Using Motivational Communication to Optimize Patient Adherence and Outcomes in Pediatric Asthma

Silvana Barone, BSc, MD
Canadian Respiratory Conference
April 25, 2014
Calgary, Alberta
Financial Interest Disclosure
Dr Silvana Barone

• I have no conflicts of interest to declare
Pediatric Asthma

- Most common pediatric chronic illness
  (Public Health Agency of Canada, 2007)

- Lifetime prevalence in Canadian children: 11-16%
  (To et al, 2009)

- Asthma exacerbations = leading cause of hospitalization in children
  (Garner & Cohen, 2008)
Pediatric asthma - hospitalizations

Figure 1-3 Proportion of all hospitalizations due to select respiratory diseases (listed among first five diagnoses), children aged 0 to 14 years by age group, Canada, 2004/05.

<table>
<thead>
<tr>
<th></th>
<th>0-4 years</th>
<th>5-14 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>9.9</td>
<td>7.9</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>10.9</td>
<td>0.1</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>10.9</td>
<td>4.5</td>
</tr>
</tbody>
</table>

Source: Centre for Chronic Disease Prevention and Control, Public Health Agency of Canada, using data from Hospital Morbidity File (acute and chronic care), Canadian Institute for Health Information.
Adherence in pediatric asthma

- Suboptimal control of asthma at baseline is a known risk factor for exacerbation (Bloomberg, 2010)

- Children generally take only 50%-60% of prescribed doses (McQuaid et al, 2002)

- Non-adherence is the primary cause of treatment failure in pediatric long-term conditions (Santer et al, 2014)
Adherence in pediatric asthma

- Burden of treatment generally lies with caregivers
- Therapeutic triad

Santer et al, 2014
Factors influencing adherence

• Caregiver beliefs about long-term conditions and treatments

• Fears about potential side effects of ICS weighed against fears of acute exacerbations → « trials » of withholding medication to observe whether child still needs them

Santer et al, 2014
Challenges in pediatric asthma

- Getting parents to accept the diagnosis
- Getting parents to adopt healthier lifestyle (e.g., quit smoking)
- Getting parents and children/teens to manage environmental triggers (e.g., use mattress covers, remove family pet)
- Adherence
  - Parents and teenagers
Challenges in pediatric asthma

• Caregivers trying to balance many competing concerns about condition and its treatment in the context of everyday family life
• Threat to « normal life » for the child and siblings
Motivational communication strategies

• Asking
  ▫ Using open questions to engage and explore motivation and confidence

• Listening
  ▫ To express empathy and « roll with resistance »

• Giving information
  ▫ Ask permission, provide information neutrally, keep it simple, ask for feedback
The adolescent: a particular challenge!

• Increased risk for asthma morbidity and death

• Adherence to medical regimens declines during adolescence → use preventive asthma medication less than children and adults

Bruzzese et al, 2004
Adherence in adolescents

McQuaid et al, 2003
Barriers
Adolescents
Barriers

- This...
Barriers

- More socially acceptable than this...

- Contrivance may stem from finding the proper use of an inhaler inconvenient or socially unacceptable
Barriers reported by adolescents

- Treatment and daily activities interfering with each other
- Forgetfulness
- Psychosocial difficulties
- Wanting to appear normal to their peers

Bitsko et al, 2014
Traditional approaches

• Education and self-management
  ▫ predicated on the questionable assumption that participants are motivated to change
  ▫ increase resistance among patients not ready or willing to follow medical recommendations

• High self-efficacy without comparable levels of motivation to change can lead to decreased likelihood of change (Riekert et al, 2011)
Adolescent adherence

• Importance of focusing on the adolescent’s beliefs related to health behavior change

• Motivational communication: *patient-centered* approach to health *behavior change* that helps patients to resolve ambivalence about change and enhances *intrinsic motivation*

(Miller & Rollnik, 2002)
Role of MC in adolescents

- Developmentally appropriate
- Does not assume that health is the most important factor motivating the adolescent
- Acknowledges and incorporates other motivators within the unique context of the teen’s life
- **Ambivalence** is common during this time, so normalizing both the resistance and desire to change may reduce frustration
MC in adolescents - Asking

- If patient loves to play basketball, ask how taking his or her asthma medication can help him or her play better
MC: Some strategies

• Discussing a typical day
  ▫ Instead of « how many times did you take your medication this week? »
  ▫ Try: « What is a typical day like for you, from start to finish, and, tell me about where taking your medication fits into your day »
MC in adolescents - Listening

- Use reflective listening to express empathy and ‘roll with resistance’
Using reflective listening to ‘roll with resistance’

- Reflecting back to the patient what you think you’ve heard, key for expressing empathy

- Involves making statements, NOT asking questions
  - “You’re not sure you want to take your meds?”
  - “You’re not sure you want to take your meds.”

- Allows you to test hypotheses about what may be going on
How to use reflections to deal with resistance

• When you detect resistance (and/or hostility), the goal is **not behaviour change** but avoiding a power struggle!

• Goal becomes ‘**popping the balloon**’...diffusing the resistance and avoiding an argument

• **How you both benefit**: patient’s resistance does not go up (ideally it comes down) and you avoid a frustrating and counter-productive argument
Types of reflections

• **Simple reflection** (paraphrasing)
  ▫ Moves beyond the patient’s words and presents information in new light

• **Double-sided reflection**
  ▫ Reflects both sides of the patient’s ambivalence

• **Amplified reflection**
  ▫ Overstates what the patient has said by emphasizing the “absoluteness” or resistance element
“I know smoking is bad for my asthma, but I have tried to quit and just can’t. Plus, all my friends smoke – I would be the only one left out.”

**Simple reflection**
- “Quitting smoking is one of the hardest lifestyle changes to make, and perhaps now is not the right time.”

**Double-sided reflection**
- “So on the one hand, you see how smoking impacts your asthma, but on the other, you don’t want to be alienated from your friends.”

**Amplified reflection**
- “We may just need to accept that it may never be the right time to quit.”
Using Reflections to Deal With Anxious, Resistant Patients (parents)

• “I know my son’s asthma is poorly controlled and he needs more treatment, but I am just not convinced he needs a daily medication. It comes and goes – and we’ve only had to go the hospital once. I heard the medication is a ‘steroid’ and am really concerned about the side effects. I am not sure the benefits outweigh the risks, and I am not taking any chances with my child. There has to be another option.”
Possibilities

A. “I know it sounds scary, but these medications are very safe. You don’t want his condition to get worse, do you?”

B. “I know you have concerns, but the benefits far outweigh the costs of any side effects.”

C. “I know, but I am really concerned about your son’s asthma being so out of control. So we have to find another solution so we can keep him out of the ED.”
Possibilities

A. “I know sounds scary, but these medications are very safe. You don’t want his condition to get worse, do you?”
   ▫ *Arguing, lecturing, threatening*

B. “I know you have concerns, but the benefits far outweigh the costs of any side effects.”
   ▫ *Invalidating, dismissive*

C. “I know, but I am really concerned about your son’s asthma being so out of control. So we have to have to find another solution so we can keep him out of the ED.”
   ▫ *HCP more concerned than patient; imposing their agenda*
Other Ideas

A. “It sounds like you really want to help your son and are willing to start therapy, but you have fears about the side effects.”
   ▫   *Simple/double-sided reflection*

B. “You are not alone, many parents have expressed the same concerns, even when they saw a need and clear benefits.”
   ▫   *Simple reflection (validating), rolling with resistance (backing off)*

C. “Many parents have expressed the same concerns, even when they saw a need and clear benefits. Unfortunately, given your strong concerns your son’s condition may be the best we can hope for.”
   ▫   *Amplified reflection*
MC: Feasible? Efficacious?

- Minimal time differences between patient centered counselling and delivery of standard approaches
  - Typically no more than 2 mins!
    (Weston & Brown, 2003)

- Evidence base for MC as an appropriate and effective intervention with children and adolescents is emerging
  (Gayes & Steele, 2014)
Take-home messages

• Many factors influencing pediatric asthma adherence
• Traditional approaches associated with low adherence
• Must not assume health is the most important factor motivating the adolescent
• Overall, MC is an effective and feasible approach for improving adherence in pediatric asthma (Gayes & Steele, 2014)
Future challenges

• Further research specifically examining the efficacy of MC in promoting asthma management, particularly for children and adolescents

• Inclusion of cost-effectiveness measures in future studies

• Integration of motivational communication strategies into the medical curriculum
References

• Public Health Agency of Canada. Life and Breath: Respiratory Disease in Canada. 2007.
• Bitsko MJ, Everhard RS, Rubin BK. The adolescent with asthma. Paediatr Respir Rev 2014; http://dx.doi.org/10.1016/
• Shams MR, Fineman SM. Asthma adherence: how can we help our patients do it better? *Ann Allergy Asthma Immunol*. 2014;112: 9-12.
Acknowledgements

Montreal Behavioral Medicine Center
Dr Kim Lavoie, PhD
Dr Simon Bacon, PhD

Canadian Respiratory Conference

CHU Sainte-Justine
Pediatrics Department