Counselling in Chronic Disease Management

Adrian Schoo

A/Prof of Physiotherapy, Rural Health School, La Trobe University
Adjunct A/Prof, School of Medicine, Flinders University

(Motivational Interviewing)
What will be covered

- Client focus in chronic disease management
- Relevance of program adherence
- Principles and characteristics of Motivational Interviewing (MI) or Counselling
- MI is solution-focused and effective. Effect diminishes over time and follow-up is needed
- Importance of fostering ambivalence and using stepwise change talk
- Decisional balance list and SMART goal setting
- Goal ownership & the need to practice MI
Focus (Doak, 1996)

**Professional**
- Anatomy & physiology
- Behaviours to maintain or improve health
- Facts about the disease
- Skills to master health-related behaviours
- Frustration that patients do not do what they should
- Fear about malpractice

**Client**
- Why do I feel bad?
- Behaviours to solve disease problems
- Disease beliefs
- Skills to maintain a “normal” life
- Frustration, fear, depression about living with the disease
- Fear about the future
Generalisation Chronic-Acute  
(Adapted from Lawn & Schoo, 2010)

**Chronic conditions**
- Ongoing
- No cure to be expected
- Client is the expert
- Clients’ decision making and self-management influence health outcomes
- Health outcomes depend on ongoing support services
- SMART and short-term goal setting to meet outcomes over the longer term
- Program adherence is important and can be challenging

**Acute conditions**
- Relatively short episode
- Cure to be expected
- Professional is the expert
- Professional care influences health outcomes
- Health outcomes depend on short-term service provision
- Goals are short term
- Program adherence is expected and less problematic
Relevant Adherence Questions
(Lorig, 1996)

- Is adherence important for the problem?
- Is adherence believed to be important?
- Are problem and strategy understood?
- Are there the needed skills to manage?
- Is there confidence in own ability?
- Is there a willingness to adhere?
- Is adherence punishing or rewarding?
- Is required behaviour too complex?
- Is there the mental/physical capacity?
Rogers appealed on internal ability to control life by:

- Unblocking internal communication
- Taking responsibility for problems
- Recognising causality
- Increasing mobility
- Owning one’s feelings
- Living in present moment
- Recognising and accepting negative feelings
- Increased independence from therapy
General counselling principles

1. Create ambience
2. Listen
3. Ask open-ended questions (e.g., strategic Q)
4. Detect opinions and values
5. Structure by reframing and deframing
6. Ask the miracle question
7. Identify underlying needs
8. Provide opportunities to self-evaluate
9. Explore willingness to change picture album
10. Facilitate a responsible plan
Principles of motivational interviewing (MI)

- Express empathy
- Develop discrepancy
- Avoid argumentation
- Roll with resistance
- Support self-efficacy
Characteristics of MI

- Client centered
- Non-judgmental
- Expressing empathy
- Building trust
- Being collaborative
- Reflective listening
- Increasing discrepancy
- Exploring ambivalence
- Reducing resistance
- Increasing readiness
- Eliciting change talk
- Increasing self-efficacy
MI & Effect over time

- Immediate effect
- Two treatments can be sufficient
- Effect sizes diminish over time (from $d = 0.77$ at post-intervention to $d = 0.30$ at 6-12 months) (Hettema, Steele, & Miller, 2005)
- 6-monthly follow-up sessions are likely to increase effectiveness of MI in the management of chronic diseases

- Although interviewing requires a process, the approach is not rigid (training is available)
- Skills are used to facilitate behavioural change
MI: Advantages & Barriers
(Lawn & Schoo, 2010)

- **Advantages:**
  - Flexible and can be applied in many health settings, and incorporated in models of care
  - Suits many clients with chronic disease
  - Can be used in lengthy as well as short consultations
  - Well suited to support ongoing self-management and behavioural change

- **Barriers:**
  - Provides little formal structure and, as such, requires training of professionals that are not experienced in counselling
Theoretical models used in client-centered counselling

- Health belief models
- Theory of critical conditions for change
- Cognitive dissonance theory
- Trans-theoretical model of change
- Self-perception theory
- Choice theory
- Self-determination and the innate ability to sort things out
MI & self-determination theory
(Markland et al. 2005)

- Involvement leads to relatedness
- Structure leads to competence
- Autonomy support leads to autonomy
Involvement leads to relatedness

- Express empathy
- Explore client’s concerns
- Demonstrate understanding
- Avoid judgment or blame
Structure leads to competence

- Clear and neutral information
- Agree on appropriate goals
- Provide positive feedback
- Support self-efficacy
Autonomy support leads to autonomy

- Avoid coercion
- Roll with resistance
- Explore options
- Encourage change talk
- Client decides what and how to change
How to motivate to become active and to stay active?

‘Inspiration drives action, more action ……… more inspiration’
Fostering ambivalence & Stepwise change talk

**Ambivalence** (promoted by empathy)

(direction is influenced by positively reinforcing client’s speech)

*Desire* → *Ability* → *Reasons* → *Need* → *Commitment* → *Change*
Useful tools for MI

- **Decisional balance list**
  - Benefits/costs for making change or not making change

- **Change plan worksheet**
  - Identify desirable changes, reasons, steps, support of others, realisation of success, enablers & barriers, and back-up plan

- **Readiness ruler**
  - How ready are you to change (e.g., physical activity & diet)? What is needed to increase this?

- **Expectation**
  - What is wanted from the intervention?

- **Goal Setting**
  - Importance of Clarity, Attainability and Payoff
<table>
<thead>
<tr>
<th>Decision</th>
<th>Changing</th>
<th>Not changing</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAYOFF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pros (Benefits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cons (Costs)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Strengths-based approach

(McCashen 2005)

<table>
<thead>
<tr>
<th>Issue(s)</th>
<th>Future</th>
<th>Strengths</th>
<th>Resources</th>
<th>Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stories</td>
<td>Picture</td>
<td>Explore</td>
<td>Identify</td>
<td>Concrete</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SMART goal setting

- Focus on process goals (not outcome goals) (Wilson & Brookfield, 2009)

- Client’s goals need to be:
  - Specific
  - Measurable
  - Achievable
  - Realistic
  - Timely
Target practice enhancement

- Agree together (client and health professional) on one topic appropriate for the session (e.g., increasing level of physical activity)
- Identify what client wants to know about topic
- Provide the requested information
- Identify disease concerns, desired outcome, required steps to reach that outcome, and the barriers that may arise
- Provide additional information if needed
Agree on goals and action plan needed to address clients’ concerns
Provide clarification of goals and action plan, and utilize personal action plan worksheet
Identify client’s confidence in ability to carry out agreed action plan on a scale from zero to 10.
  - In case confidence rates less than seven, identify what needs to happen to make it higher
Evaluate and refine the plan
Agree on one other relevant topic (e.g., diet)
Etc.
Keeping a diary

- Can assist in detecting adherence
- Can assist in detecting levels of physical activity
- Can remind people to exercise
- Can assist in establishing a routine
In conclusion: What has worked

- Identify the individual drivers for participation
- Eliminate barriers
- Process goals work better than outcome goals
- Programs requiring less intensity/structure work better
- Facilitate self-management ownership. Let go of your role as provider of solutions and doing things for clients
- Use strategies such as motivational counselling, follow-up telephone calls, diary
- Whatever the program is, it needs to be relevant to the participant!!!
References

  download.ncadi.samhsa.gov/ken/pdf/toolkits/cooccurring/DDWorkbookAJ1_04.pdf.


http://www.groups.psychology.org.au/chp


http://patienteducation.stanford.edu/programs/cdsmp.html


http://userpage.fu-berlin.de/~health/hapa.htm

http://www motivationalinterview.org

http://www.peersforprogress.org/
Counselling in Chronic Disease Management 2

Adrian Schoo

A/Prof of Physiotherapy, Rural Health School, La Trobe University
Adjunct A/Prof, School of Medicine, Flinders University

(Motivational Interviewing)
Time to Practice: Where to start and how to finish?

To do:
- Open-ended Qs
- What bars you from ...? Have ever thought of...?
- Explore client’s values, goals etc.
- Balance pros & cons
- Ask what is more important, and how they think they can get where they want to be
- Observe cooperation

Not to do:
- Closed Qs
- Question ‘why’ (it causes defence of behaviour)
- Judging and setting your own goals
- Telling what is important
- Telling what to do and how to get there
- Outcome focused, being absorbed in questions, not observing resistance
Application of MI: A case scenario

Role play - Case scenario of a stroke victim

Based on the sample question sections in the handout
(Impact of the problem/disease, desired outcome, feelings/emotion, reality, value, strengths, change talk (solution-focused) and goal setting)

Brief background of client:
Anne is 66 years old. She lives with her husband in a small rural township. Anne had a stroke 30 years ago due to high blood pressure. Just over a year ago she had a second attack that could have been prevented if she would have followed a different lifestyle and had used her prescribed medication. Anne said that she thought she could do without the blood pressure tablets and stopped taking them. She suffered a second stroke as a consequence.

The role play: (I = Interviewer/counsellor, A = Anne)
I: How has the stroke affected you?
A: I cannot move as well any more and my speech is affected, however I have been to the speech pathologist and we are well on track. I think that I am back to normal to be honest.
I: You are saying that is has a great impact still on your ability to move and go where you would like to go?
A: That's right.
I: Are you saying that this affecting you socially?
A: Indeed. I retired only a few years ago and was really enjoying myself going to the local CFA, Red Cross and Senior Citizens. I also went to craft sessions although I do not really do much else but talking there. I am not a very crafty person.
I: So you are saying that as a result of your stroke you are not participating in social activities any more?
A: That's right. The only thing I do is attend the stroke support group because the speech therapist (speech pathologist) picks me up.
I: Do you believe that not being able to move well is affecting you in another way, such as doing house duties or so?
A: Indeed, I can shower and dress myself, but I get home help. Luckily my husband is a good cook, so I am not missing out on having good meals.
I: In other words, all is pretty well on track besides you not attending any of your social functions?
A: That's correct.
I: If somehow you would be able to paint me a great picture, and you would paint yourself doing something that would make you feel really happy, what would you paint?
A: I would paint myself in my car driving to all the different venues.
I: What does it mean for you to be able to drive your car?
A: I can fill in my day differently than what I do now. All I do is watching TV.

Madeleine Schoo (CRT)
Motivational Interviewing and Choice Theory in chronic disease management

Questions asked during motivational interviewing may differ between clients and settings. For example, a person who is at risk of developing heart disease, diabetes and/or osteoarthritis due to overweight/obesity but has no symptoms is likely to require a different approach than someone with symptoms. It is useful to explore the impact of a chronic disease (CD) on the client (e.g., symptoms, function, social participation); the desired outcome as well as the client’s personal values around management of the CD and the ambivalence to change behavior. Change talk can tap into individual strengths (appreciating strengths) and intrinsic motivation. Finally, outcomes should be solution-focused and achieved by utilizing SMART goal setting. The following sample questions show how a motivational interviewer can assist the client in coming up with a plan.

<table>
<thead>
<tr>
<th>Sample questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>How is the chronic disease (CD) affecting you physically? Response …</td>
</tr>
<tr>
<td>Are you saying that ‘response’ is restricting you or stopping you from doing/visiting/attending: ……….</td>
</tr>
<tr>
<td>If you did not have CD, how would things be different? Response …</td>
</tr>
<tr>
<td>To what extent has CD stopped you from participating in social outings/physical exercise/home duties/showering/going outdoors etc?</td>
</tr>
<tr>
<td>Do you believe CD is affecting you in another way? If so, how?</td>
</tr>
</tbody>
</table>

SMART goal setting

<table>
<thead>
<tr>
<th>Impact of CD</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you could wave the magic wand, what would you like to see yourself doing?</td>
</tr>
<tr>
<td>What is the most significant part of the picture you are seeing?</td>
</tr>
<tr>
<td>How do you see yourself in this picture?</td>
</tr>
<tr>
<td>Describe the sort of activities you see yourself undertaking</td>
</tr>
<tr>
<td>What does that mean to you to undertake these activities?</td>
</tr>
<tr>
<td>Would you say that you value …? (see value section)</td>
</tr>
<tr>
<td>How important is it for you to be able to do these things?</td>
</tr>
<tr>
<td>How often do you think ‘I wish I could do ……….’</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Desired outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>How is the CD affecting you emotionally?</td>
</tr>
<tr>
<td>How are you managing your frustrations?</td>
</tr>
<tr>
<td>How are you managing your mood?</td>
</tr>
<tr>
<td>What have you done to date to deal with your CD better? Response: …</td>
</tr>
<tr>
<td>What was good about ‘response’?</td>
</tr>
<tr>
<td>What was it not so good about ‘response’?</td>
</tr>
<tr>
<td>What are the things you tried to get that you wanted but did not work?</td>
</tr>
<tr>
<td>What do you feel inside when you look at the ideal picture?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fore-sight</th>
</tr>
</thead>
<tbody>
<tr>
<td>If so, you could go to the value section below</td>
</tr>
<tr>
<td>If not, do you think you could change this picture?</td>
</tr>
<tr>
<td>Is what you are doing helping you to change the picture you currently have?</td>
</tr>
<tr>
<td>What could you start doing differently so that you would feel a little better?</td>
</tr>
<tr>
<td>So you are saying that doing ………. might help you to get what you want?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
What can go wrong and why?

- Poor SMART goal setting, no backup plan
- The counsellor taking control and denying the opportunity for the client to have ownership of the process
- Health professionals are trained to answer questions and to come up with solutions
- This is one of the reasons that intervention programs that use health professionals with short training in counselling can fail (Rosinin et al. 1999)
HERE IS YOUR WEBSITE ......
Practical

Scenario 1:
- Primary prevention setting (lifestyle)

Scenario 2:
- Secondary prevention setting (lowering specific risk factors)

Scenario 3:
- Tertiary prevention (disease-specific)

(Teams of 3-6)
- Client / actor
- Counsellor(s)
- Observer(s)
Practical

(Teams of 3-6)

- One client or patient (actor)
- Two can help each other to ask questions
- Remaining members of the team observe (Notice when there is energy, when it clicks)

Keep asking open-ended questions and find out:

- What the person likes
- Long-term vision
- Lifestyle behaviours
- How behaviours assist in getting what is needed in long-term
- What bars them from achieving what is desired? What will help?
- Underlying values. Not taking responsibility for own behaviour (e.g., blaming)
Evaluate practical 1

- What went well? Why?
- When did you feel energy/cooperation?
- Where could you improve?

- What did not go so well? Why?
- When did you feel resistance?
- How could you improve next time?
Thank you