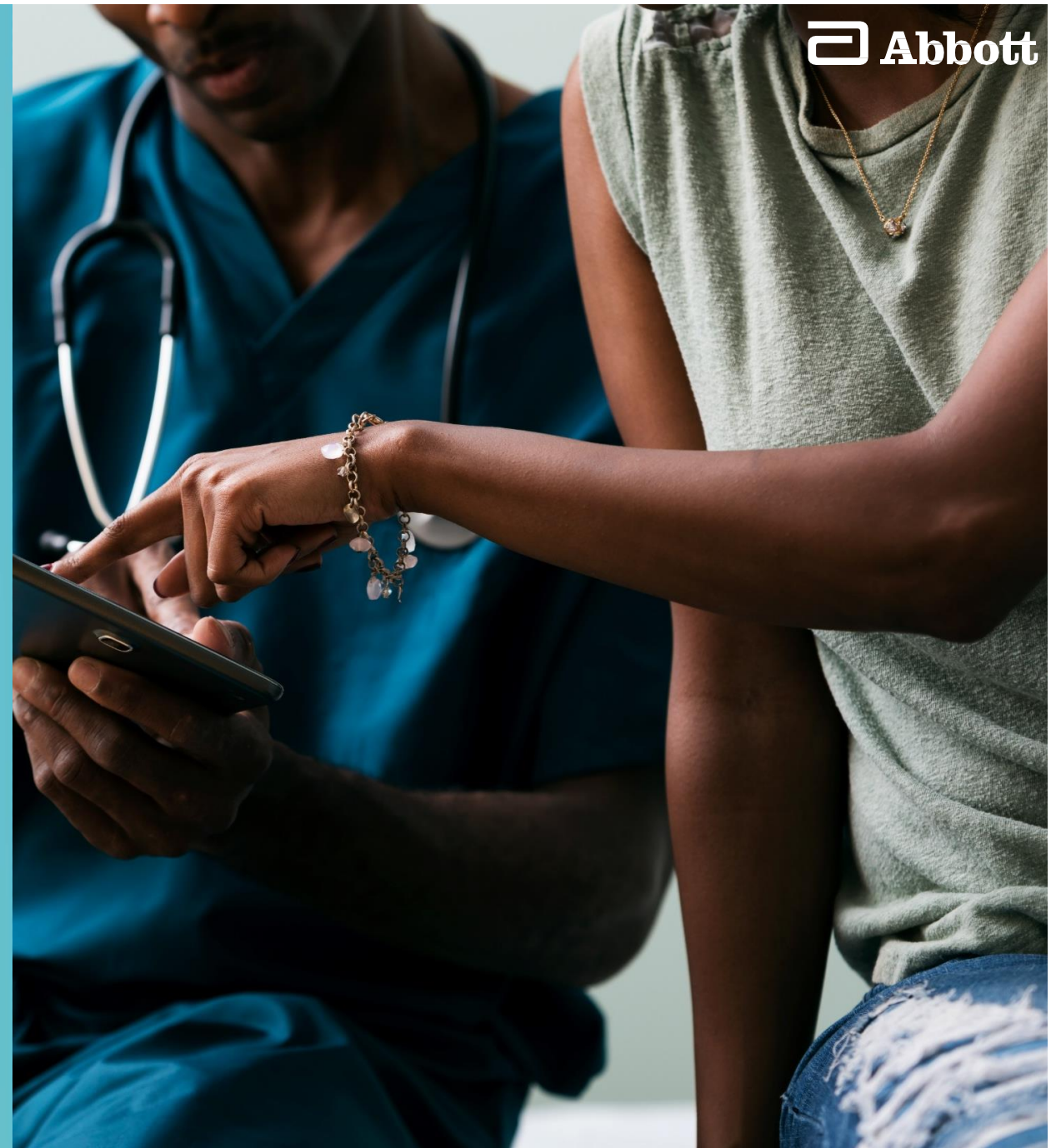


Behavioral frameworks to analyze adherence



How can healthcare professionals deal with medication adherence in menopause setup

Information is necessary
but **not enough**
to produce or change a
behavior like adherence
for most people



Using the consultation to facilitate informed adherence



Check patient's understanding of treatment and, if necessary



Provide clear rationale for **necessity** of treatment



Elicit and address **concerns**



Agree practical plan for **how, where** and **when** to take treatment



Identify any possible barriers

Most used communication strategies to influence the behavior of others



Ordering, directing, demanding



Warning or threatening



Persuading with reason, logic, argument, or lecture



Moralizing, preaching, telling what you “should” do



Disagreeing, judging, criticizing, blaming





Shaming, ridiculing, labeling





May work in some settings, but is often least effective to change behavior!


Most effective communication strategies to influence the behavior of others

-  Collaboration

-  Curiosity

-  Nonjudgmental

-  Empathy

-  Other-focused



Least used strategies!

A different approach is needed.....

Motivational Interviewing



A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence²³

Miller & Rollnick (1995)

23. Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *behavioral and cognitive Psychotherapy*, 23(4), 325-334

Motivational Interviewing



Builds rapport and creates positive relationships with patients



Scientifically supported clinical method for helping people change behavior; it is patient-focused and goal-directed



Can assess and support adherence behavior



May be different from the way you currently communicate with patients

- If you ever struggle with getting patients to change behavior, consider trying a new approach!

Spirit of Motivational Interviewing



Collaboration

The key to communication and patient-centered care



Expertise

Patient is the expert on their own life



Autonomy

It is the patient who is in charge

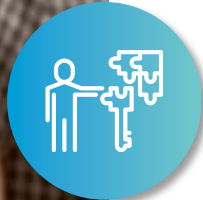
Switch-off the “righting reflex”



Natural to wish to solve problems



Facilitate the patient to find their own solutions



Enable the patient to hear their own reasons for adherence

4 Basic Principles of Motivational Interviewing



Express
empathy

Develop and
explore
discrepancy

Deal with
discord

Support
self-efficacy
(confidence)

Basic Skills in MI: Oars



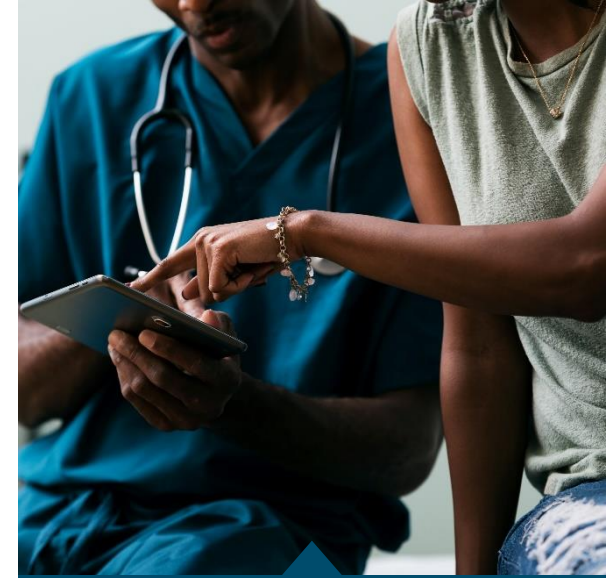
Open questions



Affirmation



Reflection



Summary

O is for Open Questions



(Closed)

- Are you taking your MHT medicine correctly?
- Did that make you feel bad?
- Do you want to change your eating habits?
- Do you do enough exercise?
- Is your diet unhealthy?

Open questions

- How are you getting on with your MHT?
- Take me through your medicine-taking over the last week
- How do you feel about your lifestyle?
- What do you think about your smoking?

A is for Affirmation



Affirmations build a patient's belief that a change in behavior is possible, recognizing the patient's strengths

Any change, that is in a positive direction, are presented as evidence that this behavior change is important to the patient. You might say...

“You showed a lot of commitment and drive in taking your new meds this week even though you still have some concerns”

Validate their reasons for non-adherence



I completely understand

Sometimes life gets in the way

You clearly care about what you put into your body; it really shows you care about your health

Would you like us to think about a possible solution together?

R is for Reflective listening



Paraphrasing what the patient has said



Reflecting back the feelings underlying what they have said



Reflecting with statements rather than questions



Encouraging the patient to elaborate further



Enabling you to check your understanding



Indicating that you are listening

“So it seems as if now is not the right time for you to think about starting MHT as well as taking your other medicines”

S is for Summarizing



Confirms your understanding



Demonstrates listening



Structures the patient's thoughts and concerns



Structures the consultation to move onto action planning

“You are obviously concerned about your menopausal symptoms and the effects they are having on your life but you are reluctant to start taking medication because you are worried about possible side effects...”

Can I still give information?



Permission

“Would you like information on...”



Ask

“What do you already know about/understand by...”



Provide

Informing not advising



Ask

What do they think?

How will they use the information?

Do they have any questions?

Basic Elements of Motivational Interviewing



Asks open-ended questions vs. telling patients what to do



Focuses on the patient's preferences, values, and personal situations, not the HCP's agenda



Views the patient as expert



Helps HCPs get insight into how to help patients better adhere



Helps the patient toward an acceptable outcome



Allows HCPs to share advice that will be better received and more likely acted upon



We don't have enough time ...



Learning Motivational Interviewing takes a lot of time, practice, and coaching

We have time to learn a few questions that embody the Motivational Interviewing approach

“Motivating questions” could make a difference for you and your patients

Dealing with emotional problems

Cognitive Behavior Therapy (CBT)



Cognitive Behavior Therapy for Menopause²⁴

Physical Symptoms

Tension, butterflies, heart racing



Thoughts

I'm not good enough, I'll never get this finished

Behavior

Avoid situations, overeating, doing too much

Feelings

Anxious, stressed, upset, worried

24. Myra Hunter, Dr Melanie Smith in collaboration with British Menopause Society, Cognitive behavior Therapy for Menopausal Symptoms, <https://www.womens-health-concern.org/help-and-advice/factsheets/cognitive-behavior-therapy-cbt-menopausal-symptoms/>

Summary



- Menopause can be disruptive for many women
- Although widely available, there is often reluctance to prescribe and/or take MHT
- Good support and communication is crucial
- Motivational Interviewing approaches can be very helpful for discussing problems and encouraging adherence to treatment
- CBT can be very helpful for managing physical and emotional symptoms

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Abbott

Thank you!

