

# Transtheoretical Model of Behavioural Change for Oral Habit, Tobacco and Alcohol Cessation.

Anurag Satpathy

Professor, Department of Periodontics and Oral Implantology, Institute of Dental Sciences, Siksha 'O' Anusandhan (Deemed to be University), Bhubaneswar-751003 Odisha, India

## Abstract

The transtheoretical model of change is one of the most accepted strategies to bring about an intentional change. It addresses the process of change in a structured manner which can be beneficially implemented to bring about positive changes to achieve habit breaking, tobacco and alcohol cessation. In addition, it may help acquire and establish positive habits such as maintenance of oral hygiene.

**Keywords:** *Transtheoretical Model; Behavioural Change; Oral Health; Tobacco and Alcohol Cessation.*

## Introduction

People who intend to change a prevailing behavior, habit or an addiction exist in good numbers. Although several strategies have been put forth to achieve this, a model that makes an approach though health behavioral change such as the transtheoretical model<sup>2</sup> has become quite acceptable over the years. Initially it addressed

smoking cessation, however, its success has encouraged its application across a variety of health behaviors including physical exercise, nutrition and diet. It may be further applied to oral care in the area of cessation of tobacco smoking and alcohol, maintenance of oral hygiene<sup>3</sup> and habits such as thumbsucking and oral breathing.

## Transtheoretical Model:

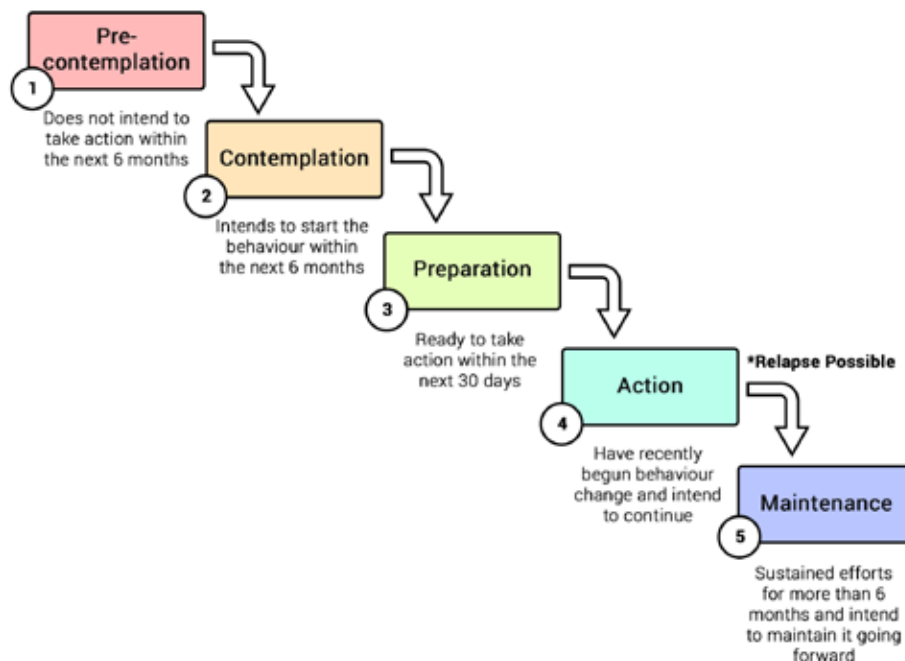


Figure 1. Stages of behavior change within the Transtheoretical Model adapted from Hartin et al.1

Transtheoretical model (TTM) of behavioral change is an integrative theory of therapy that works on the premise that change in behavior is a process and not merely a concurrence<sup>4</sup>.

Individuals may be at different stages of change and readiness to adapt. The model is an accumulation of several constructs which include various aspects of change such as the stage, process, level, efficacy, and determination.

**Pre-Contemplation Stage<sup>5</sup>:** In this stage patients are usually not interested and do not indulge in thoughts pertaining to any kind of change in their routine. On the contrary, there is a tendency to defend their current state and do not consider it as a problem. The defense may even come upfront when they perceive any external pressure. Patients do not lay their attention on the change and avoid any kind of discussion with others.

In this stage, motivational interventions can help raise awareness of the adverse effects of the habit or behavior. In this state, addictions often outweigh the advantages of their current habit or behaviour and are unwilling to modify them. In this stage, the role of the therapist or a counselor is primarily to guide the patient<sup>6,7</sup>.

**Contemplation Stage<sup>8</sup>:** In the contemplation stage patients have a better awareness about the ill effects of their habit and spend some of their time thinking about it. Although there is a consideration of the possibility of changing, they display uncertainty in their thoughts and speech. Patients are undecided and are still in a mode of assessing the benefit of modifying their behavior. Although they are aware of the negative and the positive aspects of their habit and also the benefits of choosing to quit or reducing, they may doubt on the fact that the long-term advantages of the change will outweigh the short-term costs. For a patient to be in this stage it may take from a few weeks to an entire lifetime to get through this stage. This is true as some patients plan and plan and keep planning about the change may end up in this stage. On the positive side, patients in this stage are open to suggestions and are more likely to actually self-assess their feelings and thoughts on the change.

Patients are asked to change in the next 6 months, or any date as per the consent of the patient is arrived at. Usually, the vast majority of patients are unaware of what to change and often get caught up in the "chronic contemplation." They replace the idea for acting.

Motivational interventions are beneficial for increasing the knowledge about the adverse effects of their present behaviour/habit or addiction. The adverse effects should be clarified<sup>6,7</sup>.

**Preparation Stage<sup>9</sup>:** In this stage patients have taken a decision to change. And this is revealed in their reciprocation such as: "I've got to do something about this—this is serious. Something has to change. What can I do?"

In other words, this is an experimentation stage and patients are now moving ahead slowly towards the change. They collect information by reading or asking about what they will need to do. Sometimes they may make a call to help centers to figure out what strategies and resources are available. In a good number of times patients tend to omit this stage and jump from the contemplation stage into the action stage. This often leads them to stumble as their knowledge is incomplete.

Preparation of change is underway and a deadline is set within 30 days. At this time a clinical evaluation using the various assessment tools may be made<sup>10</sup>.

**Action Stage<sup>11</sup>:** This is the stage where patients gather acceptance in the fact that they will be able to change and are seen actively involved in taking progressive steps and are now open to the use of alternative approaches. This could be the shortest stage, however, the actual amount of time spent by patients in this stage varies. It usually takes as long as six months, but can get over in an hour! In this stage, patients depend chiefly on their strength of will. At the same time where there is an effort to quit or change the behavior there exists a great threat for reversion.

Patients assess their self-pledge to themselves and chalk out tactics to counter own and outer demands that may result in relapse. Intermittently they introduce instant incentives of sustenance of impetus, and evaluate the change achieved so that it enhances their self-assurance. Patients are most likely to be open to receiving professional help in this stage.

Beginning is made to stop the prevailing habit or behaviour. Habits can be stopped using drugs appliances, behavior modification, will power, informal exit strategy or some or all of these procedures. This phase of effort lasts 6 months from start to finish. It is the most frequent stage of decline, which may change with treatment approach, lifestyle, mental health and gender. Increased

initial relapse occurs in the first few weeks. Therefore, the first support is very important and interventions that address disruptions, avoidance and satisfying positive actions are most useful. To continue this step, it is important to repeatedly contact the therapist to redirect efforts and celebrate success.

**Maintenance Stage<sup>12</sup>:** This stage involves the ability toward off any persuasion that may cause the return of the behavior or habit. This stage aims to preserve the acquired status. Patients also tend to be reminiscent about the quantum of progress they have made and devise ways of living so as to counter relapse. They are now able to foresee the possibility and circumstances which might lead to a relapse and formulate strategies to manage it in advance.

Beneficially, they become aware that their goal is individually valuable and consequential. They become increasingly self-tolerant and come to terms with the fact that achieving a stable change takes time and it takes a little while to get accustomed to acquired status until they become like second nature to them. In spite of temptations coming their way, they are able to keep themselves out the way. Relapses occur frequently, on an average, 3-4 times successful quaternary relapses and cycles occur before the change.

### Conclusion

The Transtheoretical model handles the change through a structured and continuous approach. It allows interventions tailoring to meet the needs of the patients. In addition, there can be movement through phases which may be the case for some who succumb to relapses.

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