



Why is changing health-related behaviour so difficult?

Behaviour is of course critical to health, and kiwi's health stats are looking pretty scary! New Zealand has seen dramatic rises in the last decade alone in the number of people living with type-2 diabetes, cardiovascular disease and other lifestyle related diseases.

- The number of New Zealanders with diabetes has doubled in the past 10 years and now more than 250,000 Kiwis live with diabetes.
- More than 170,000 Kiwis were living with heart disease in 2017.
- In 1977, only 10% of New Zealanders were classified as obese, but by 2017 this had risen to 30%

It's not just individual behaviour that drives these epidemics though; everyone operates in a social, economic and political environment and we must consider wider forces that influence people's behaviour.

When it comes to public health interventions, changing the behaviour of individuals is clearly seen as "easier" than addressing changes in the broader socio-economic-political context. But this focus on individual behaviour change, has not led to great success.

Most public efforts to get people to change health-related behaviour around drinking, smoking, eating and physical activity for example have had only limited success. Dr Barker and Professor Kelly say that although there is plenty of evidence on record about how to effectively support behaviour change, there has been a failure to put this into practice. Instead, most efforts focus on approaches that are based on nothing much more than anecdote and gut feeling.

Barker and Kelly say that discussions and interventions around lifestyle behaviour change are often influenced by six commonly held beliefs that are actually myths. These myths have made the business of health-related behaviour change much more difficult than it needs to be.

These myths are that behaviour change is just common sense and about getting message across, that knowledge and information drive behaviour, that people always act rationally or irrationally, and that it is possible to predict behaviour.

Myth 1: that behaviour change is just common sense

All too often thinking about behaviour change has been driven by the belief that human behaviour is so obvious that it needs little or no serious thought. This appeal to common sense is anti-scientific; it leads to thoughts such as: “it is obvious what needs to be done, so let us just get on and do it.”

However, if changing behaviour was simply about making common sense simple changes and good choices then we would all be able to make whatever changes we wanted, whenever we wanted. Obviously, we do not.

What this kind of thinking ignores is that human behaviour is influenced by social and cultural factors and is the result of the complex interplay between habit, automatic reactions, and conscious as well as unconscious choices.

There is a science to human behaviour and more than two centuries of psychological, sociological and anthropological evidence which we can draw on. We ignore this at our peril.

Myth 2: that behaviour change is just about getting the message across

In a slightly more sophisticated vein, some argue that changing health behaviour is simply a matter of getting the right messages across.

The idea here is very simple. If we could only get the message out there in some form which people could understand and identify with, then they would change in response. It's like advertising a product, except we're advertising a positive or healthy behaviour.

However, this is a simplistic approach which does not take account of the complex interplay of activities, decisions and environmental factors which influence human behaviour.

The key point is that purchasing a car or a tube of toothpaste is not the same kind of behaviour as making a plan to stop drinking fizzy drinks or to start exercising regularly. There is a great deal more to it than just getting the message across.

Campaigns can have an important role and can be effective, but they are only one part of a total strategy and behaviour change is not just about simple messaging.

Myth 3: that knowledge and information drive behaviour

All too often, we believe information from expert sources will drive behaviour change. This stems from a belief in the traditional medical model of the doctor–patient relationship, which is based on the premise that the patient comes to the doctor for their expert knowledge and understanding.

This is a model that works well for patients with acute conditions, emergency needs and infectious diseases for example, but it is less effective for chronic lifestyle related conditions, such as obesity and type-2 diabetes, which represent the great medical challenge we now face.

If it were true that knowledge and information drive behaviour, a practitioner would only need to tell someone about the negative consequences of eating too much or exercising too little for example and then the patient would change their behaviour accordingly. However every frontline clinician and practitioner will know it doesn't work like this.

A fundamental belief that information and knowledge will drive behaviour change is simplistic and unscientific. Giving people information alone does not make them change.

Myth 4: that people act rationally

Similarly, many people assume that other people act rationally, meaning that they will do what they know to be sensible and logical.

If this were the case we would only need to tell people what is good for them and what they need to do to protect their health, and they would do it. Sadly this is not the case.

People's usual behaviour around smoking, drinking, eating and physical activity are all examples of lifestyle behaviours that are ingrained in their everyday lives, routines and habits. These things may even be a strong part of someone's identity.

The idea that simply providing people with information will lead to them changing their sense of who and what they are is false.

Myth 5: that people act irrationally

While people can't be counted on to act rationally all of the time, neither do they act irrationally all of the time.

When someone with asthma refuses to stop smoking, we might regard them as foolish or addicted or both. But what we tend not to see is that this may not be an irrational decision given their lives and experiences. People have their own reasons for doing things. Behaviours that persist tend to be functional for people in some way even if destructive in others.

For any behaviour or choice, one person's rationality is another's irrationality. It is arrogant to assume that people consume alcohol, chocolate, or cream cakes because they are irrational or are simply behaving thoughtlessly or stupidly.

It is important not to dismiss the explanations people give for what they do just because the medical evidence dictates that what they do carries a health risk.

Myth 6: that it is possible to predict behaviour accurately

Lastly, although science has made great strides in identifying key factors which shape behaviour, it is still very difficult to say with any certainty how individual people will behave in any given situation.

We need to rethink the way we, as health professionals, work with our patients and clients.

Predicting behaviour and supporting behaviour change is neither obvious nor common sense. It requires careful, thoughtful science that leads to a deep understanding of what drives behaviour and the social and economic pressures that shape our “choices”. We should not treat the people who need to make behaviour changes as “dopes” but as knowledgeable human beings who understand their own conduct.

The field of health psychology has identified a range of behaviour change techniques that can help us understand and support behaviour change. *Healthy Conversation Skills* training is promising in its ability to help practitioners be more effective in their efforts to support patients or clients to produce sustained lifestyle behaviour changes.

The movement to ‘make every contact count’ recognises the opportunity practitioners have to improve public health through supporting behaviour change in the thousands of people with whom they come into contact.

[You can read the full article by Dr Mary Barker and Professor Michael Kelly here.](#)