



Change Management

Presented by
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Overview

- What is change and what does it mean for us?
- The rehabilitation process and change
- Different approaches to and models of change
- A short case study



What does it mean?

- Think of changes you have needed to make and then think about:
- How did you feel about having to make those changes?
- How did you begin making the changes?
- How easy or difficult was it to make the changes?
- How long did it take you to make those changes?



What is change?

- Dissatisfaction + an achievable alternative = change



What can we do to help?

- Patients come to us because they are dissatisfied (struggling to participate in conversations, feeling “left out”, unable to cope with head noises etc)
- We need to provide alternatives – “enabling” role
- We can “enable” patients to change



The Rehabilitation Process and Change

- Chronic illness or disability cuts across people's lives
- Change is forced upon them
- Rehabilitation is about supporting them as they work through those changes



What are the changes?

Changes in

- attitudes
- beliefs
- values
- knowledge
- behaviour

All these changes need to be addressed for the rehabilitative process to be successful



Heraclitus says.....

Heraclitus was an ancient Greek philosopher, who maintained that “you never step into the same river twice”



Two worlds

External world

- The river never stays the same
- Always changing
- In constant flux

Internal world

- The “you” who steps into the river today is not the same “you” who steps into the river tomorrow
- Internal reaction to external change is often why external changes succeed or fail



4 Approaches to Individual Change

- **Behavioural** – changing behaviours
- **Cognitive** – achieving results
- **Psychodynamic** – the inner world of change
- **Humanistic psychology** – maximising potential



Learning and the process of change

A definition of learning: “the process of acquiring knowledge through experience which leads to a change in behaviour” Buchanan and Huczynski (1985)

Learning is not only an acquisition of knowledge, but the application of it through doing something different



Change scenarios

- Learn something new
- Adjust to a new way of operating
- Unlearn something

An example: Driving a new car for the first time



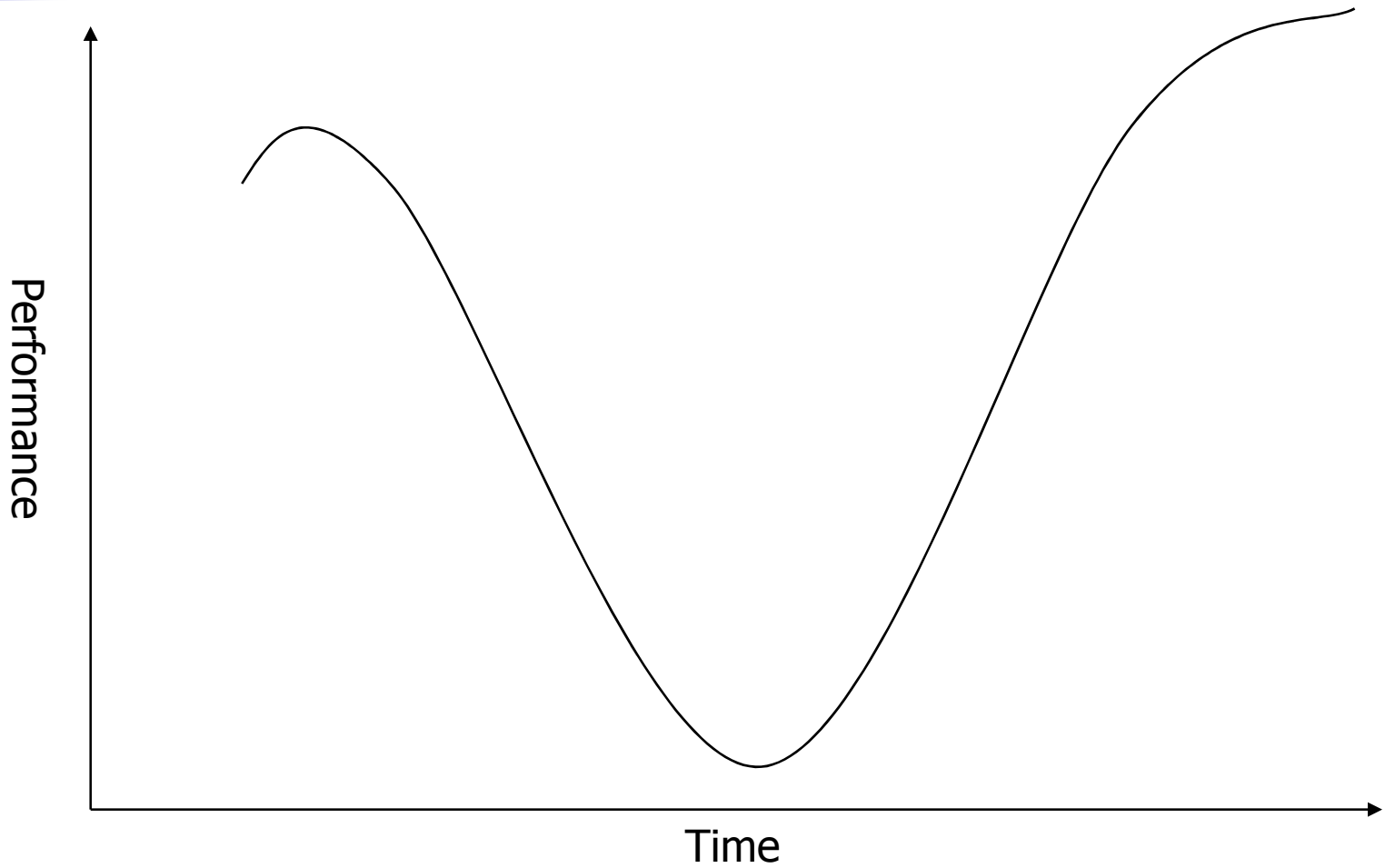
Old

- Automatic responses
- Normal checks
- Turn the key
- Drive off

New

- Have to think
- Controls in different positions (Locate through trial and error, or read manual)
- Driving along, responses less instantaneous – need “psychological space”
- Nervous

The Learning Dip





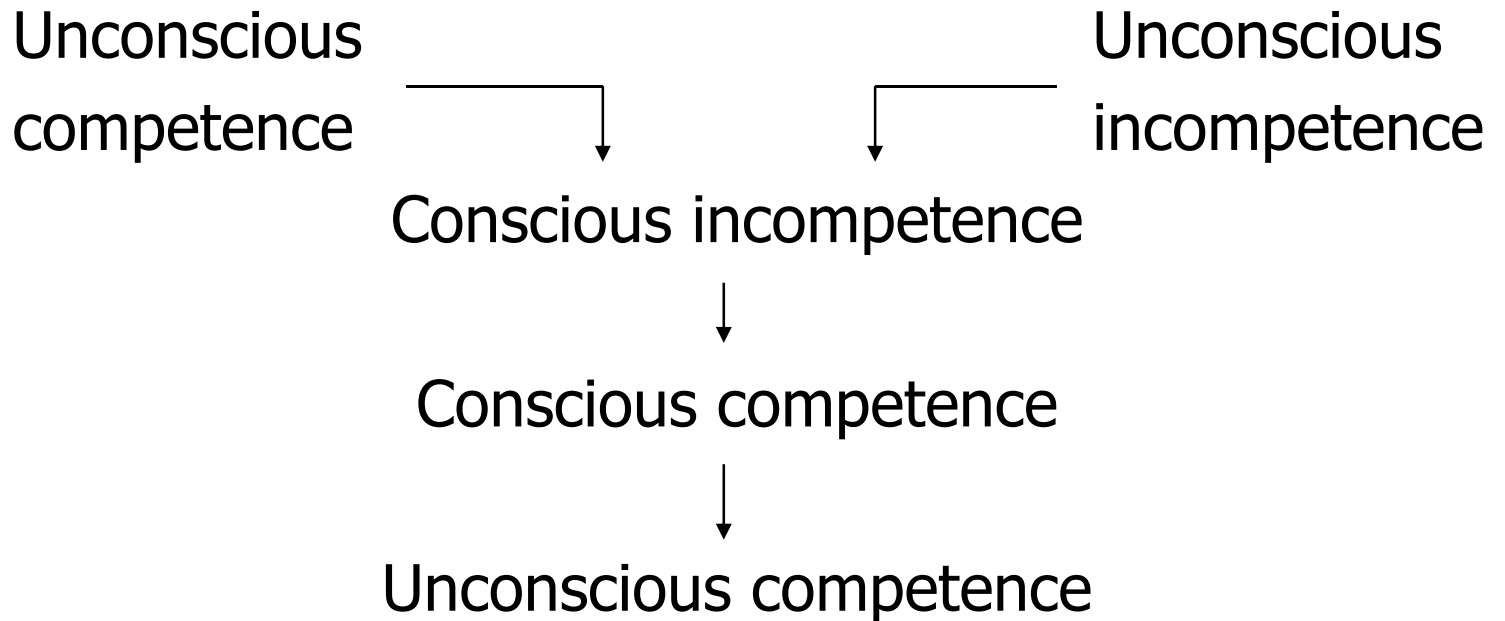
Going through the process

- Reduction in efficiency
- Reduction is effectiveness
- Reduction in confidence levels
- Increase in anxiety



Learning theories

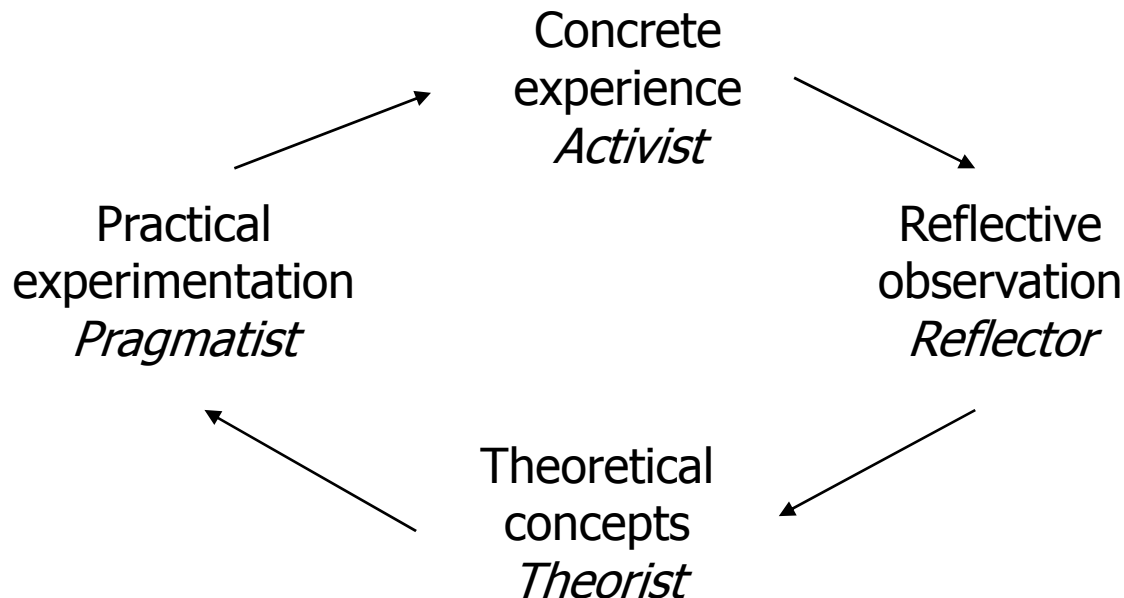
- Gestalt “conscious competence” model





Learning Theories

- Kolb's "learning cycle"



David Kolb "*Model of experiential learning*" (1984)



Kolb's Learning Cycle

The individual:

- Does something
- Reflects upon his experience
- Makes some sense of the experience by drawing some general conclusions
- Plans to do something different in the future

Kolb argued true learning could not take place without someone going through all stages of the cycle



Learning preferences and styles

- **Activist** – wants to experience what he wants to learn and immerses himself in the task
- **Reflector** – wants to think about it first; reflect on other people's experience before taking action
- **Theorist** – how an experience compares to other similar forms of experience
- **Pragmatist** – wants to relate what is happening to his own circumstances; how will the experience help him to achieve his goals



Model of Transformative Change

Edgar Shein

- **Stage One** – Unfreezing: Creating the motivation to change
- **Stage Two** – Learning new concepts and new meanings for old concepts
- **Stage Three** – Refreezing: Internalising new concepts and meanings



Shein: 2 forces at play

- “Learning anxiety” - associated with learning something new: Will I fail? Will I be exposed?
- “Survival anxiety” – concerns the pressure to change: “What if I don’t change? Will I get left behind?”



Shein's 4 associated fears

- Fear of temporary incompetence
- Fear of punishment for incompetence
- Fear of loss of personal identity
- Fear of loss of group membership



What gets in the way of change?

- Resistance to change – when individuals do not or cannot embrace changes



Shein's 2 Principles

For transformative change to work:

- Survival anxiety must be greater than learning anxiety
- Learning anxiety must be reduced rather than increasing survival anxiety

How do you reduce learning anxiety?



Recommendations by Shein to increase the learner's sense of psychological safety through:

- A compelling vision of the future
- Formal training
- Involvement of the learner
- Informal training of relevant family groups/teams
- Practice environments, coaching, feedback
- Positive role models
- Support groups
- Consistent systems and structures



Health Behaviour Models

- Health Belief Model (Rosenstock, 1974)
- Theory of Reasoned Action (Ajzen and Fishbein, 1980)
- Stages of Change Model (Prochaska and DiClemente, 1982)
- Health Action Process Approach (Schwarzer, 1992)



Health Belief Model

This is the oldest model

- When people are pressured to change, individuals weigh up the pros and cons
- Behaviour depends upon the perception of susceptibility to disease, its seriousness, costs and benefits of changing
- Criticised as seeing people as glorified accountants
- Doesn't take into account environmental and social factors



Theory of Reasoned Action

- This attaches more weight to the influence of significant others
- Suggests behaviour can be predicted by a person's intentions - their attitudes, beliefs, perceptions of how others expect them to behave
- Criticised as too dependent on people's ability to rationalise and ignores important drives that affect motivation and attitudes



Health Action Process Model

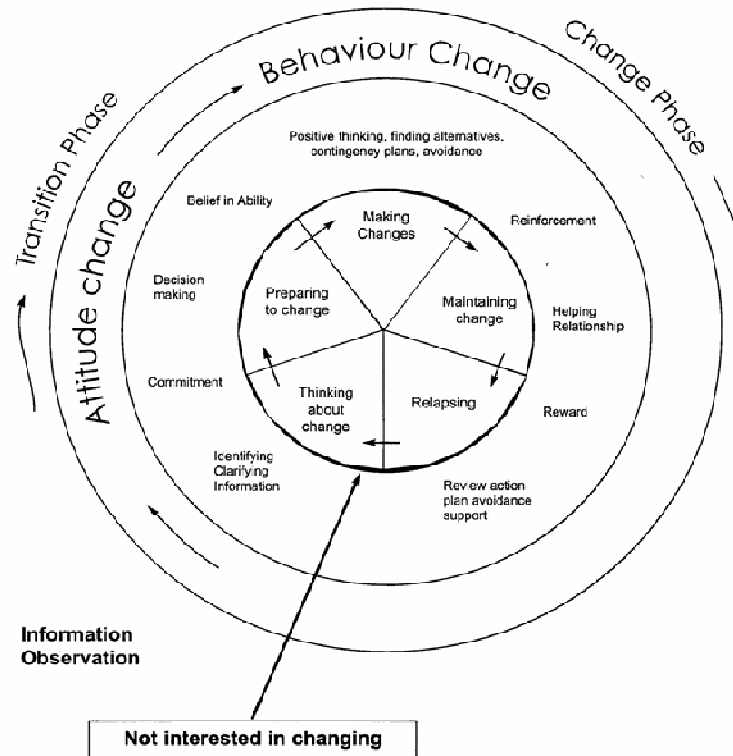
- Recognises the importance of primitive drives
- Incorporates concept of self-esteem - ideas about our appearance, intelligence, physical skills, perception of how others will react
- Practising decision-making skills and assertiveness may be essential before change can occur (Schwarzer, 1992)
- Criticised for not considering emotional factors such as denial or fear



Stages of Change Model

- Suggests there are distinct changes that people go through to change behaviour
- Individuals can remain at one stage or another for a long time but will work their way through them
- Our role is to identify the patient's stage and support them through the process of change

Stages of Change





Adapting to Change

It is believed that there are four stages to adaptation:

1. Denial whilst we ignore the problem
2. Anger about the situation we are in
3. Accepting that there is a problem
4. Facing up to it and dealing with it



Transition and Change

- Transition = change + the human dimension
- Dissatisfaction + achievable alternative = change



Transition

- Psychological / emotional responses to a situation where change is needed
- Where we help patients acknowledge, understand and work through the process of creating change, change is more likely to be successful



An Example

- Jim Parker, age 45
- Occupation – self-employed builder
- Married with 2 teenage daughters still living at home
- Mild bilateral SNHF hearing loss
- Tinnitus onset – gradual over past 3-4 years
- High pitched hissing noise both ears and in head



Psychosocial profile

- At home: irritable with family and family irritable with him!
- Social – “what social life?” Too busy working!
- Work – 7 days a week (6 days out on the job / 1 day paperwork)



Emotional / Attitudinal aspects

- Tinnitus is to blame for his stress
- Not sleeping (can't get to sleep at night because of tinnitus noises)
- Worried about relationships at home
- Worried he can't keep up with work commitments
- Stressed by complaining customers wanting job done "yesterday"!



Where was Jim at assessment?

Using the 5 Stages of Change Model

- Was it “Not interested in changing” or was it “Thinking about change”?.....
- Been to GP, then to see ENT but had been told nothing could be done about tinnitus and he’d have to learn to live with it
- However, there had been a “BUT” by ENT – “But I’ll refer you to Hearing Therapy”.....
(This could have been to any specialist clinician who has responsibility for tinnitus management)



Reminder - Shein

4 fears and perpetuation of survival anxiety:

- **Fear of incompetence** – Jim had been told that nothing could be done; he had no reason to disbelieve; in fact, he did believe it, and so his anxiety grew
- **Fear of punishment for incompetence** – his tinnitus was punishment enough, but now his family would expect him to “learn to live with it”
- **Fear of loss of personal identity** – inner turmoil over how was he supposed to learn to live with it; his own beliefs were that he couldn't. This made him a failure
- **Fear of loss of group membership** – what had been a stable equilibrium in the family was now destabilised and this was having disturbing effects



What actually happened to Jim?

- Jim came along for his appointment because he was “desperate”!
- Assessment gave the opportunity to “identify, clarify and inform” Jim
- After the assessment he was relieved of some of his “survival anxiety” because he had found out something could be done to help him
- He was now in a better position to think about making changes. He agreed to attend the programme (commitment) and believed he would be helped to prepare to make changes, so “learning anxiety” was reduced as far as possible



Jim and the group

- Jim joined a group of seven others for the first meeting of the programme
- Good rapport established early between group members because they “we all in the same boat”!
- At last he’d found others he could identify with



Working individually

- Just as rapport needs to be established early in the group setting, it's the same when working one-to-one
- Good communication skills – listening carefully, reflecting back, agreeing goals etc
- Empathy not sympathy



Back to Jim and the group

- Group members are asked to undertake certain tasks between sessions
- Part of “preparing to change” (Stage 2)
- Reinforces commitment
- Leads to belief in their ability to make changes



Jim and the new learning

- Jim learned about tinnitus, what it was, why it behaved in the way that it did, and how he could learn to have control over how he reacted to it
- He easily understood the theory behind managing tinnitus
- He learned that he could change his old learned behaviour towards his tinnitus by challenging negative thoughts



Stumbling block.....

- As the weeks progressed, group members returned each week reporting improvements they'd noticed
- Each week Jim returned, reporting he'd been "too busy" to undertake the tasks he'd been set
- Jim also noticed he wasn't progressing as well as the others – getting to sleep was still a major problem



Challenging Jim

- Although each week I challenged Jim when he reported he'd been "too busy" to undertake the set tasks, nothing seemed to work!
- Group members also challenged him, and this had to be managed carefully so as not to make him alienated from the group
- Reward and punishment (behaviourist approach) bears little fruit other than exacerbating feelings of failure and increased survival anxiety state



Finding alternatives

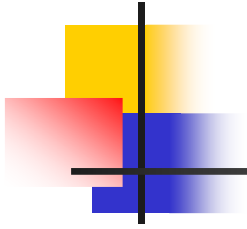
- 4 weeks following completion of the programme, all group members are given a one-to-one appointment to review their progress and measure changes
- Jim's outcomes demonstrated an improvement, but he persisted with the same story of not having time to undertake relaxation practice



Further investigation

Detailed questioning regarding how he actually spent his days led to some enlightenment:

- Woke up tired every morning
- 12 hour working days the norm
- Rarely took longer than 30 minutes to each lunch
- Arrived home at 7pm most evenings
- Dinner always ready for him
- Fell asleep in his chair in front of the TV
- When it was bedtime, he'd toss and turn as his "tinnitus kept him awake"



!



Identify what to change and how to change it

Jim's tinnitus was still a problem because:

- He wasn't using relaxation
- He didn't have time to use relaxation
- He fell asleep in the chair as soon as dinner was over
- When bedtime came, he'd already been asleep so had difficulty getting back to sleep
- Identify target problem – change his habit of falling asleep in his chair after dinner



How?

- A programme of sleep management (numerous approaches to this including using CBT approach)
- In this case, one session of hypnotherapy



Jim fixed it!

- Jim returned for follow-up 2 weeks after the hypnotherapy session
- Reported session had been successful
- Had not fallen asleep in his chair once since the session
- Went to bed at bed time, no problem with tinnitus
- Woke refreshed every morning
- Relaxation exercise after his morning shower
- Outcome measure demonstrated substantial change



Stages 4 and 5

- Maintaining change and action plan for relapse avoidance support:
- Discussed with group in final session of programme
- Again individually at review
- In Jim's case, at his hypnotherapy follow-up
- Repeat OM questionnaire one year on



Thank you

Question time



References

- Azjen I, Fishbein M (1980) *Understanding Attitudes and Predicting Social Behaviour*. Englewood Cliffs. Prentice Hall
- Cameron W, Green M (2004) *Making Sense of Change Management. A Complete Guide to the Models, Tools and Techniques of Organisational Change*. Kogan Page
- Prochaska JO, DiClemente CC (1982). Transtheoretical therapy toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*. 19(3), 276-287
- Rosenstock IM (1974) The Health Belief Model and preventative health behaviour. *Health Education Monographs*. 2:354-386
- Schein E (1992) *Organisational Culture and Leadership*. (2nd ed) Jossey-Bass
- Shwarzer R. 1992, Self Efficacy in the Adoption and Maintenance of Health Behaviours: Theoretical Approaches and a new model. In R. Schwarzer (ed) *Self Efficacy: Thought Control of Action*. 217-243, Hemisphere