**BEHAVIORAL OBJECTIVES**

After reading this newsletter the learner will be able to:

1. Discuss common population-specific factors which often contribute to adolescents, adults and aging adults' inability to make lifestyle changes related to their health.

2. Discuss implications for healthcare providers when caring for a "non-compliant" patient.

An adolescent practices unprotected sex, has four children, and has no support system; a middle adult smokes 3 packs of cigarettes a day and has a chronic cough and emphysema; an aging adult with severe hypertension has a history of two MIs and does not take prescribed blood pressure and cardiac medications. When a problem related to health is identified, a prime role of the healthcare professional is to educate the patient concerning lifestyle modification and health promotion. After patients are taught and understand what they need to know, a change in behavior is expected. If the problematic behavior isn't changed, a negative judgment is commonly made. Such patients are often labeled as “non-compliant”. But, education doesn't necessarily change human behavior. Consider yourself. Surely there has been a behavior you wished to change, such as saving money, or even one related to health, such as losing weight. You are knowledgeable about what you need to know – what foods to eat and the importance of exercise. Perhaps you are successful for a day or two, but then slide back into your previous pattern. You are "non-compliant". Why?

This newsletter will discuss common population-specific factors that may contribute to adolescents, adults and aging adults' inability to make healthy lifestyle changes. Implications for healthcare providers when caring for a "non-compliant patient will also be discussed.

**NON-COMPLIANCE**

"Non-compliance" may be defined as "unwillingness to practice prescribed health-related behaviors." By mere definition, there is an underlying tone that the patient who does not follow through with instructions or advice is defiant, disobedient, and unwilling to cooperate. However, there are complex factors that may prevent adolescents, adults and aging adults from automatically following through with health recommendations.

Patients are more likely to comply when they believe that they are susceptible to an illness or disease that could seriously affect their health, that certain behaviors will reduce the likelihood of contracting the disease, and that the actions taught them are less threatening than the disease itself. Factors that may predict noncompliance include a past history of noncompliance, stressful lifestyles, contrary cultural or religious beliefs and values, lack of social support, lack of financial resources, and a compromised emotional state. People living in adverse social situations, such as battered women, homeless individuals, those living amidst street violence, the unemployed, or those in poverty, may purposefully defer following medical recommendations until their acute socioeconomic situation is improved. The rising costs of health care, and the growing number of uninsured and underinsured patients often forces patients with limited incomes to choose between food and medications. Some factors are also related to the patient’s age and development. Considerations that may prevent adolescents, adults, and aging adults from automatically following through with a prescribed plan are outlined below:

**POPULATION-SPECIFIC CONSIDERATIONS**

**Adolescence:**

Developmental factors can significantly lead to “noncompliance” during the adolescent period, 12–18 years. In an attempt to establish personal identity, finding out who they are, what their purpose is, and where they belong, adolescents typically rebel against authority, conform to peer pressure, and engage in risk-taking behaviors.

Adolescents may be more likely to adhere to education related to health promotion, if they are approached more as peers. Consider using your first name when caring for an adolescent. Introducing yourself as Miss Todd or Mr. Jones may signal an authority figure to the teenager. Additionally, health education by “preaching” to teens will likely be rejected – “Don’t smoke!”; “Eat right!”; “Don’t drink!” Teens are quick to reject an adult who directly tells them what to do or attempts to impose his or her personal values on them. Instead of “complying”, they will likely do the opposite of what is advised. Providing privacy, establishing a rapport and trusting relationship with the adolescent, exchanging ideas, listening, answering questions, and clarifying misinformation is essential.

Adolescents have the cognitive ability to understand cause and effect, such as that smoking causes lung disease, but may not have the emotional or social ability to abstain from behavior that is unhealthy.
Peer pressure and the need to fit in are the overwhelming influencing forces during this period. If the adolescent’s peer group has a candy bar on the way to school, that’s likely what the diabetic teen will eat, too. They may very well know what to eat, but the influence of peers can overpower that knowledge. If what is important to the teen is not considered in health teaching, the teen will do as his or her peers do and not "comply." Understanding and accepting the teen’s values, without judgment, may lead to a more successful outcome – “It must be frustrating to eat differently from your friends. Let’s see if we can plan your diet around what’s important to you.”

Teens live for the here and now. Developmentally, their smoking and fitting in is. For example, lung disease is not of concern to the teen, behaviors are common at this age. Additionally, the risks future outcome of their actions. Consequently, risk-taking concern is for the present, with often little concern for the any ill effects of a behavior won’t happen to them – “I’ll be like over-consumed by adults, such as food, cigarettes, alcohol and meet personal needs, including those related to health. To cope demands inherent during adulthood, little time may remain to motivation, personal energy and time. Because of increased Making lifestyle changes often takes considerable and middle adults, 20 – 65 years. Parents, is a challenge and stressor for many adults. Career, financial responsibilities, as well as caring for aging parents, is a challenge and stressor for many adults. Making lifestyle changes often takes considerable motivation, personal energy and time. Because of increased demands inherent during adulthood, little time may remain to meet personal needs, including those related to health. To cope with life pressures, a variety of substances may be used and over-consumed by adults, such as food, cigarettes, alcohol and drugs. Knowledgeable adults may subconsciously believe than any ill effects of a behavior won’t happen to them – “I’ll be like the 90 year old who has smoked since age 13, still smokes and has never been sick a day in her life.” Or, they may plan to make the necessary lifestyle change during a time of less stress – “I’ll quit drinking as soon as my teenager is out of the house.” The decision to make a change in behavior may continuously be put off, as stressful situations continue. The motivation needed to admit to a problem, and then make the necessary changes, may be very high during this period. It can be as simple as an upcoming reunion being the impetus to lose weight. Or, it may be a significant health event, for example, liver disease, as the trigger to quit drinking, or having a heart attack may be the motivator to quit smoking. Such consequences of unhealthy behaviors fundamentally shake the “it won’t happen to me” mentality. However, the person may not choose to change their behavior – “I will die someday anyway, so I’ll do what I please.” Compliance is a choice, as difficult as not changing an unhealthy behavior is to family members, as well as healthcare professionals, to understand.

Obtaining an honest assessment of unhealthy lifestyles in adults can be challenging. Some patients will answer direct questions, such as, “Do you drink alcohol?” with a “No” or a response, “Oh, just a beer now and then.” By giving the “socially acceptable” answer, what the patient thinks you want to hear, the patient feels he or she can hide a problem, and avoid hearing what they already know – how unhealthy excessive alcohol consumption can be and what they need to do about it. Asking opened-ended questions, such as, “How are you coping with all the responsibilities you told me about?” may be more helpful. When information is shared, not judging the patient is essential. Instead, if the patient shares, “Alcohol is about the only thing that numbs my pain”, a supportive response might be, “There are a lot of resources available if you think drinking is becoming a problem. Just let me know.”

Adulthood:

Multiple age-related factors may contribute to “non-compliance” in young and middle adults, 20 – 65 years. Maintaining intimacy, nurturing children and feeling productive are important components in this developmental period. However, combining family, childrearing, career, financial responsibilities, as well as caring for aging parents, is a challenge and stressor for many adults.

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Aging Adult Period:

“Non-compliance” is a major problem for many aging adults, over 65 years of age. Realizing their mortality, this age-group is commonly highly motivated to practice healthy behaviors. However, there are many age-specific factors at play, such as living alone without a support system or having visual or auditory impairments. New situations, including those related to illness, are often anxiety-producing and may be confusing for many aging adults. The patient’s ability to understand and remember what has been advised during patient teaching may be hindered. Instructions may be misinterpreted and, therefore, not adhered to. More than 50% of aging adults fail to adhere to instructions given at discharge.

“Non-compliance” with medications is a major concern in older adulthood. One drug is taken daily by 90% of aging adults, with an average of 4.5 different prescription or over-the-counter medications taken each day. It is estimated that 125,000 elderly deaths occur each year, and many more hospitalizations because of “non-compliance” with cardiac drugs alone. The elderly may forget to take medications as scheduled or may forget whether they’ve taken the medication or not. Others may not be able to afford to buy them or may cut pills in half to save money. It is also common for aging adults to independently stop taking prescribed drugs if an adverse effect, such as constipation, occurs.

Measures, such as involving the patient in scheduling drugs convenient to his or her routine, and, if possible, involving family members with administration, may help with “compliance”. Devising a system to help the patient remember to take medications as prescribed, such as a weekly or monthly pill organizer, is helpful.

Because the term, “non-compliance” connotes judgment – the patient refused to comply with advice or instructions, it should be used cautiously. Using individualized terms, such as “would rather do what peers do” or “misunderstood instructions,” is more appropriate. Population-specific interventions could then be planned to support the patient. When a patient doesn’t adhere to a prescribed plan, a conflict of values may occur between the healthcare provider’s professional and personal values and those of the patient. Care of the patient may then be avoided – “I’m not caring for him, he refuses to accept my help. He keeps drinking and now he has cirrhosis.” Keep in mind, every patient has the right to make his or her own health decisions.

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Jim Maxwell, 15 years old, is admitted for uncontrolled type 1 diabetes.

1. You overhear Jim tell his mother, “I need to get out of here. There’s a big party tonight and everyone will be there.” His response is likely due to the:
   a. influence peers have on this age-group.
   b. denial that he has for a chronic illness.
   c. the fact that he feels so bad.
   d. fear he has of the hospital environment.

2. Telling Jim the long-term consequences of diabetes, if he does not adhere to the prescribed treatment plan, is often not effective because teens commonly:
   a. have difficulty coping with life stresses and responsibilities.
   b. are more concerned with the present than with the future.
   c. have a poor support system and experience social isolation.
   d. get indirect benefits from being ill.

3. To reinforce diabetic teaching and “compliance”, the healthcare provider correctly says to Jim, who is becoming angry with his mother,:
   a. “Since you’re diabetic, you have to always eat what’s on your diet.”
   b. “Your health has to be your focus above anything else.”
   c. “If I were you, I’d be glad your Mom cares so much for you.”
   d. “If you help me, your diet can be planned around what’s important to you.”

4. If healthcare providers use their first name when introducing themselves to adolescents, they will not be respected.
   a. True
   b. False

5. Patient teaching will solve patient “non-compliance”.
   a. True
   b. False
6. Which of the following is appropriate when assessing the health practices of aging adults?

   a. “You take your medications on time, right?”
   b. “Do you have enough money to meet your needs?”
   c. “Tell me how you are doing with taking your medications.”
   d. “Do you have chest pain because you’ve forgotten to take your medications?”

7. Which of the following interventions is priority to initially include in Mrs. Bradley’s plan of care?

   a. Explain to her that she is “non-compliant”, so she feels shame in her disobedience.
   b. Assess for memory, sensory or auditory, as well as financial difficulties.
   c. Call Mrs. Bradley’s children and report her negligence.
   d. Teach her the physiological actions and side effects of her medicine.

8. After determining that Mrs. Bradley is knowledgeable about how and when to take her medications, the healthcare provider should:

   a. keep focusing on the need to comply.
   b. explain to her that taking them when she remembers is okay, if that’s what she’s wants to do.
   c. scare Mrs. Bradley into compliance by telling her she will die if she forgets again.
   d. help devise a method so she’ll remember to take her medications.

Ms. Sam, 36 years old, works full-time and is a single mother of two. She is 55 pounds overweight, but shares, “I can’t seem to stick to a diet or exercise program to get this weight off.”

9. The healthcare provider should identify Ms. Sam’s reasons for not adhering to a diet or exercise program.

   a. True
   b. False

10. Which of the following is likely an age-related factor contributing to Ms. Sam’s overeating?

    a. Excessive pressure from friends to socially eat.
    b. A mechanism of coping with life pressures.
    c. Limitations from difficulty seeing and hearing.
    d. Lack of knowledge about diet and exercise.