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Behavioral Science and Menopause

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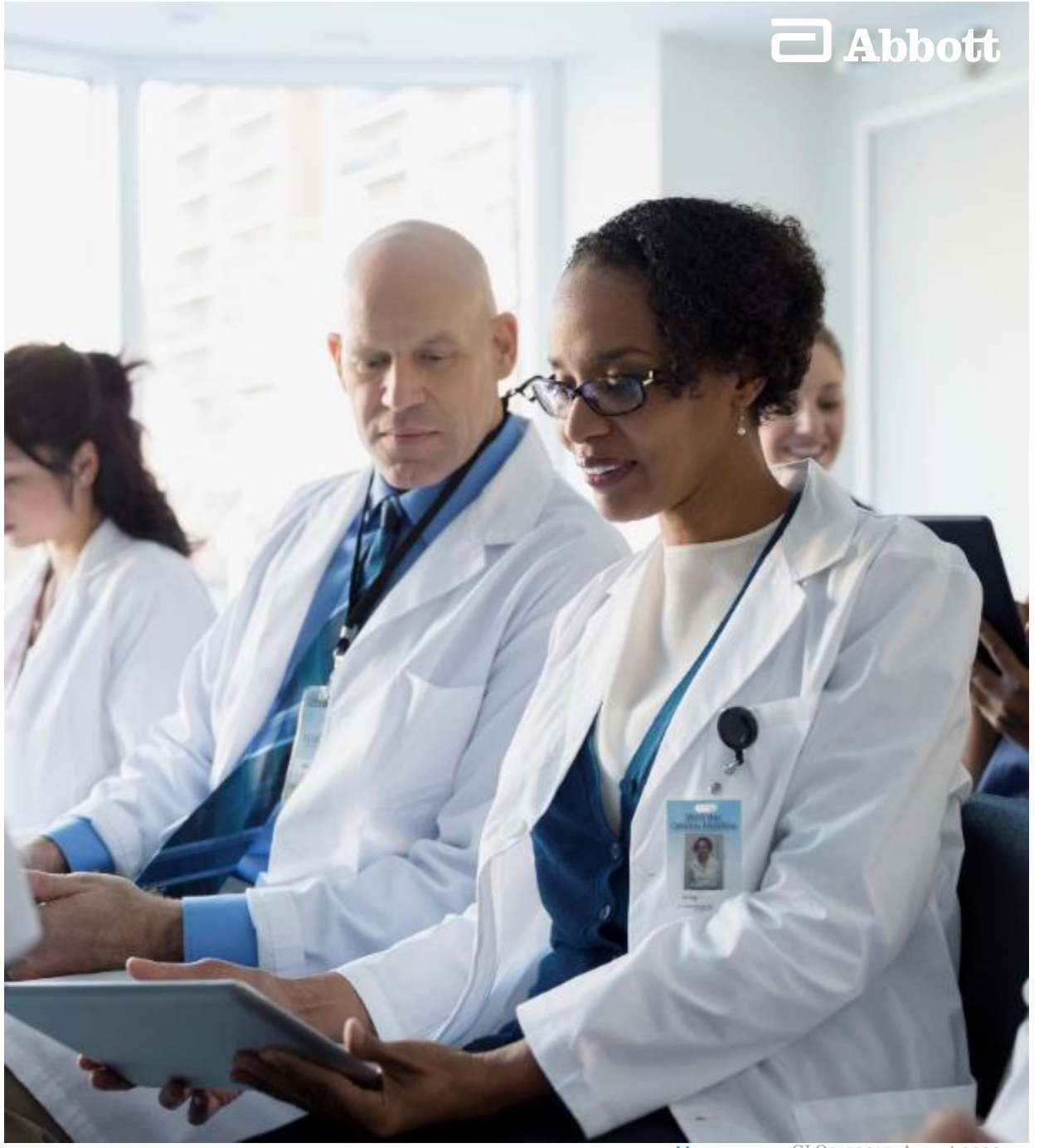

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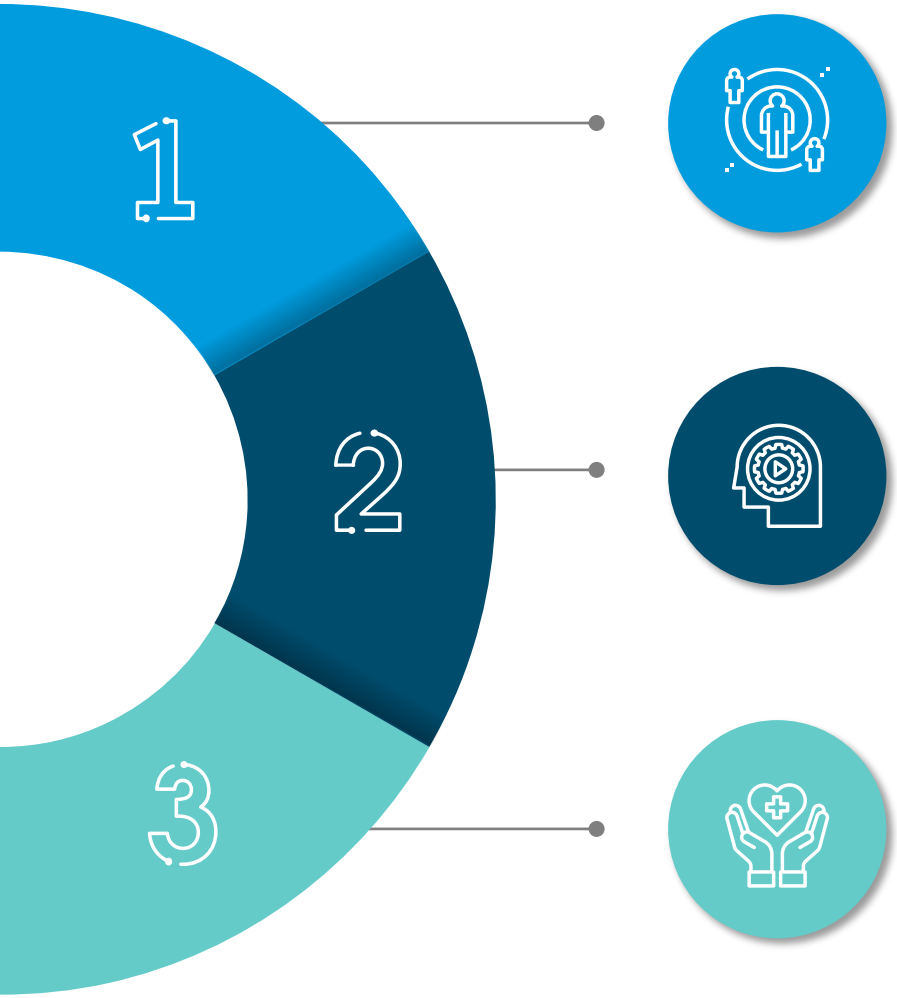
Presentation outline

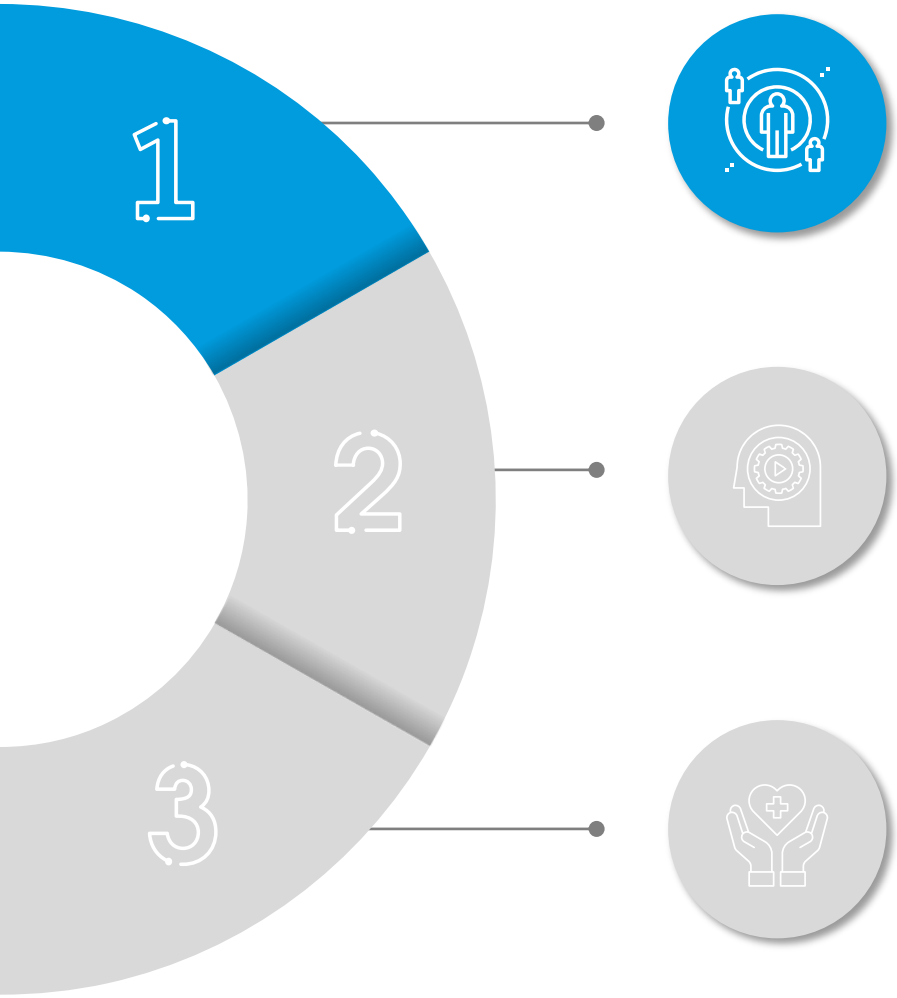


Impact of menopause on behavior & adherence

Behavioral frameworks to analyze adherence

How can healthcare professionals deal with medication adherence in menopause setup

Presentation outline



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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.

3 axes of adherence[1]

FULFILMENT
of a treatment means that the patient has received the medicines prescribed by the doctor[1,2]

PERSISTENCE
of a treatment means that the patient has taken the medicine over the initially intended duration[1,3]

COMPLIANCE
with treatment means that the patient has taken the medicines as prescribed[1,3]

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.

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Menopause – a crucial moment in women's lives

Menopause occurs on average at 50[4] y.o., – one of the most crucial age in the lives of many women, as at this age

1. Careers are usually at peak[5]
2. Children are starting their own adult life[6]
3. Parents are often aged and sick and may require attention/care[6]

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 taboo[9]

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 taboo[9] 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 flushes, menopausal women may suffer from depression, anxiety, sleep deprivation and cognitive impairment.[11, 12, 13]

Impact on the professional environment

Hot flushes 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

Approx. 31%, 45.6%*[15]

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 adherance 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-Garcia 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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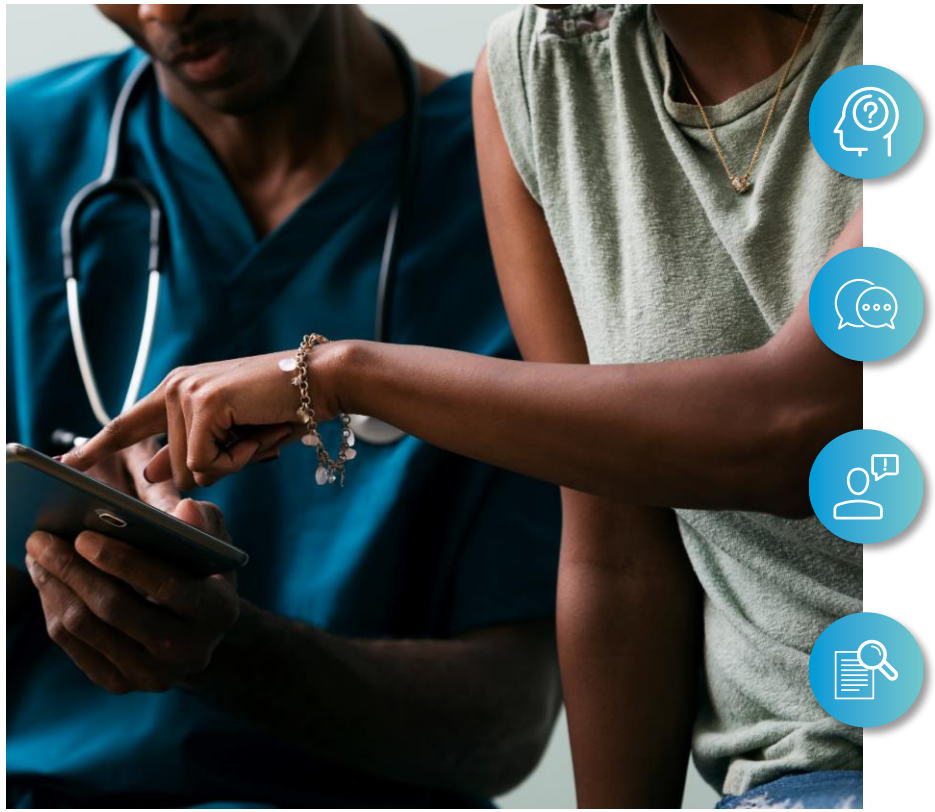
What are the reasons for non-adherence?



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

These still form the basis of many interventions

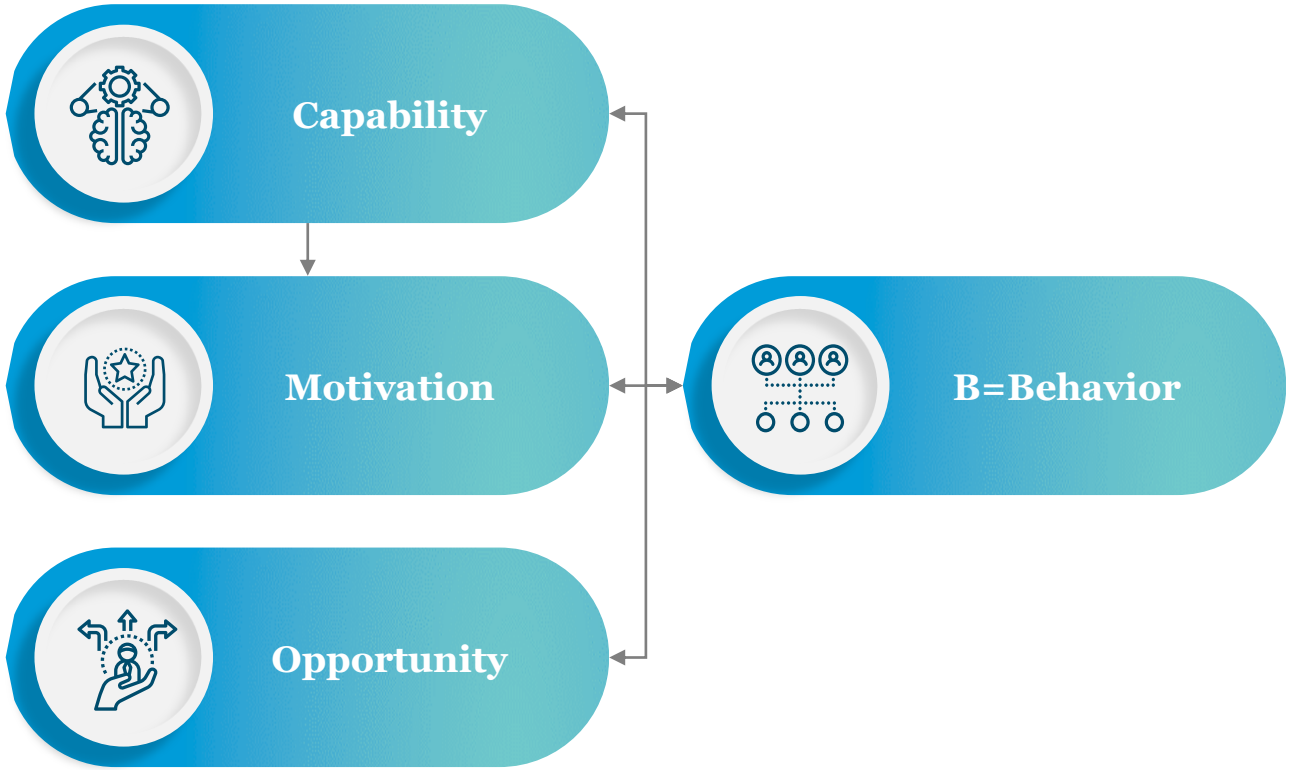
But interventions which provide information or reminders are not effective for those who are non-adherent[19] (e.g. Choudhry et al, 2017)

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 framework[20]
- **Incorporates all the factors which have been found to influence health-related behaviors**, and puts then 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-B[21]

ehps.net/ehp applying COM-B to medication adherence

original article

Applying COM-B to medication adherence

A suggested framework for research and interventions

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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; Sabaté, 2003). Medication non-adherence leads to reduced clinical benefit, avoidable morbidity and mortality and medication wastage (DiMatteo, Giordani, Lepper, & Croghan, 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; Sabaté, 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 (Ley, 1988). 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 behaviours 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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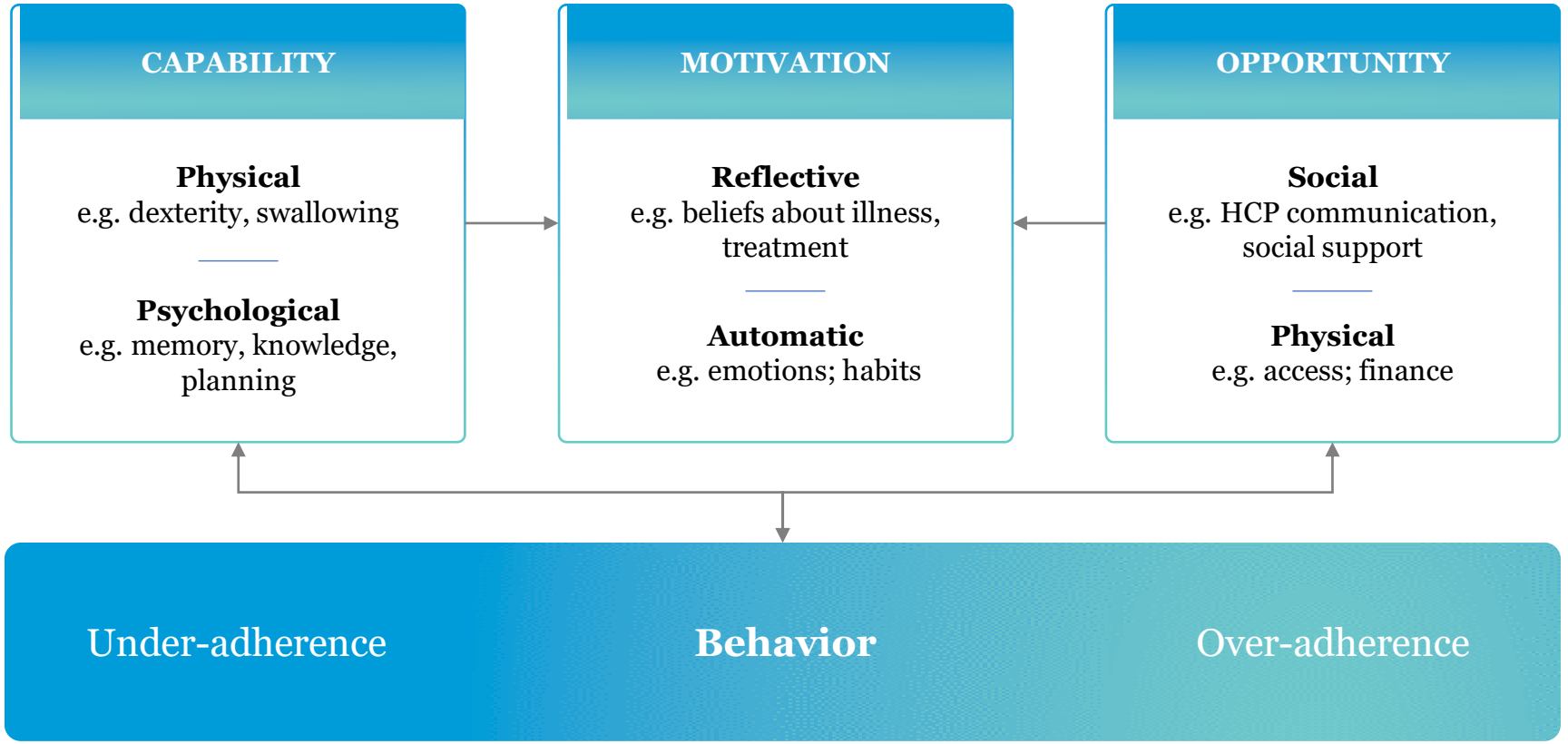

21. Christina Jackson, Lina Eliasson, Nick Barber and John Weinman: Applying COM-B to medication adherence: a suggested framework for research and interventions, The European Health Psychologist, Jan 2014 [Accessed 26 June 2020], https://pdfs.semanticscholar.org/bfdb/62f5430b90243959e8a989abf5ddb12ee32b.pdf

Applying COM-B framework to medication adherence in menopause

*confidence in one's own ability to do something

CAPABILITY

- Poor knowledge of menopause/**available treatments**
- Poor understanding of risk
- Problems in planning/memory

MOTIVATION

- Beliefs about menopause/ **available treatments**
- Concerns about side-effects
- Low self-efficacy*
- Mood disorders - particularly anxiety & depression.
- Low habit strength (weak medicine-taking habits)

OPPORTUNITY

- Complexity of regimen in patients with comorbid conditions
- Beliefs/support of partners & caregivers
- Lack of perceived support from HCP
- HCP reluctance to move to other treatments

Under-adherence | **Adherence to daily menopause medication** | Over-adherence

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Implications for changing adherence behavior

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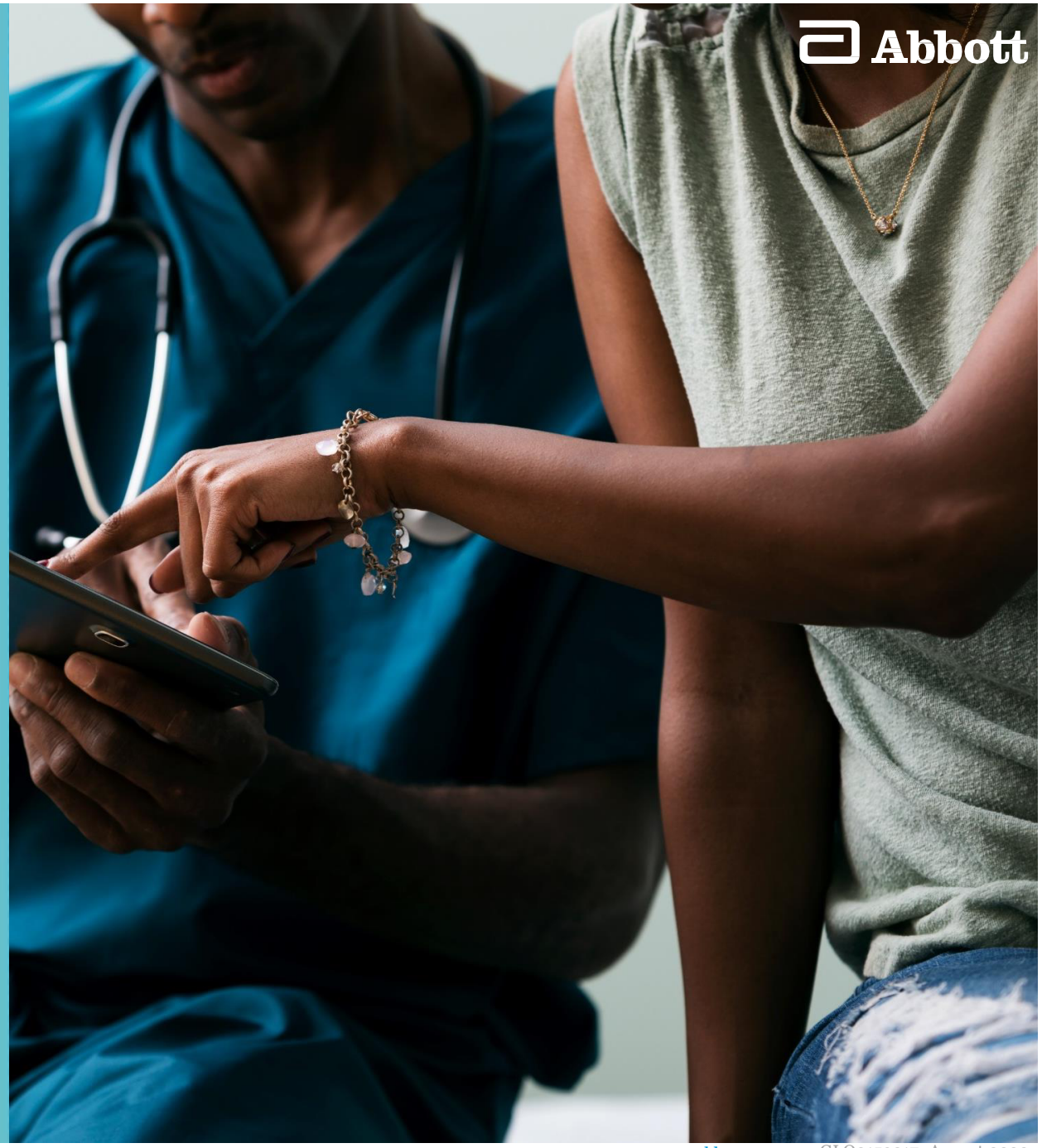
Information is necessary but **not enough** to produce or change a behavior like adherence for most people



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

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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!

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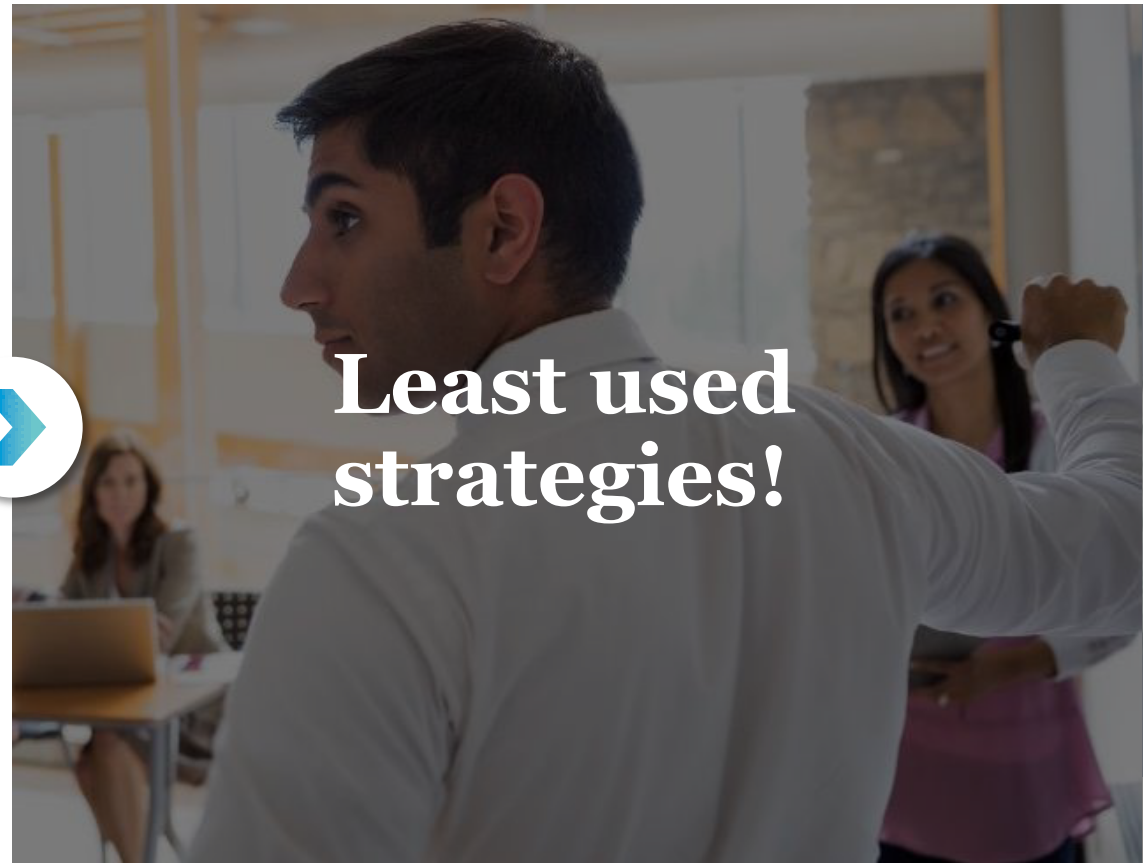
Most effective communication strategies to influence the behavior of others

- Collaboration
- Curiosity
- Nonjudgmental
- Empathy
- Other-focused



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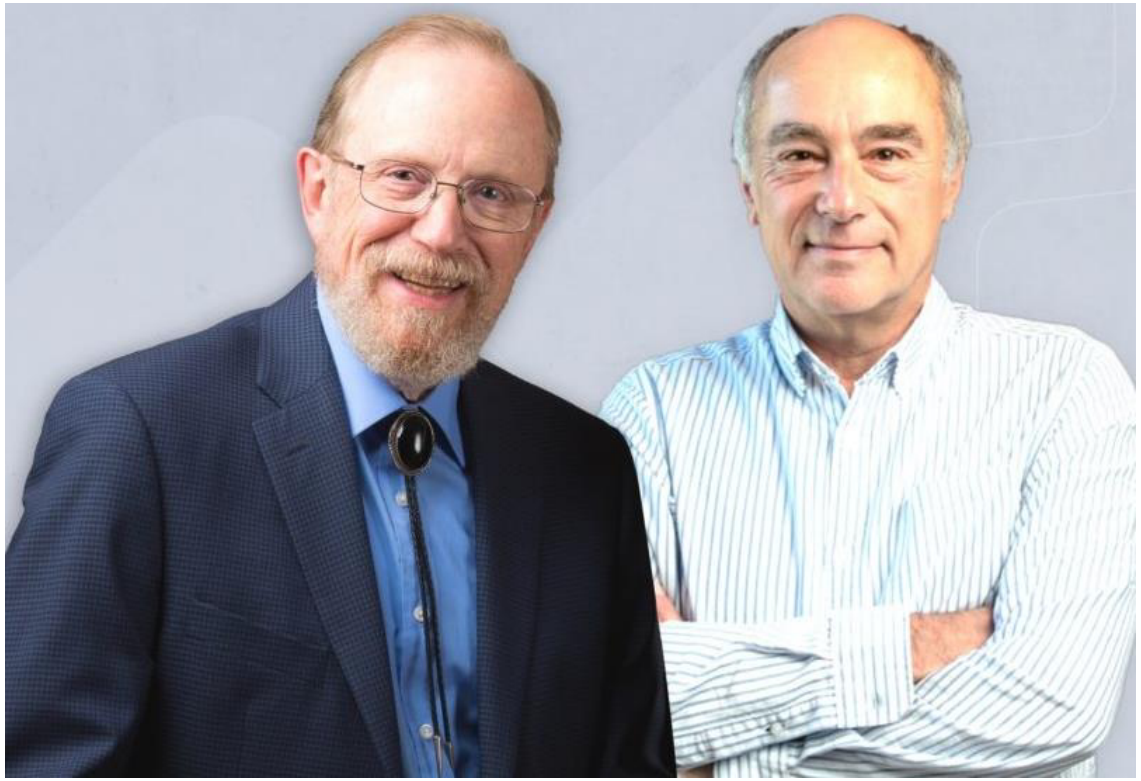
A different approach is needed…….
Motivational Interviewing



> A client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence[23]
>
> 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!

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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

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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

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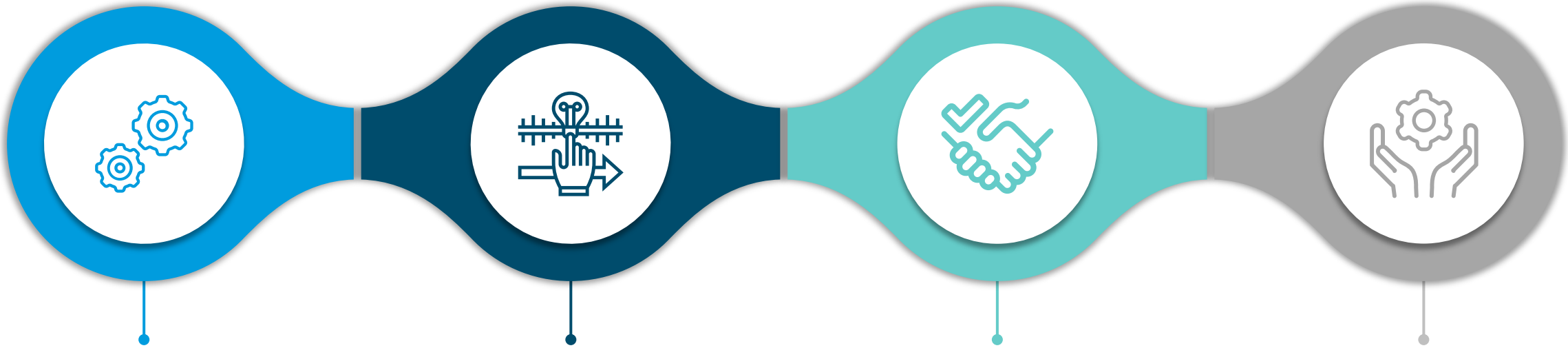
4 Basic Principles of Motivational Interviewing



Express empathy

Develop and explore discrepancy

Deal with discord

Support self-efficacy (confidence)

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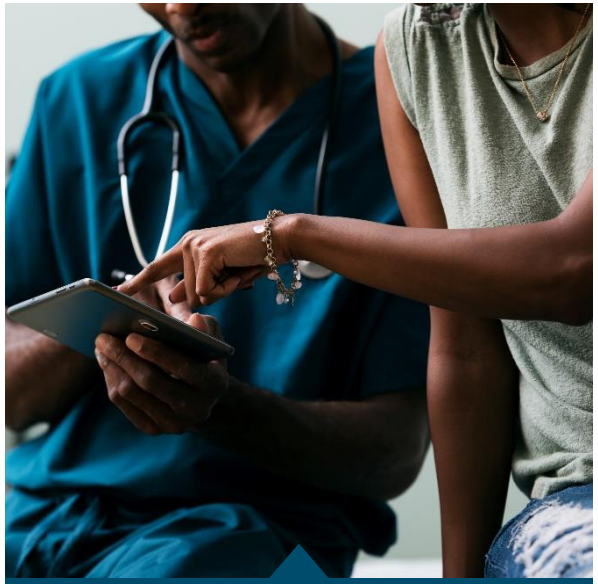
Basic Skills in MI: Oars

Open questions

Affirmation

Reflection



Summary

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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?

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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?

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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"

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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..."

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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?

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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

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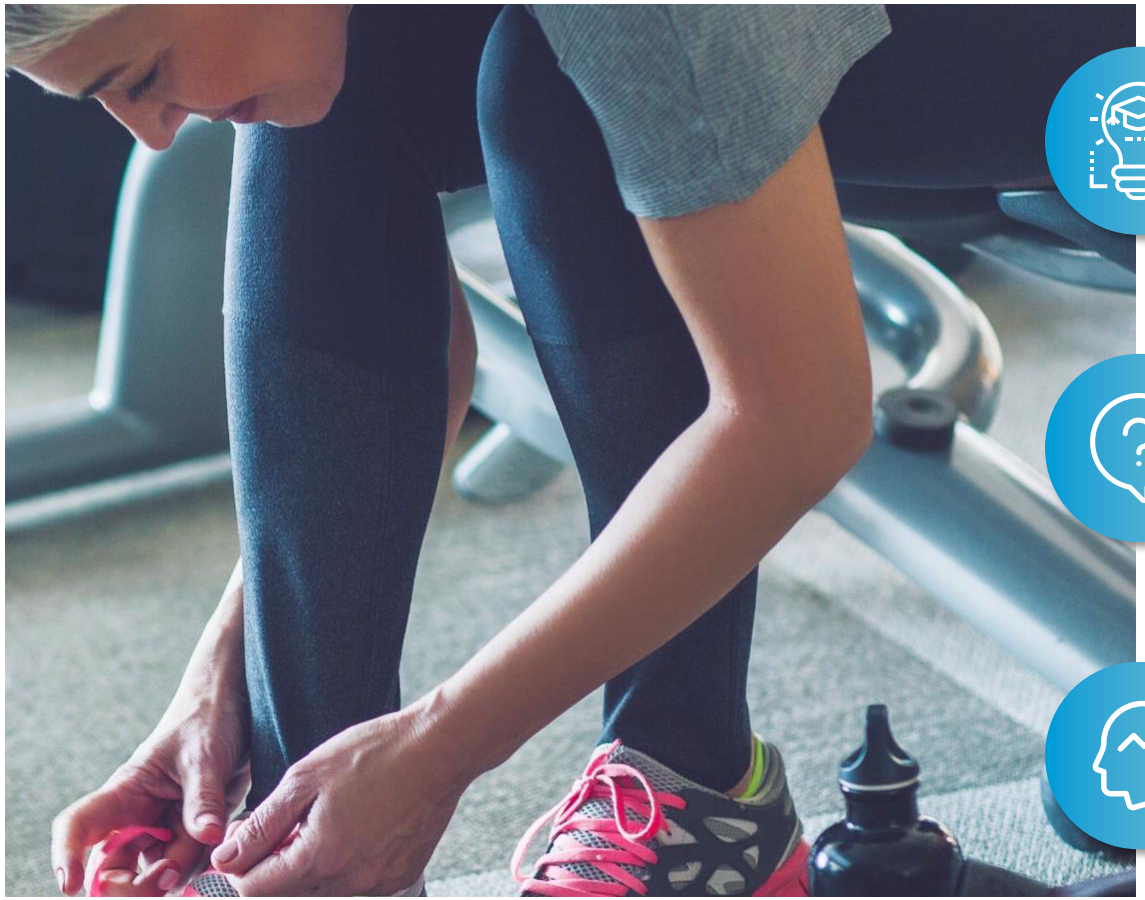
We don’t have enough time …



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

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Dealing with emotional problems

Cognitive Behavior Therapy (CBT)

Cognitive Behavior Therapy for Menopause[24]

Physical Symptoms
Tension, butterflies, heart racing

Behavior
Avoid situations, overeating, doing too much

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

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/

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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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Thank you!