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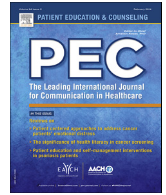

Translating person-centered care into practice: A comparative analysis of motivational interviewing, illness-integration support, and guided self-determination

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ABSTRACT

Objective: Person-centred care [PCC] can engage people in living well with a chronic condition. However, translating PCC into practice is challenging. We aimed to compare the translational potentials of three approaches: motivational interviewing [MI], illness integration support [IIS] and guided self-determination [GSD].
Methods: Comparative analysis included eight components: (1) philosophical origin; (2) development in original clinical setting; (3) theoretical underpinnings; (4) overarching goal and supportive processes; (5) general principles, strategies or tools for engaging peoples; (6) health care professionals' background and training; (7) fidelity assessment; (8) reported effects.
Results: Although all approaches promoted autonomous motivation, they differed in other ways. Their original settings explain why IIS and GSD strive for life-illness integration, whereas MI focuses on managing ambivalence. IIS and GSD were based on grounded theories, and MI was intuitively developed. All apply processes and strategies to advance professionals' communication skills and engagement; GSD includes context-specific reflection sheets. All offer training programs; MI and GSD include fidelity tools.
Conclusion: Each approach has a primary application: MI, when ambivalence threatens positive change; IIS, when integrating newly diagnosed chronic conditions; and GSD, when problem solving is difficult, or deadlocked.
Practice Implications: Professionals must critically consider the context in their choice of approach.
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1. Introduction

Person-centered care (PCC) is widely acknowledged as helping people live well with a chronic condition [1–3]. PCC is connected with empowerment [4–6], which is autonomy-supportive, respecting each person's values, appraisals, and choices in daily life. PCC supports self-reflection which, together with advanced professional communication skills, increases people's capacity for participating in mutual problem solving together with health care professionals [4] and "think critically and make autonomous, informed decisions" [7,p. 278]. PCC involves "finding common ground" [3,page 59], with outcomes such as reduced uncertainty in illness [8], better emotional health, and reduction of referrals [9]. Translating PCC into practice can help health care professionals (HCPs) understand each person's challenges and what he or she considers appropriate ways to overcome them.

However, PCC can be inhibited by an empowerment gap reported in practice in which HCPs expect people to follow their advice, rather than supporting them in finding mutually agreeable

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Table 1
Characteristics of three approaches aimed at translating person-centred care into practice.

Self-management approaches	Motivational interviewing	Illness integration support	Guided self-determination
Philosophical origins	Based on the principles of humanism—a way of being with people	Life world experiences and person centred care	Empowerment with inspiration from Loegstrup's ethical analysis on power in human relationships
Development in original clinical setting	Alcohol addiction (1983) where critical collegial questions elicited the essence of MI from clinical experience	Diabetes (1995–2004) Clinical experience, grounded theory	Complex diabetes care in busy clinical practice (1995–2004) Grounded theory, participatory research
Theoretical underpinnings	Intuitively developed, not derived from theory Congruent with the principles of Rogerian client-centred-therapy Self-perception theory Cognitive dissonance theory Trans-theoretical model of change	Grounded Theory about integration Integration process Personal understandings of illness Turning points and integration support	Grounded theories Humanistic values theory Self-determination theory Life skills, balanced self-determinism Dynamic judgement building
Overarching goal and supportive processes	Resolving ambivalence against behaviour change in a broader context	Integrating the condition into daily life as a way to facilitate self-management.	Developing life skills with the condition
	Four key processes: (1) *Engaging*—establishing a helpful connection and working relationship (2) *Focusing*—developing and maintaining a specific direction in the conversation about change (3) *Evoking*—eliciting the client's own motivation for change (heart of MI) (4) *Planning*—encompasses both developing commitment to change and formulating a concrete plan of action	Four stages: (1) Suspecting illness/being diagnosed. (2) Understanding and explaining illness. (3) Negotiating illness and taking stands about self-management. (4) Experiencing a turning point and a stable state: illness and self-management is integrated into daily life. Sometimes a regression: Doubting the effects of one's self-management, leading to a return to an earlier stage in the process of integration.	Seven stages: (1) establishing a mutual relationship with clear boundaries (2) self-exploration (3) self-understanding (4) shared decision-making (5) action (6) feedback from action (7) translating evidence for productive patient behaviour in an autonomy-supportive way
General principles, strategies or tools for engaging people	Differential evoking and strengthening of motivation and commitment to change Emphatic listening, develop discrepancy, rolling with resistance, accepting and resolving ambivalence, support self-efficacy	Person-centeredness, highlighting people's personal understandings of illness related to self-management decisions today and for future. Emotional and existential issues in focus. Balancing illness and life today and for the future	People-provider relationships comprise a potential for change which is difficult to access because it is interwoven in difficult feelings and different points of view. It can be released through self-reflection, mutual reflection, shared decision-making, dynamic judgment-building and autonomous motivation leading to self-concordance. Requires changes by both HCPs and patients in their relationship
	Asking open questions, affirming, reflective listening, summarizing, providing information, advice with permission Bring up a theme through menu/agenda, explore ambivalence, elect change talk, give information in a dialog, develop discrepancy	Person-centeredness, including empathy and active listening, courage to focus on emotional and existential issues related to the illness experience.	Written invitation to join a collaboration Reflection sheets to be filled in by patients before each of 4–8 one-hour sessions prompt independent patient reflection and mutual patient-provider reflection Reflection sheets are adjusted to each chronic condition. Communication skills, mirroring, active listening, and values-clarifying responses are used by HCPs
Providers' background and training	2-day workshop: introduction, specialization, post training support, supervision, coding and feedback, Training new Trainers, Motivational Interviewing Network of Trainers (MINT)	20 h of preparation consisting of lectures on illness-disease perspectives, role-play and reflections in group discussions.	HCPs go through 24–32 h of structured and supervised training. Gain knowledge of the grounded theories behind GSD, document the ability to use GSD sheets and communication skills in two full courses with patients. Passing a test.
Fidelity assessment	Motivational Interviewing Treatment Integrity (MITI)	No fidelity assessment included	Figures from grounded theories are used as qualitative fidelity assessment tools. Communication and reflection model can be used in quantifying the time where zone 5-communication and level III and IV situational reflection take place
Reported effect in diabetes care	RCTs showed weight loss in overweight women with T2DM 18 months after MI intervention and decreased HbA1c 24 months after MI in teenagers with T1DM. Two meta-analyses failed to find significant effect on HbA1c	RCT in T2DM showed a significantly lower HbA1c 12 months after an IIS intervention. This difference remained statistically significant 5 years after.	RCTs showed significant decrease of HbA1c in adults with T1DM 3-12 months after GSD group training and18 months after a flexible GSD training in younger adult women with T1DM. Psychosocial effects include decreases in distress and amotivation and increases in perceived competence and autonomous motivation.

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