

Shared Decision Making in Asthma Treatment: Using Motivational Communication to Elevate Your Consultations

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Introduction

The extent to which patients are adherent to their medication regimen is critical for achieving good asthma control, preventing exacerbations, and optimizing the likelihood that patients can lead full and productive lives.¹ Knowing this, physicians might perceive that their role is to convince their patients to comply with their prescribed medicines using educational or persuasive advice-giving strategies that focus on the health benefits of treatment compliance and the negative health consequences of non-compliance.² However, evidence suggests that evoking fear of negative consequences is a poor motivator for both the adoption, and long-term maintenance, of good health behaviours such as medication adherence.³ In an effort to make the maladaptive behaviour the 'less desirable choice', physicians often inadvertently become associated with the fear messages they share (through classical conditioning) and the negative emotions they elicit (through operant conditioning).⁴ This may result in physicians themselves becoming aversive to their patients, leading to patients disengaging from the therapeutic relationship and becoming resistant to treatment recommendations. In fact, treatment success depends not on the imperative to convince and control patient behaviour (which defines compliance), but on the willingness to collaborate with the patient to co-construct a treatment plan that they agree with and want to follow (which defines adherence). The key takeaway is to recognize that non-collaborative communication is ineffective for behaviour change, and may actually be counterproductive, if not harmful.³

Asthma is a major global health problem affecting as many as 235 million people

worldwide.⁵ It is characterized by episodic or persistent respiratory symptoms (e.g. cough, wheezing, shortness of breath, chest tightness) and airflow limitation.⁵ The treatment of this chronic disease is centred on symptom reduction (i.e. symptom control to maintain normal function) and reducing the occurrence of adverse events such as exacerbations, fixed airflow limitation, and treatment side effects.⁶ In all chronic diseases, but particularly in asthma, treatment adherence is paramount to treatment success because asthma management often involves conducting iterative reassessments, leading to frequent treatment adjustments (i.e. pharmacological, non-pharmacological, and treatment of modifiable risk factors) and reviews of the patient's response. Effective asthma management therefore depends on a cooperative partnership between the physician and the person with asthma.⁶ Unfortunately, adherence to asthma medications has been shown to be suboptimal across the globe (i.e., as low as 13.8% in China and only as high as 52% in Brazil), with many patients only taking their controller medication when symptomatic and over-using reliever therapies when symptoms worsen, a pattern shown to increase risk of death from asthma.¹

For physicians, addressing these challenges with patients means learning how to 'communicate for behaviour change'. To achieve this, it may be useful to become familiar with some basic knowledge about human psychology that recognizes all human behaviour—including ambivalence and resistance to change—as being normal and predictable reactions to change, rather than psychopathology.

Ambivalence toward engaging in good health behaviours (both wanting and not wanting

to engage in a behaviour simultaneously) is a natural and predictable reaction to change. This is because many health behaviours are metabolically costly and require effort that may conflict with our established routines and comfort.⁷ Our choices are typically guided by pleasure, convenience, and their immediate consequences (we seek good consequences and avoid bad ones). When these preferences are threatened, individuals commonly resort to avoidance as a coping mechanism.⁸ Avoidance can also occur when a physician responds to their patient's ambivalence with negative judgement or persistent advice-giving. This can erode trust and result in feelings of shame and self-blame in the patient, which can lead to disengagement and treatment resistance or refusal.⁹

Communicating effectively for behaviour change also requires some basic knowledge of the major determinants of behaviour change, which include motivation (what drives our behaviour) and self-efficacy (which relates to being confident in our ability to succeed at a task). Human motivation exhibits multiple dimensions that can be defined along a continuum from extrinsic (when behaviour occurs in response to external rewards and punishments) to intrinsic/internal (when behaviour occurs to experience pleasure or satisfaction, or because it is consistent with our identities, goals and values).¹⁰ Research has shown that people are more likely to engage in behaviours that are intrinsically/internally motivating (tied to goals and values) and when they feel confident in their ability to succeed. Gaining an understanding of this information can therefore be used to improve medication adherence by eliciting patients' therapeutic goals (e.g., reducing breathlessness and participating in sports) and determining the necessary support to help them succeed in taking their medication as prescribed (e.g., a device that is easy to use or reminders).

When people feel compelled to engage in behaviours that they did not choose for themselves, two outcomes are possible: a) psychological reactance, characterized by defiance against health recommendations, or b) begrudging acceptance leading to learned helplessness.¹¹ When setbacks occur and people lack intrinsic/internal motivation or confidence, their problem-solving abilities, which enable them to overcome barriers to success, are also limited.¹² Although people might re-attempt the target behaviour for external reasons (e.g., seeking approval, avoiding feelings of shame), over time, prolonged exposure to repetitive failures will result

in a deep and persistent state of helplessness (resignation) and eventually, hopelessness (depression). This also tends to result in refusal of the treatment plan or disengagement from disease self-management.¹³

Finally, there are two distinct areas of the brain controlling behavioural choices: the logical executive system (located in the prefrontal cortex), and the emotional system (located in the limbic system). When these systems compete with each other, often the emotional brain prevails.¹⁴ This, coupled with a need for self-determinism—feeling in control of one's life and choices—explains why people do not tend to follow advice and prefer to follow their own beliefs.¹⁰ Physicians attempting to persuade their patients of the benefits of their pharmacological and behavioural prescriptions when a patient is presenting a conflicting opinion or an emotional reason against change can be risky and counterproductive because this approach challenges patients' beliefs, desires, and the comfort and predictability of the status quo.¹⁵ Ultimately, this will also tend to result in treatment disengagement or refusal.

Understanding these basic behavioural concepts allows healthcare providers to recognize how, despite our best intentions and substantial expertise, we may be inadvertently contributing to our patients' resistance and poor adherence to treatment. We may have unintentionally restricted our patients' autonomy by imposing our own motivation for change (e.g., controlling their asthma symptoms) instead of eliciting their own motivation (e.g., being able to keep up with their family on their holidays). For example, we might have unwittingly contributed to our patient's abandoning their exercise routine because they did not receive the necessary support to strengthen their self-efficacy and overcome their setbacks. Our patients might have avoided sharing their obstacles owing to the fear of being judged, because we did not convey acceptance of their ambivalence. We may have unintentionally dismissed a patient's belief, without realizing that we were limiting their sense of agency.

In order to address these important clinical behavioural challenges, we co-developed, along with behaviour change experts and chronic disease physicians, a training program in motivational communication. This program was designed to better support physicians in their efforts to motivate and guide patients in their self-management efforts.¹⁶ Motivational Communication (MC) is defined as an evidence-based, time-efficient



Figure 1. The 11 core competencies of Motivational Communication; *courtesy of Anda I. Dragomir, PhD and Kim L. Lavoie, PhD*

communication style used by health care providers to promote sustained patient engagement and support self-management of chronic conditions.¹⁷ MC is a communication style that was designed to be seamlessly integrated into a typical clinical consultation, without requiring additional time.¹⁸ MC is time saving because it focuses on addressing the actual barriers to change as stated by the patient. Persuasive, education-driven interventions tend to assume patients are not changing because they do not know a behaviour is important. This leads to physicians providing potentially time-consuming and unnecessary information at the expense of spending that time strengthening motivation or self-efficacy. The goal is to be more strategic about what information is provided while emphasizing patient-physician collaboration in the spirit of non-judgemental acceptance, tolerance, and respect that avoids argumentation. MC represents a subtle departure from other motivational approaches (e.g., motivational interviewing), which tend to discourage using other evidence-based behaviour change techniques such as goal setting and positive reinforcement. It also incorporates elements from cognitive-behavioural

theories such as identifying value-based determinants for change.¹⁹

How does MC work? MC presents 11 core communication competencies that can be easily integrated into any clinical consultation (**Figure 1**). While mastering all 11 competencies can be a long-term goal, adopting one or two competencies may be more attainable in the short term. Research has shown that doing so is associated with significant increases in patient motivation and confidence, health behaviour change, and improvements in the therapeutic relationship.¹⁸ For example, adopting this approach can include choosing to use more open questions to explore ambivalence and elicit change-talk, or employing reflections to communicate acceptance and avoid argumentation and impatience. It can also involve simply working more collaboratively with patients to understand their treatment goals and preferences.²⁰ See **Table 1** for an example which compares MC to a more traditional persuasive consultation style. If you are considering using MC in your practice, or if you wish to obtain additional training, contact the Montreal Behavioural Medicine Centre (<https://mbmc-cmcm.ca/>).

Conclusion

In conclusion, the imperative for effective asthma management extends beyond mere prescription adherence; it necessitates a profound shift in the patient-physician interaction. By prioritizing shared decision-making, the principles of MC can enable physicians to bridge the gap between treatment recommendations and patient engagement. This approach not only acknowledges the complexities of human behaviour but also respects the autonomy and intrinsic motivations of individuals living with asthma.

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Notes	Traditional Approach	Motivational Communication Approach	Notes
<p>Agenda set independently Closed question explores adherence</p>	<p>Physician: Let's have a chat about your medication use. Have you been using your daily inhaler as prescribed?</p>	<p>Physician: Would it be ok to talk about your medication? Tell me, what medications are you taking and how often do you take them?</p>	<p>Asking permission to set the agenda, open question to explore adherence</p>
<p>[Patient provides 'correct' answer to closed question, but it may not be valid]</p>	<p>Patient: Yeah.</p>	<p>Patient: Sure. I use my controller inhaler twice a day, and the rescue inhaler as needed. But I noticed I have been using the as-needed inhaler more often than usual, which worries me.</p>	<p>[Patient provides a more elaborate answer; expresses a concern]</p>
<p>Argumentation, impatience</p>	<p>Physician: Ok, then I don't understand why you are having so many symptoms. If you are using your controller medication as prescribed, your asthma should be well controlled on this dose of medication.</p>	<p>Physician: It's great that you seem to be using your inhalers as prescribed, but your rescue inhaler use concerns you, which is understandable. What do you think might be causing you to use your rescue inhaler more?</p>	<p>Reflects on good behaviour and validating concerns Open question to explore rescue inhaler use</p>
<p>[Patient gets defensive and expresses some resistance]</p>	<p>Patient: Well, I don't understand it either, or why I came to see you. I am also using my rescue inhaler several times a week, and it's not really helping. I am not sure what's going on.</p>	<p>Patient: Well, I have to admit that I don't like the idea of taking steroids every day because of the long-term side effects, so sometimes I skip doses of my controller medication, especially when I feel well. Maybe it's finally catching up with me...</p>	<p>[Patient admits they are not always adherent due to concerns about side effects]</p>
<p>Argumentation, impatience, and unsolicited advice-giving</p>	<p>Physician: As you know, taking too much rescue medication is not good for you, and can lead to a phenomenon called "rebound effect," where your symptoms worsen over time and your asthma becomes harder to control. But if you use your daily controller as prescribed, you should not need to use the rescue inhaler so much.</p>	<p>Physician: Many of my patients have expressed the same concerns. One of the challenges associated with treating asthma is that sometimes, the medications are so effective at treating the underlying inflammation, some people think the medication is no longer needed. What do you think about that?</p>	<p>Validates and normalizes feelings; Gives information neutrally without giving advice; Asks open question to elicit feedback</p>
<p>[Patient expresses some ambivalence – she takes the medication, but has concerns]</p>	<p>Patient: I know, and I am taking it, but I really don't like the idea of taking steroids because of all the side effects, so sometimes I skip doses when I feel well.</p>	<p>Patient: I understand that using my controller medication regularly is what helps reduce my attacks, which is important. However, I was feeling so much better for once, so I thought I could ease back a bit thinking I would be ok.</p>	<p>Validation, acceptance, and empathy through reflective listening</p>
<p>Lack of acceptance, negatively judging, fear-based messaging</p>	<p>Physician: Feeling better doesn't mean your asthma has disappeared. You are probably feeling better because you are using your controller medication as prescribed. Skipping doses when you feel well can lead to attacks, which can require more intensive treatment and even hospitalization. This is probably why you are feeling so breathless.</p>	<p>Physician: I understand. It's natural to want to avoid taking more medication than we need.</p>	<p>Validation, acceptance, and empathy through reflective listening</p>

Notes	Traditional Approach	Motivational Communication Approach	Notes
	<p>Patient: <i>I thought that I could ease back a bit if I was doing well. But now my symptoms seem really out of control, and my rescue medication is no longer working.</i></p> <p>Physician: That's probably because there is more underlying inflammation. Therefore, we need to get you back on track with taking your daily controller as prescribed, and I will have to increase the dose in order to get your symptoms under control, which unfortunately may cause some additional side effects.</p> <p>Patient: <i>I'm really not happy about the idea of taking a higher dose, but I am really not doing well, so I guess I have no choice.</i></p>	<p>Patient: <i>Exactly! I was feeling normal for once, and I thought it would be good to take less steroids.</i></p> <p>Physician: Tell me, what would it mean for you if your symptoms were well controlled again, and you could feel good everyday?</p> <p>Patient: <i>It would mean a lot! I felt really good for about a month. I slept well and could keep up with my friends during workouts. I wasn't out of breath walking up the hill to the office everyday. It was great.</i></p> <p>Physician: Sounds like taking your daily controller medication really helped manage your symptoms and allowed you to feel more in control of your life.</p> <p>Patient: <i>Yeah, it did. I guess I was so excited about feeling good that I forgot how I got there. It's a good reminder to go back to using my controller every day as prescribed.</i></p>	<p>[Patient agrees with physician, does not express any resistance]</p> <p>Open question to explore motivation</p> <p>[Patient describes advantages of good control]</p> <p>Validation through reflective listening</p> <p>[Patient agrees that using their daily controller helped them achieve good control]</p>
Hostility and impatience, fear-based messaging	<p>Physician: I really think this is best. If you want to avoid serious complications, you need to take your medication consistently. Here is your prescription, and we can follow up in a few months.</p> <p>Patient: <i>Ok, thanks.</i></p>		

Table 1. Comparing Motivational Communication to traditional advice-giving consultation style; courtesy of Anda I. Dragomir, PhD and Kim L. Lavoie, PhD

Case: A 45-year-old female patient with moderate asthma, usually well controlled, reports experiencing increased breathlessness, increased use of her rescue inhaler, and greater difficulties performing daily activities.