

The Autonomy-supportive Approach: The Key to Promoting Rehabilitation Adherence?

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Autonomy-supportive Approach

Poor adherence (i.e., “the extent to which a person’s behaviour . . . corresponds with agreed recommendations from a healthcare provider” [1]) is a common problem in a range of healthcare settings, including those offering physiotherapy [2]. In fact, research has suggested that adherence to rehabilitation is as low as 30% [3]. A systematic review by Jack et al. [4] proposed that common barriers to treatment adherence in physiotherapy include previously low levels of physical activity, low self-efficacy, depression, anxiety, numerous perceived barriers to exercise, and increased pain during exercise. At the same time, motivation is another critical factor that affects adherence to prescribed treatment in healthcare settings [5,6]. It has been suggested that theory should guide interventions in the health domain [7,8], as theory can provide a deeper understanding of the process of change and contribute to more effective interventions [9,10]. One such theory, self-determination theory, has gained increasing attention in the health domain recently [11]. From the perspective of self-determination theory, autonomy support has been advocated as an approach to facilitate patients’ motivation for rehabilitation and ultimately their rehabilitation adherence [11]. In healthcare settings, autonomy support refers to acknowledging the patients’ perspectives, allowing them free choice, responding to their initiations, providing them with relevant information, and minimizing control [12]. In following the autonomy-supportive approach, healthcare providers should (I) nurture patients’ inner motivational resources, (II) use non-controlling language, (III) offer rationales meaningful to patients, (IV) provide patients with choice, and (V) acknowledge and accept patients’ negative feelings [13]. More specifically:

(I) To support patients’ inner motivational resources, healthcare providers should ask questions to induce patients’ curiosity, provide patients with challenging but achievable goals, provide patients with opportunities for interaction, and vitalize patients’ satisfaction in terms of their psychological needs [13,14], including autonomy (i.e., feelings of control over personal actions and participation in self-chosen activities), competence (i.e., feelings of having effectively mastered challenging tasks and the exercise of personal capacity in given domains), and relatedness (i.e., feelings of having meaningful connections with others and feeling comfortable and involved in a given context) [15].

(II) Non-controlling language implies that demands are communicated by healthcare providers in an informational, flexible, responsive, and non-pressuring manner and by relying on phrases such as “you may” and “you might want to.” In contrast, controlling language involves communicating demands in a controlling, coercive, intrusive, and pressuring manner and by using phrases such as “you must” and “you have to” [13,14].

(III) Healthcare providers can offer meaningful rationales by communicating and raising awareness about activities and exercises of value, meaning, relevance, and utility to patients [13,14].

(IV) Healthcare providers should communicate to patients information about options and allow them free choice, as well as encourage choice-making and self-initiative [13,16].

(V) Healthcare providers can acknowledge and accept patients’ resistance and negative feelings by acknowledging, accepting, and even welcoming such feelings as reasonable reactions to demands and restrictions [13,17].

Several cross-sectional and longitudinal studies in healthcare settings support this notion that is, perceived autonomy support from healthcare providers is associated with autonomous motivation, which in turn is related to rehabilitation adherence [18-22]. For example, in a sample of 115 post-surgery anterior cruciate ligament patients, Chan et al. [18] investigated the relationship between physiotherapists’ autonomy-supportive behaviors, patients’ motivation for rehabilitation, and patients’ post-surgery rehabilitation adherence. Results showed that patients’ perceived autonomy support from physiotherapists predicted autonomous rehabilitation motivation, which in turn predicted patients’ adherence to rehabilitation [18]. Moreover, an extensive meta-analysis of 184 independent datasets examined the relationship between practitioners’ approaches and patients’ mental and physical health in healthcare and health-promotion contexts. Overall, results revealed that patients’ perceived autonomy support from their healthcare provider was associated with greater quality of life; vitality; positive affect; smoking abstinence; exercise and physical activity; weight loss; glycemic control; medication adherence; healthy diet; dental hygiene; and reduced depression, negative affect, and anxiety [11].

Initially, it was believed that the instruction or communication style of people who are in a position of power of others (e.g. physician-patient relationship, teacher-pupil relationship, and parent-child relationship) is rather stable and unmalleable (i.e. either you have a controlling or autonomy supportive approach [23]). Recent decades of evidence, however, suggests otherwise. In their meta-analysis, Su and Reeve [13] set out to determine whether interventions designed to help people support the autonomy of others are effective, by systematically identifying 19 intervention studies. Findings showed that it is possible to train teachers, parents, and healthcare providers (i.e., physicians, medical students, and counsellors) to adopt an autonomy-supportive approach, preferably through rather brief training sessions (one to three hours). Generally, interventions targeting teachers were more effective (effect size: 1.16) than interventions targeting healthcare providers (effect size: 0.44). These findings should, however, be interpreted with caution since there were more interventions targeting

teachers (n=11) than healthcare providers (n=5). In relation to this, a growing number of autonomy-supportive intervention studies in physical education (PE) have shown promising results. Findings from these studies suggest that training PE teachers to become more autonomy-supportive increases pupils' perceived autonomy support, basic needs satisfaction (i.e., autonomy, competence, relatedness), autonomous motivation, physical activity during PE class, self-reported leisure-time physical activity, and future intentions to be physically active [24-30].

Autonomy-supportive intervention studies in healthcare settings are comparatively limited and provide mixed findings [31-35]. Murray et al. [31] examined the effects of communication skills training on physiotherapists' supportive behavior during clinical practice through a randomized controlled trial (RCT) that included 24 physiotherapists. Physiotherapists in the intervention group provided their patients, diagnosed with chronic low back pain, with greater autonomy support, compared with controls [31]. Initial evidence from that same trial suggests that patients in the intervention group rated their home-based adherence higher, compared to the control group, at 1, 4, and 12 weeks, but not at the 24-week follow-up [32]. In another cluster RCT, Duda et al. [33] compared the effects of standard provision exercise referral with an exercise referral intervention based on the principles of autonomy support, including 347 patients on an exercise referral scheme. At the six-month follow-up, both groups reported significantly increased physical activity and improved quality of life and well-being, with no differences between the groups. The only between-group difference observed at the six-month follow-up was decreased anxiety for patients in the exercise referral intervention based on the principles of autonomy support.

Taken together, these findings indicate that training healthcare providers to embrace an autonomy-supportive approach may increase patients' adherence to rehabilitation. It is, however, too early to draw any conclusions since findings are inconclusive and more research is warranted. For example, more comprehensive RCTs with longer follow-ups targeting different healthcare providers and different groups of patients are necessary. Further, as suggested by Weman [36], another potential avenue for future research is to test the possible synergy of combining person-centered care [37,38] and autonomy support in healthcare settings. Lastly, another future research direction is to test the proposed marriage of self-determination theory and motivational interviewing [39-41] in the context of rehabilitation.

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