Patient Education and Counseling 99 (2016) 400–407

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

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

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ARTICLE INFO

Article history:
Received 24 March 2015
Received in revised form 16 September 2015
Accepted 18 October 2015

Keywords:
Empowerment
Person-centred care
Chronic illness
Translational research
Self-management
Motivational interviewing
Life skills
Illness integration
Guided self-determination
Comparative analysis

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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http://dx.doi.org/10.1016/j.pec.2015.10.015
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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.

solutions [7,10,11]. On the other hand, when barriers to empowerment are understood, tailored methods can be developed to overcome them [12]. Hernandez suggests shifting from a paradigm expecting compliance from people to one supporting their process of integration [11], meaning that HCPs' overall purpose is to support people in overcoming all facets of the complex challenges associated with integrating illness into their lives [13,14]. PCC is seldom seen in practice, even in studies in which HCPs explicitly reported that they worked in empowerment-based ways [10]. Implementing PCC as an integral part of care for people with chronic conditions is thus challenging and far from complete.

Many people are dependent on HCPs' ability to provide PCC in practice, given the high prevalence of chronic conditions and long-term challenges that remain after surviving acute conditions through advanced medical treatment [15]. Translation of PCC is thus important. Our conception of translation aligns with that of Reuben et al., in which it develops through five stages: basic research, early translation, late translation, dissemination, and adoption [16]. Only PCC approaches with a high potential for translation into practice will reach the adoption stage, in which multidisciplinary decision-makers agree that it is sufficiently feasible and cost-effective to warrant organizational and budgetary support.

In this article, we compare the potential of three approaches for translating PCC into practice: motivational interviewing (MI) [17] and two comparatively new approaches, illness integration support (IIS) [18] and guided self-determination (GSD) [19].

2. Methods

We chose these approaches because they all shared the goal of translating PCC into practice, they varied sufficiently to warrant comparison in terms of overcoming translation challenges and had been used in diabetes care.

We conducted the comparison using a model for analysis developed during several debates on components related to robustness and consistency, which we regarded as essential for translation into practice, as proposed by Graham and Tetroe [20]. (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 in diabetes care from RCTs or meta-analyses. We emphasize that exhaustive reports on effects are beyond the scope of this article.

We included literature written by the developers of each approach to provide a coherent picture of the original concept, theoretical foundation, and choice of tools and processes in overcoming specific challenges in translation into practice. For example, with respect to MI, Miller and Rollnick aimed to eradicate misconceptions that had occurred during its three decades of history [21]. Literature pertaining to IIS and GSD was less comprehensive. IIS was inspired by research among people with well-managed type 1 diabetes (T1DM) [11] and a study among people with type 2 diabetes (T2DM) that developed interventions to promote a personal understanding of illness [22]. GSD was a product of research on people-provider relationships in difficult T1DM [19], guiding GSD's development toward overcoming barriers to empowerment [12,23] identified in grounded theories [13,24,25].

3. Results

3.1. Motivational interviewing [MI]

MI is both person-centred and directive, aimed at enhancing intrinsic motivation to change by exploring and resolving ambivalence [26]. MI is directive through the use of empathetic reflection to elicit discussion related to behaviour change (Table 1).

3.1.1. The philosophical origin of MI

MI's developers did not detail its philosophical origins. It has been recognized as containing principles of humanism [27], reflected in descriptions of the spirit of MI as a way of being with people [28]. MI is characterized as collaborative, supportive of client autonomy, and focused on eliciting people's values, motivation, abilities, and resources [26].

3.1.2. MI's development and original clinical setting

MI was originally developed to motivate people to address alcohol addiction. There is also increasing research and application of MI to other lifestyle behaviours: diabetes management, dietary change, eating disorders, gambling, and physical activity [17].

3.1.3. Theoretical underpinnings of MI

The foundation and principles of MI derive from psychologist William Miller's theory and research on motivation and behaviour change [26]. MI was developed intuitively, not derived from theory [29]. Role playing and incisive questions from young psychologists helped develop MI, which had been a tacit competence learned through interaction with clients, into a concrete approach first described in 1983 [30]. In conjunction with Rollnick, Miller further developed MI, detailing it in a seminal book [26]. Several theories influence MI, although it was not developed from a coherent theory. They include Rogers' client-centered therapy [27], Festinger's cognitive dissonance theory [31], Bem's self-perception theory [32], and Prochaska and diClemente's stages of change model [33]. MI was later described as having two active components: a relational component focused on empathy and the interpersonal spirit of MI and a technical component involving evoking and reinforcing client change talk [17]. Furthermore, it is suggested that MI and self-determination theory (SDT) support each other; SDT concepts are useful in MI and MI principles are useful in SDT applications [28,34].

3.1.4. MI's overarching goal and supportive processes

MI's overarching goal is resolving ambivalence against behaviour change in a broader context (Table 1). Four overlapping processes in MI guide the flow of people-provider conversations. *Engaging* aims to establish a helpful connection and working relationship; *focusing* develops and maintains a specific direction in the conversation about change; *evoking* elicits people's personal motivations for change (the heart of MI); and *planning* encompasses both a developing commitment to change and a concrete plan of action [28].

3.1.5. MI's general principles, strategies or tools for engaging people

MI is a relatively brief intervention in which the number of sessions depends on people's individual needs. The most essential component of the approach, the spirit of MI, is characterized by partnership, acceptance, compassion, and evocation [26]. In addition to the spirit of MI, four principles guide its use: expressing empathy, developing discrepancy between people's goals for the future and the current situation, avoiding argument and rolling with resistance, and improving people's self-efficacy and optimism for change [35]. MI emphasizes that intentional behaviour change requires active and constructive participation, and studies show that verbal discussion of change has a great impact on actual behaviour change. MI also involves a number of micro-skills, including open questions, affirming, reflecting, and summarizing.

3.1.6. MI-providers' background and training

Training HCPs in MI is usually conducted as a two-day workshop with subsequent supervision, a total of 20–24 h. Research on MI emphasizes the necessity of supervision, feedback, and response; MI is simple to understand but more difficult to accomplish. Professional background is less important to the use of MI because studies indicate no relationship between education level and ability to learn the approach [36].

3.1.7. Fidelity assessment of MI

Several instruments measure the extent to which HCPs use MI; these tools may be used for quality assurance and professional development purposes, as well as for research. Motivational Interviewing Treatment Integrity (MITI) and Motivational Interviewing Skill Code (MISC) are both frequently used [37,38].

3.1.8. Reported effects of MI in diabetes care

Examples of effects of MI in diabetes were weight loss over 18 months in overweight women with T2DM [39] and decreased HbA1c after 24 months in teenagers with T1DM [40]. However, two meta-analyses failed to find significant effects [41,42].

3.2. Illness Integration Support [IIS]

IIS is a method of supporting illness integration by highlighting areas of individuals' personal understanding of illness, with a focus on emotional and existential issues (Table 1) [22,43,44].

3.2.1. The philosophical origin of IIS

The personal meaning of living with an illness is essential, and the philosophical origin of IIS is phenomenology and research on life-world experience. Johansson et al. present an example of life-world research when reporting that a fight to avoid becoming one's illness was essential when diagnosed with diabetes [45].

3.2.2. IIS's development and original clinical setting

IIS was developed in relation to people with T2DM [22,43,44,46,47], among whom research revealed that illness integration ran parallel to the self-management process.

3.2.3. 12 Theoretical underpinnings of IIS

IIS aims at a personal understanding of illness in the care of people with chronic conditions [18,22]. It was theoretically inspired by Hernandez's research among people with good self-management of T1DM [48,49] and validated in other settings [43,50,51]. According to Hernandez achieving good glycemic control is not a consequence of simply following advice from HCPs; it is achieved by patients after they have passed through a process of integration. The first stage after diagnosis is characterized by a tendency to keep diabetes at a psychological distance and focus on normality, which supports only limited knowledge about diabetes. The second stage involves a turning point where opposition to diabetes is replaced by an active interest in learning about all aspects of diabetes management. This leads to the third and final phase involving an ongoing process of reflection and making daily adjustments relying on a unique body of personal knowledge. In this phase, called 'the science of one' by Hernandez, people create the potential to live well with diabetes [47]. Hörnsten et al. suggest an expansion of the theory to include the period of pre-diagnosis of T2DM, in which people may suspect illness and try various remedies before seeking help [18].

3.2.4. IIS's overarching goal and supportive processes

IIS's overarching goal is integrating the condition into daily life as a way to facilitate self-management. Following Hernandez's suggestion that diabetes educators utilize empathy to get to know their people**,** IIS recommends that HCP**s** focus less on diabetes facts and more on highlighting people's illness experiences to accelerate their progress toward a turning point. People's personal understandings of illness are discussed in six reflective sessions addressing their views on: (1) the image of the illness, including its seriousness; (2) the meaning and consequences of being diagnosed; (3) the integration (acceptance and adaptation) of illness in one's life; (4) space for illness and self-management in daily life; (5) responsibility for self-management; and 6) future prospects, taking illness into consideration [22,43,44,46,47].

3.2.5. IIS's general principles, strategies or tools for engaging people

Excluding a single sheet covering the six themes of personal understanding of illness in T2DM, no tools have been used beyond empathic active listening. The strategy for engaging people is to provide support as they pass from pre-diagnosis to adaptation to illness viewed as a natural part of life [18,43].

3.2.6. IIS-providers' background and training

Diabetes specialist nurses, responsible for diabetes clinics at primary health care centres, had varying professional preparation [43,52]. Their preparation for an IIS intervention consisted of 20 h of education over three sessions that included lectures and discussions contrasting people's perspectives on illness and self-management with a biomedical view. A workshop included role playing in which diabetes specialist nurses were trained to lead a group in IIS, followed by group discussion.

3.2.7. Fidelity assessment of IIS

No fidelity assessments have been reported. However, in an interview-based evaluation [52], participating diabetes specialist nurses reported that implementing IIS altered their professional role. They experienced courage about discussing the severity of diabetes with people, accompanied by ambivalence toward and doubts about PCC that were largely due to the inconvenience of changing professional practice routines and a position of withdrawn expertise. However, a follow-up study indicated that these difficulties did not preclude improvements in metabolic control and diabetes empowerment among people [43].

3.2.8. Reported effects of IIS in diabetes care

In T2DM, a significantly lower HbA1c was seen 12 months after an IIS intervention [46]. This difference remained statistically significant after 5 years [47].

3.3. Guided self-determination (GSD)

GSD was developed as an empowering decision-making and problem-solving method through a four-stage research program in difficult diabetes care in 1996–2004 (Table 1) [19]. In stage 1, grounded theory methods identified barriers to empowerment and reasons they were seldom overcome in people-provider relationships [13,24,25]. In stage 2, participatory research with diabetes nurses and diabetes people developed GSD as an approach to overcoming barriers to empowerment [19]. In stage 3, a theory-driven evaluation demonstrated that GSD overcame barriers to empowerment when used in a one-on-one setting [12], and stage 4 was a randomized controlled trial testing the effect of GSD in group education [23].

3.3.1. The philosophical origin of GSD

GSD was inspired by the philosophy of Loegstrup [53] and developed to be consistent with providing empowerment-based nursing care and to close empowerment gaps revealed through grounded theories in difficult diabetes care.

3.3.2. GSD's development and original clinical setting

In diabetes care, interactions between HCPs and people with poorly controlled T1DM can be especially difficult. This area was chosen for development to increase GSD's potential influence on HCPs and people struggling with challenges related to chronic conditions.

3.3.3. Theoretical underpinnings of GSD

Three grounded theories constitute GSD's foundation. One explains how a mutuality-expecting approach is superior to a compliance-expecting and failure-expecting approach in resolving a life-versus-disease conflict [24]. Another theory explains why three types of people-provider relationships have differing potentials to effect change [25]. The third theory, a decision-making model, explains how to best facilitate person-centered communication and shared decision-making [13]. GSD's formal theories are humanistic values theory [54], self-determination theory [55], and life skills theory [56], which recommends that people develop balanced self-determinism in their way of living with a condition instead of other-determined or selfish-determined ways.

3.3.4. GSD'overarching goal and supportive processes

GSD utilizes a seven-stage process to develop illness-related life skills: establishing a mutual people-provider relationship with clear boundaries; self-exploration; self-understanding; shared decision making; action; and feedback from action.

3.3.5. GSD's general principles, strategies or tools for engaging people

Discovering and expressing their personal difficulties and priorities related to their conditions enable people to discover their potential for change [25]. GSD promotes shared decision making and mutual problem solving through reflection sheets and advanced professional communication skills. The development of reflection sheets was inspired by Arborelius [57] and based on grounded and selected formal theories [33,58]. People prepare the sheets at home, recording their reflections as a way of becoming active in a change process [see supplementary material]. By hearing people read aloud what they have expressed on the sheets, HCPs learn about specific difficulties they had not considered. To mutually explore these difficulties, HCPs use three communication skills: mirroring [59], active listening [60], and values-clarifying responses [61]. Reflection sheets and advanced communication enable people and providers to establish a collaboration in which people clarify their values and express their needs [62]. The sheets also support people in prioritizing problems and prompt self-determined goal setting.

3.3.6. GSD-providers' background and training

GSD providers in diabetes have a professional background: nurses, physicians, or dieticians. A total of 24–32 h of supervised training over four days provides the theoretical background and enables trainees to use reflection sheets and communication skills.

3.3.7. Fidelity assessment of GSD

Trainees document provision of GSD to two people in their usual practice and pass a test. A fidelity assessment tool based on the grounded theories behind GSD evaluates whether their performance is congruent with its theoretical foundation [63].

3.3.8. Reported effects of GSD in diabetes care

In diabetes, RCTs showed significantly decreased HbA1c in adults with T1DM 3–12 months after GSD group training [23] and18 months after a flexible GSD training among younger adult women with T1DM [64]. Psychosocial effects include decreases in distress [23,64] and amotivation [64,65] and increases in perceived competence [23,64] and autonomous motivation [64].

4. Discussion and conclusion

4.1. Discussion

Our comparison of the potential of MI, IIS, and GSD to translate PCC into practice revealed no conflicts of philosophy. All approaches support autonomy and seek to engage people in collaborative explorations of strategies for living well with a chronic condition [66]. However, differences in their original clinical settings seemed to determine differences in overarching goals and, to some degree, processes and tools (Table 1). In addition, differences in development methods related to varying theoretical foundations. All approaches had HCP training programs, but only MI and GSD incorporated tools for assessing fidelity (Table 1).

MI's development to address alcohol addiction explains why resolving ambivalence to change is an overarching goal. Addressing alcohol addiction requires a life-long commitment that cannot be achieved without a clear understanding of people's ambivalence about making it. Any pressure from HCPs would interfere with people's ability to make personal decisions to change and, consequently, their chances of success [27]. Indeed, the approach warns against ruining the MI spirit, recommending that HCPs elicit individuals' personal motivation and roll with resistance. MI is a brief intervention that, according to Bricker and Tollison, lacks a procedure for "teaching clients skills to change" and cannot be regarded as "a stand-alone therapy" [67,p. 542] because it supports people in deciding to change, not in accomplishing change.

IIS's and GSD's development in diabetes care explains their elaboration of challenges with integrating this chronic condition in beneficial ways where knowledge and skills necessary for eating, exercising, and taking medicine are used in ways that are congruent with personal values [47].

The approaches' theoretical foundations also differed. In contrast to MI's intuitive development, IIS and GSD are based on empirically-developed conceptual frameworks in the form of grounded theories. Sandelowski recommends grounded theories as a foundation for interventions to ensure they fit the needs of those for whom they are developed [68]. The developers of MI appear to acknowledge the importance of extending its theoretical foundation [17] through articles describing an emergent theory of MI and suggesting its complementary relationship with self-determination theory [69]. It is likely that the many deviations from MI's original form observed by the developers during dissemination [21] might arise from MI's intuitive and non-theoretical development. Clear concepts and connections between approaches' theoretical underpinnings and their assumed mechanisms might increase their ability to be translated into practice (Table 1). Future research will show whether the grounded theory foundations of IIS and GSD will facilitate their translation by helping HCPs recognize patterns requiring change. In a theory-driven qualitative evaluation of GSD, grounded theory elements confirmed that expected changes in people-provider interactions had occurred [12].

Essential differences existed in the tools and processes used in each approach (Table 1). According to Miller and Rollnick, techniques must be used with caution. For example, a decisional balance tool might deepen some people's ambivalence, especially when they have decided to change [70]. They also warn against HCPs becoming obsessed with a structured manual because it might ruin the MI spirit [21]. Conversely, they consider ratings of confidence and importance to be useful [21].

Differences between IIS and GSD tools can be explained by the clinical settings in which they were developed. IIS was inspired by the discovery of the stages people had moved through by the time they achieved successful T1DM self-management. These stages are followed when supporting people with newly diagnosed T2DM to move beyond a turning point. IIS offers no tools other than themes of personal understanding (Table 1). In contrast, GSD was developed in the context of busy clinical practice, where a difficult and sometimes deadlocked interaction occurred between people with poorly controlled type 1 diabetes and HCPs. Escalation of conflict between HCPs and people might inhibit problem solving, perhaps even to the extent that both parties expect their interaction to fail [24]. Consequently, a genuine pattern interruption was needed to facilitate a constructive interaction in the limited time available, and a written invitation to collaborate and semi-structured reflection sheets for people to complete at home were incorporated into GSD. By unburdening themselves of hidden and unexpressed difficulties and sharing them with HCPs, people become able to control and direct their lives [62]. Mutual reflection increases HCPs' humility rather than sustaining overconfidence in their professional competence [12], as also reported from medical education using reflective writing [71].

Despite HCPs' interest in using all three PCC approaches, they often find them initially challenging. Among MI trainees, 31% of highly educated and experienced therapists failed their first attempt at empathy and 16% failed their second attempt [36]. Interviews with IIS and GSD trainees revealed that learning to incorporate these empowerment-based approaches resulted in temporary loss of perceived expertise, which made HCPs feel unsure about their professional roles [72,73]. HCPs using GSD reported that supervision and reflection sheets completed by people helped them regain confidence [73]. In IIS, HCPs regained confidence when HbA1c was reduced [72].

The key difficulty in translating PCC into practice is convincing HCPs that they are not already practicing it [1]. The approaches support this effort to varying degrees. In MI, the use of MITI and MISC assesses the degree to which HCPs follow the MI principles [37]. In GSD training, HCPs' awareness of barriers to empowerment is enhanced by presenting the patterns revealed by grounded theory, enabling HCPs to distinguish between different zones of communication and levels of situational reflection (Table 1). These theoretical patterns constitute a central ingredient in a newly developed fidelity assessment tool [63].

The included reports of effects in diabetes care are neither comparable nor exhaustive and must be interpreted with caution. PCC is beneficial in diabetes with or without an effect on HbA1c; tailored support in itself can serve as a reason for implementing PCC in practice [74].

Dissemination to other areas, another part of translation [16], will involve diverse challenges in highly specialized hospital settings, primary care settings [75], and nursing homes [76]. IIS has not yet been used beyond outpatient diabetes care, whereas GSD and MI have been used in other settings. However, their application is different. MI is a global approach that is independent of the clinical setting; in contrast, GSD applies both global communication skills and context-specific sets of reflection sheets. The latter maintain the approach's rigor across difficult areas, such as adolescents with poorly controlled T1DM and their parents [77], younger adults with poorly controlled T1DM [64], schizophrenia [78,79], gynaecological cancer [63], and stroke-related aphasia [80].

4.2. Conclusion

MI, IIS, and GSD may appeal to different professionals according to personal preferences, illness stage, and complexity of the clinical context. MI is especially valuable when people express ambivalence, and the IIS approach is likely to be translated into early stages of T2DM and other chronic conditions. GSD is particularly valuable when people-provider problem solving and collaboration have become difficult.

4.3. Practical implications

Although numerous interventions have been tested and many have proven to be effective, we must consider which intervention characteristics enhance the chances of its translation into practice in an increasingly resource-restricted health care environment. HCPs must critically consider the context, starting with preferences of people with chronic conditions, in choosing the most appropriate delivery mode in their clinical setting. Whichever approach they choose, HCPs must be aware of the difficulty of learning to work in a way that is consistent with PCC. Leaders must therefore be prepared to invest in training, time for practice, and supervision of trainees. Moreover, they must reassess their personal ownership as a leader [81] because active ownership, not just acceptance, is associated with successful implementation.

Conflict of interest

We declare no conflict of interest.

Funding

No financial support was received for this research.

Acknowledgement

We acknowledge Jennifer Green for editing and proof reading the article.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at http://dx.doi.org/10.1016/j.pec.2015.10.015.

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