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The Relationship Between Adherence and Perceived Self-Efficacy:

*How to improve functional outcomes by motivating your clients*

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**CREDENTIALS**

- 2009-2011 SUNY Downstate Occupational Therapy Master’s of Science program
- 2012 NJ/NY Licensed occupational therapist
  - Geriatrics/sub-acute/PACE
  - Homecare
  - Out-patient upper extremity orthopedics
  - Pediatrics
- 2012-2015 Adjunct Professor
  - NYU in New York, NY
  - Eastwick College in Ramsey, NJ
CREDENTIALS

- Conference Speaker:
  - October 2017 Speaker “Short Session” The Relationship Between Adherence and Perceived Self-Efficacy: How to improve functional outcomes by motivating your clients, NJOTA Conference 2017

- Webinar Presenter
  - February 2016 Course Presenter “Sleep: The Unconscious ADL”, www.OccupationalTherapy.com
  - October 2017 Speaker “Short Session” The Relationship Between Adherence and Perceived Self-Efficacy: How to improve functional outcomes by motivating your clients; www.OccupationalTherapy.com

INTRODUCTION

In the ever changing climate of medical reimbursement, it remains more relevant than ever to focus on generating improved functional outcomes for our patients. It is well documented that therapeutic interventions will be ineffectual if clients are unsuccessful in generalizing them into their daily routine. The field of occupational therapy believes that through therapeutic use of self the skilled practitioner can select the just right challenge and in the process have a positive impact on the self-efficacy of their clients. The current evidence-based literature indicates a direct correlation between perceived efficacy and adherence. Nonetheless, why it is that adherence is such an uncommon phenomenon?
OBJECTIVES

At the conclusion of the presentation participants will be able to:

1) Explain the unique perspective that the field of occupational therapy holds regarding the relationship between motivation and self-efficacy
2) Apply the principles of the Transtheoretical Model to determine which stage of change their client is experiencing
3) Select the appropriate Therapeutic Tool(s) with which to effectively motivate their clients

OPERATIONAL DEFINITIONS

- **Adherence**
  - The degree to which patients and research participants act in accordance with the advice of their clinician or researcher

- **Compliance**
  - Connotes patient passivity and obedience and suggests behavioral change without internal acceptance

(Vining Radomski, 2011)
BARRIERS

- Physical Dysfunction (athletes/physical activity)
  - Cognitive “issues”
    - Understanding the
      - Nature of the injury
      - Goals of prescribed treatment
      - Prognosis for recovery
  - Emotional “issues”
    - Anxiety/blame/guilt/anger
  - Behavioral “issues”
    - Action is required by the patient

(Christakou and Lavalle, 2009)
BARRIERS, cont.

- Physical Dysfunction (geriatrics/physical activity)
  - Ill health and change in health status
    - Pain
  - Unsatisfactory physical environments
    - Poor sidewalks
    - High neighborhood crime rate
  - Lack of time
  - Lack of transportation (to a recreational facility)
  - Disinterest*
  - Lack of social support
  - Lack of funds
  - Fear of injury
  - Lack of knowledge and understanding (regarding the need for increased activity)
    - Opportunity for intervention

(Adams-Fryatt, 2010)

BARRIERS, cont.

- Older adults (geriatrics/medication management)
  - Deliberate
    - Adverse effect profiles
    - Self control and other internal health beliefs
  - Unintended
    - Forgetfulness
    - Financial strains that limit accessibility
    - Failure to properly understand the medications regimen
    - Disabilities that interfere with self-administration
      - Risk Factor
      - Opportunity for intervention
BARRIERS, cont.

- Other
  - Impaired cognition and/or Depressive symptoms (elder self-neglect)
    - Risk Factor
  - Complex regimens/high number of medications/comorbidities
    - Opportunity for intervention

*It is possible that medication non-adherence may contribute to the occurrence or the exacerbate the conditions associated with self-neglect.*

(Turner et al., 2012)

BARRIERS, cont.

- Mental Health (medication management)
  - Environment*
    - Lack of support
      - For diagnosis
      - For the need for treatment
    - Cost
      - Cannot afford the medication
      - Not wanting to pay for the medication
  - Side effects:
    - Impaired functioning
      - Work
      - Interpersonal functioning
BARRIERS, cont.

- Mental Health (medication management), cont.
  - Insight and knowledge
    - Nonuse of medication
      - Beneficial effects of medications not recognized
      - Medications not effective
      - Medications viewed as punitive
    - Fear
      - Of medications (on going care)
      - Of overdosing
      - Of becoming addicted
  - Self-stigma
    - Putting self down
    - Embarrassed

BARRIERS, cont.

- Mental Health (medication management), cont.
  - Symptoms and outcomes
    - Memory problems
      - Not remembering reasons why medications are needed
      - Being easily distracted
      - Thought disorganization
    - Nihilism
      - Medication doesn’t help anyway
      - Not desiring a good outcome
  - Provider and family*
    - Anger with
  - Substance abuse
    - Use of alcohol or street drugs instead of medication
    - Fear of combining medication with alcohol or street drugs
BARRIERS, cont.

- Mental Health (medication management), cont.
  - Dosing
    - Missing midday doses of medications
    - Sleeping late and missing morning medications
  - Patients were less likely than providers to identify medication adherence as an important factor in controlling symptoms or maintaining health
  - Providers were less likely than patients to identify stigma as a problem or to identify stress reduction and engaging in spiritual activity as important to maintaining health
  - There were 3 categories barriers for which patients did not provide potential remedies
    - Side effects
    - Stigma
    - Substance abuse
  - There appears to be a mismatch between patients’ and providers’ understanding…which could impact adherence to treatment and contribute to medication nonadherence

(Pyne, McSweeney, Kane, Harvey, Bragg, & Fischer, 2006)

FACILITATORS & MOTIVATING FACTORS
Facilitators

- Environment*
  - Reminders
    - Use of medication devices
    - Environmental cues
    - Planning ahead for time away from home
- Insight and knowledge
  - Need for medication
    - Knowledge that medication is necessary
    - Acceptance of diagnosis
- Provider (and family)*
  - Trust in knowledge of diagnosis
- Dosing
  - Preference for injection or oral medication
  - Taking medication once per day
  - Taking fewer pills each day

Motivators

- Environment*
  - Example of others
    - Seeing others do well on medications
- Symptoms and outcomes
  - Avoid bad consequences
    - Losing freedom
    - Worsening of
      - Symptom severity
      - Living situation
      - Interpersonal relationships
    - Potential for harm to self or others
- Provider and family*
  - Improved relationships
    - With providers or family member when on medication

(Pyne et al., 2006)
TENDENCIES

THE FOUR TENDENCIES FRAMEWORK

1. Upholders
   - Respond readily to **both** outer expectations and inner expectations

2. Questioners
   - Question **all** expectations, **and** will meet an expectation only if they believe it’s justified

3. Obligers
   - Respond readily to outer expectations, **but** struggle to meet inner expectations

4. Rebels
   - Resists **all** expectations, outer and inner alike

(Rubin, 2015)

- **New Release**
  - The Four Tendencies book
- The Four Tendencies Quiz
  - [https://www.surveymonkey.com/s/43725520/gretcherrubinfourtendenciesquiz](https://www.surveymonkey.com/s/43725520/gretcherrubinfourtendenciesquiz)
- Tips for Using the Four Tendencies in Healthcare: quick guide
  - [https://gretcherrubin.com/resources/](https://gretcherrubin.com/resources/)
SELF-EFFICACY

Bandura’s Social Cognitive Theory

...an individual’s perceptions of his or her ability to perform an action and his or her expectations that the behavior will have a desirable result are important mediators of performance.

- Methods for developing and enhancing efficacy expectations
  1. Performance accomplishments
  2. Vicarious experience or modeling
  3. Verbal persuasion
  4. Interpretation of physiological state

(Lorig, 2001)
MODELS

1. Protection Motivation Theory
   a. Cognitive Processes
      i. Threat Appraisal
         1. Perception of the severity
         2. Perceived vulnerability/susceptibility to harm
   b. Coping Appraisal
      i. Response efficacy
         1. Perception of how likely a particular course of action reduces or prevents the threat
         a. How effective will the patient’s response be
      ii. Self-efficacy
         1. Perception of how likely one can perform particular actions
         a. Patient’s perceptions of their abilities to follow the recommended rehabilitation program
MODELS, cont.

2. Personal Investment Theory
   ○ Motivation in specific situations is determined by
     ○ Personal incentives (less important)
       1. A person’s subjective goals for involvement in a particular activity
          • Task incentives (aka “involvement”)*
            1. 5 senses of belief (social support/trait confidence/self-motivation/internal locus of control/perceived physical ability)
          • Ego incentives
          • Extrinsic incentives
     ○ Sense of self-belief
       1. A person’s thoughts and feelings regarding their existence
          • Perceptions of competence and self-reliance
          • Tendency to behave in accordance with personal goals
          • Sense of relationship with significant others

MODELS, cont.

2. Personal Investment Theory, cont.
   ○ Perceived option*
     1. Perceived alternative behaviors that can determine motivation in specific situations
        • Belief on efficacy of treatment
        • Knowledge of treatment
        • Plans for future (sports) activity
        • Perceived (team) role since injury
3. Cognitive Appraisal Models
   - Personal Factors
     - Stable, dispositional characteristics (associated with adherence)
       - Self-motivation
       - Pain tolerance
       - Task difficulty
   - Situational Variables
     - Perceptions of rehabilitation context
       - Belief in the efficacy of treatment
       - Comfort of the clinical environment
       - Convenience of scheduling
       - Perceived exertion
       - Important of rehabilitation
       - Perceived injury severity
       - Social support for rehabilitation
       - Practitioner expectations of adherence
         - Positive response

(Christakou et al., 2009)

4. Consumer Decision Model
   - Patient factors when deciding whether to implement rehab-related recommendations
     - Perceived susceptibility
       - To a given problem (i.e. frailty or disability)
       - perceived susceptibility to a health problem and its perceived seriousness predict change
         (Cumming, Thomas, Szonyi, Frampton, Skaikid, & Clemson, 2001)
     - Perceived severity
       - The consequences of which (the problem) can range from inconvenient to incapacitation
     - Perceived efficacy
       - The effectiveness of the specific adaptation
     - Perceived cost
       - The cost of the specific adaptation
         - Behavioral costs (i.e. disruption to life-style and self-esteem)
         - Social costs (i.e. home becomes unattractive)
         - Financial costs (i.e. affordability)

(Pynoos, J. and Nyshita, 2003)(Pyne et al., 2006)
5. **Health Belief Model**

"...perceived susceptibility to a health problem and its perceived seriousness predict change."

(Cumming, 2001)

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6. **Transtheoretical Model of Change**

- Precontemplation
  - Denial
- Contemplation
  - I am intending to take action in the next six months
- Preparation
  - I am intending to take action in the next month
- Action
  - I have taken action on my problem within the past six months
- Maintenance
  - I solved my problem more than six months ago
    - Regression
MODELS, cont.

- Prerequisites for change
  - Specific change behaviors occur when a
    - Clear priority for change is established
      - Ready
    - Desire and perceived importance for change is present
      - Willing
    - Confidence for change is high
      - Able
    - Enhance confidence to change

  (Miller et al., 1997)

MODELS, cont.

- "One factor clearly differed between adherers and non-adherers: participants who did not make recommended changes...may have been in the precontemplation stage.

  (Cummings et al., 2001)

- Precontemplation
  - Build intrinsic motivation
    - Establish rapport
    - Set the agenda
    - Explore the importance of change
    - Enhance confidence to change

- Contemplation
  - Strengthen commitment to change
    - Recognize readiness to change
    - Negotiate a change plan

  (Flinn et al., 2011)
Models, cont.

7. Ecological Model of Adherence

This model suggests that adherence... is a function of person, provider and intervention factors that are set in the context of environmental, social, and technological constraints or enablers... and... are synthesized, shaped, and actuated through self-determination (personal choice) and learning (skill acquisition and employment).

Adherence is a process involving a sequence of interrelated patient-therapist decisions and actions... consequently, occupational therapists shoulder... some of the responsibility for whether service recipients adopt occupation-enhancing recommendations.

Models, cont.

- Ecological Model of Adherence, cont.
  - Process
    - Specifying or analyzing what patients are being asked to adhere to
      - Including the impact of receiving recommendations from many individuals on a multidisciplinary team
    - Determining how patients perceive clinician recommendations
      - As options or imperatives
    - Evaluating the practices used to determine whether parties understand and can perform recommendations
    - Determining how much and what kind of supports are effective in linking a new health or therapy recommendation to a preexisting routine

(Vining Radomski, 2011)
HABITS

Performance patterns are the habits, routines, roles, and rituals used in the process of engaging in occupations or activities that can support or hinder occupational performance. Habits refers to specific, automatic behaviors; they can be useful, dominating, or impoverished.

(OTPF, 2014)
...whereas the Model of Human Occupation (MOHO), “seeks to explain how occupation is motivated, patterned and performed...Within MOHO, humans are conceptualized as being made up of three interrelated components: volition, habituation, and performance capacity...habituation refers to the process by which occupation is organized into patterns or routines.

(www.cade.uic.edu)

Habituation refers to activities that have been performed enough times to become routine and customary. Two elements of habituation are habits and internalized roles. Habits are automatic routines or patterns that a person seems to perform almost by reflexes, without much conscious awareness...Habits seem to conserve energy; tasks are accomplished without too much effort or concentration leaving more time or attention for other things.

(Early, 2013)
Researchers were surprised to find that people with strong self-control spent less time resisting desires than other people did...people with good self-control mainly use it...to develop effective **habits** and routines...

(Baumeister & Tierney, 2011)

METHODS
COGNITIVE BEHAVIORAL APPROACH (CBT)

“Learned helplessness is the giving up reaction, the quitting response that follows from the belief that whatever you do doesn’t matter. Explanatory style is the way in which you habitually explain to yourself why events happen. It is the great modulator of learned helplessness. An optimistic explanatory style stops helplessness...Your way of explaining events to yourself determines how helpless you become, or how energized.

Learned optimism is not the rediscovery of “the power of positive thinking”. Changing the destructive things you say to yourself when you are experiencing the setbacks that life deals all of us is the central skill of optimism”

(Seligman, 1991)

MOTIVATIONAL INTERVIEWING

- Empathetic, non-confrontational counseling approach
- The clinician guides (rather than pushes) the patient towards change, side-stepping resistance and actively working with the patient’s strengths to build self-efficacy towards the desired outcome
  - Tools include:
    - Open-ended questions
    - Affirmations
    - Reflections
    - Summaries
    - To evoke change talk
      - Language from patients that argues for behavior change
      - Commitment language
        - Statements from patients about their intention to implement a behavior change
MOTIVATIONAL INTERVIEWING, cont.

- Tools Include, cont.
  - Underlying mindset
    - Empathic
    - Highly respectful of the expertise and wisdom that patients have about themselves and their autonomy to make their own decisions
      (Balan, Moyers, & Lewis-Fernandez, 2013)

- (A) Spirit of partnership, acceptance, evocation, compassion [overlaps with recovery-oriented principles (finding hope and purpose in life along with acquiring a greater sense of personal control) that emphasize] shared decision making, respect for client perspective and self management of illness.

  (Glassman et al., 2013)
MOTIVATIONAL INTERVIEWING, cont.

- Principles of evoking change
  - The goal is to heighten patients’ awareness and emphasize their autonomy in the matter of change
    - Expressing empathy
      - Expressed through reflective listening and by exhibiting characteristics similar to "Rogerian therapy"
    - Developing discrepancies
      - Involves reflection of incongruity between patient's current behavior and their values or future goals
        - Feedback is given in a non-judgmental way
        - Patients are asked for permission to explore issues

MOTIVATIONAL INTERVIEWING, cont.

- Principles of evoking change
  - The goal is to heighten patients’ awareness and emphasize their autonomy in the matter of change, cont.
    - Rolling with resistance
      - Encourages professionals and patients to work together to explore and resolve ambivalence
        - Amplified reflection
          - Works on the assumption that the oppositional tendency of the patient will lead to a withdrawal because their resistance and negative position is overstated
        - Double-sided reflection
          - Highlights the contradiction between what patients are currently stating to contrary statements that have made previously
  - Supporting self-efficacy
    - The therapeutic relationship elicits hope and optimism in the feasibility of accomplishing change by uncovering patients' own strengths and resource
MOTIVATIONAL INTERVIEWING, cont.

- To encourage **collaboration, evocation, and autonomy** between patients and professionals
  - **Collaboration**
    - Allows a patient-centered partnership between patients and professionals
      - Instead of directing actions, professionals aim to draw our patient’s own **motivation** and commitment toward **change**
    - Resolving ambivalence
    - Asking **evocative** questions that elicit **change** talk
  - **Autonomy**
    - Embraced throughout the process as patients are allowed to form ideas and make decisions

(Chay Huang Tan, Wen-Hui Lee, Tan Xiong Lim, Jern-Yi Laong, & Lee, 2015)

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THERAPEUTIC TOOLS
**THERAPEUTIC TOOLS**

- Inform patients of progress (tangible and visible results)
- Education (circumstances as a result of their injury)
- Communication and listening (active listening without judgement)
- Social support (sense of self-belief or small groups)
- Thought stoppage
- Enhance patient beliefs
- Using short-term goals
- Enhancing pain tolerance (emotional and sensory experience)

(Christakou et al., 2009)

**THERAPEUTIC TOOLS, cont.**

- Providing personal feedback
- Asking open-ended questions
- Affirmations
- Reflective listening
- Negotiating realistic and attainable goals*

(Zarani et al., 2012)
THERAPEUTIC TOOLS, cont.

- According to Newell:
  - Patient Focused
    - Reminder letters/postcards
    - Reminder phone calls
    - Behavioral contracting
    - Financial incentives or package deals
  - Behavioral counseling
    - Written educational materials
    - Patient-held records
    - Prompting devices
  - Response reduction
    (i.e. parking passes, prizes, taxi)
    - Orientation videos
    - Health belief card
  - Structural
    - Providing free prepared food
    - Home visits
  - Provider focused
    - Written educational materials
    - Prompting devices
    - Letters to providers

THERAPEUTIC TOOLS, cont.

- According to Macharia:
  - Cueing
    - Letter prompt
    - Calendar prompt
    - Invitation letter
    - Physician prompt
    - Telephone prompt
  - Reducing perceived barriers
    - Orientation statement
    - Orientation video
    - Automatic appointment
    - Clerical assistance
    - Counseling on problem solving

- Increasing motivation
  - Enhanced information
  - Contracting
  - Health belief model cards

(Original text)
THERAPEUTIC TOOLS, cont.

- Non-didactic counseling skills
  - Asking open-ended questions
  - Using reflective listening
  - Direct the discussion to focus on ambivalence and its resolution

(Chay Huang Tan et al., 2015)

THERAPEUTIC TOOLS, cont.

- OCCUPATIONAL THERAPY
  - The following areas have been identified as potentially impacted by (non)adherence
    - Missing or coming late to appointments
    - Only partially implementing or failing to implement a recommended treatment or behavioral recommendations altogether
    - Making adjustments to medication without advisement from a medical professional
    - Prematurely discontinuing treatment
  - The following “adherence-promoting therapist activities” are recommended
    - Selecting and right-fitting the recommendation
      - The occupational therapist learns about the patient’s diagnosis, occupational performance strength and limitations, as well as their priorities, daily routines, contextual supports-barriers
      - The occupational therapist identifies and evidenced based home recommendation
      - The occupational therapist configures recommendation to optimize fit
        - The occupational therapist makes a therapeutic recommendation
THERAPEUTIC TOOLS, cont.

- OCCUPATIONAL THERAPY, cont.
  - The following “adherence-promoting therapist activities” are recommended
    - Advancing self-determination and learning
      - Patient makes preliminary decision regarding fit of recommendation relative to self-concept
      - Patient understands what to do and why
      - Patient is proficient in performing the recommendation and determines he/she can successfully implement
      - Patient specifies implementation intentions
        - Patient commits to implement the recommendation
    - Supporting implementation of recommendations and habit formation
      - Patient remembers to implement recommendation at home and how to do so correctly
      - Patient realizes or appreciates benefits of continuing to perform recommended action
      - Patient repeatedly performs the recommended action
        - Patient integrates recommend action into daily life as a habit
          (Vining Radomski, 2011)

QUESTIONS & ANSWERS
Recommended Resources

www.motivationalinterviewing.org

https://motivationalinterviewing.org/art-teaching-motivational-interviewing-resource-mi-trainers


REFERENCES


http://cade.uic.edu/mohi/resources/about.aspx


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