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Review Article

Motivational Interviewing in Pro-Life Palliative Care

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Abstract

Pro-life practitioners must make integrous or endogenic, a respect for life from the moment of conception until natural death. With true belief and faith in the pro-life cause, the practitioner imbues with patience and encouragement the fruits necessary to begin the process of motivational interviewing toward life for their patients. Natural death does not refer to a lack of medication or lack of intervention, but rather the opposite, natural death, or the end-of-life after *every effort* and intervention has been made to prolong a life. The word 'integrous' is rooted from the word 'integrity' or virtue; the human virtue needed to apply effortful moral value in the practice of pro-life health care. The pro-life practitioner, neither seeking permission nor validation to cease life-sustaining treatments, nor attributing lack of effortful pro-life work to that of mercy killing. Rather, the pro-life practitioner, with steadfast balance and resolute belief for each life for which they care, seeks to prolong every life until the end or natural death. With the integrous belief in life, the pro-life practitioner will develop internal motivations in patients for living and effective management of any disease course. In this article, the components of the therapeutic modality of Motivational Interviewing (a.k.a motivational counseling or coaching) in the context of end-of-life care will be explained in light of a pro-life palliative health care practice.

Keywords: Counselor; Motivational interviewing; Multidisciplinary; Palliative care; Pro-life; Social worker

End of Life Care

End-of-Life may refer to the point at which a patient is diagnosed with an illness that is expected to be fatal or terminal, or severely chronic and difficult to manage. There are primarily two outlets for end-of-life care:

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Palliative

According to the (NIH) National Institutes of Health [1] and National Institute on Aging [2], palliative care is a resource for anyone living with a serious or chronic severe illness. In addition to improving quality of life and helping with symptoms, palliative care can assist patients in understanding their choices for medical treatment. Palliative Care refers to the acts of providing medical care and curative treatments (e.g. chemotherapy) for those with such severe and chronic illnesses.

A palliative care consultation team is a multidisciplinary team that works with the patient and their family to provide medical, social, emotional, spiritual, and practical support. Such support may include, but is not limited to: Medication, medical devices, physical/occupational therapy, activities and community program referral, chaplain visits, and counseling for the patient and family. Palliative care is typically provided in a patient's prior home or residential setting.

Hospice

Hospice can be provided in most settings: home, nursing home, assisted living facility, or inpatient hospital, respective to insurance policies. Hospice is a choice for patients who are not responding to any medical interventions, and are expected to die in the near future. In hospice, attempts to cure a person's illness are usually stopped as the symptoms of death naturally begin.

As hospice is intended to be a supplementary comfort or compassion service at the very end of natural death, it is more reasonable to apply pro-life motivational interviewing care to patients in the palliative care range of services.

Aversive Actions in Palliative and Hospice

Pro-life providers are very aware of the actions taken with patients in palliative and hospice care. Many care actions or inactions come under scrutiny of pro-life providers, in what has been termed mercy killing, or allowing a patient to die, for the sake of misguided concern for them or their family, and this prior to natural death. Life and death is not a human decision, but God's decision.

Controversies exist surrounding overuse of sedation, pain killers, withholding of nutrition and hydration, and lack of effort to provide further medical interventions are all happening to patients, and thus hastening unnatural deaths. "Misuse of hospice and palliative care with an intent to end life is properly termed 'stealth euthanasia'- it is not active euthanasia or passive euthanasia, but a combination of both [3]". Pro-life advocates take a stand for the cause of life, and oppose these aversive actions, whether intentional, negligent, misguided, or unaware.

Other issues contributing to hastening death are restrictions on insurance coverage for multiple hospitalizations; and the retribution of unpaid patient bills, and readmissions costs to hospitals by insurance companies.

Illnesses adaptable to Pro-Life Motivational Interviewing

Most, if not all, disorders and diseases benefit from the therapeutic intervention of motivational interviewing-counseling or coaching.

Medical illnesses can vary broadly from Alzheimer's, Multiple Sclerosis, cancer, heart disease, smoking/lung disease, diabetes, to HIV+ expectant mothers. Psychological disorders may include depression, schizophrenia, somatic ailments, dysthymia, apathy, and substance addicted parents.

Motivational Interviewing has long been used in integrated treatment for dual disorders, and can be paired with (CBT) Cognitive-Behavioral Therapy techniques, or any range of other medical and therapeutic interventions.

Motivational interviewing involves methods of evoking cognitive and behavioral change in patients with a health condition, using evidence-based education and professional guidance. The health clinician aims at improving patient health outcomes using patient engagement strategies to progress toward specific treatment health goals.

Pro-life, again, refers to respect and value for life at every age [4], from the moment of conception until natural death. Pro-life motivational interviewing or counseling, applied to palliative care, would therefore encourage a patient toward a longer, healthier, more productive life and managed illness, and acceptance of medical interventions.

Referral Process

Referral to a pro-life doctor, provider, or company may come from any number of persons. Catholics and Catholic companies are traditionally known to be pro-life; however, Catholic companies may employ pro-choice providers. Similarly, a Catholic practitioner may be lenient in their ethics, or misguided in their awareness of the pro-life cause.

It is important to find a doctor and health care team that shares your values, prior to the point of critical need. However, you may still seek a pro-life provider at any point in your illness or life. Be cautious that when the patient and family are in crisis, fatigued, or overwhelmed, they may choose actions that are not in line with their values, and for which they may later regret.

The best way to seek pro-life care is for the patient and family to clearly and explicitly request pro-life providers. You should speak openly with your health care providers for medical and psychological education on the best methods to prolong your life with pro-life care.

It is also vital that every patient complete legal documents stating their wishes for pro-life care, should they encounter an unexpected health crisis. These documents should be completed when the patient is in their better or good state of mind, and may be notarized with two witnesses. It is not required that you hire an attorney, but many people choose this option if they have complex needs.

Pope John Paul II stated that "there is need to develop a deep critical sense capable of discerning true values and authentic needs [5]". What is at stake in the struggle between the culture of life and the culture of death is our very ability to discern true values. The needs of the most vulnerable among us cannot be truly understood or met without first recognizing the sanctity of human life. What is at stake affects not only patients but also the medical profession and the whole of society. Whether practices that are knowingly used to impose death are *justified* by principles of secular bioethics or the misuse of the principle of double effect, they are always unethical [6].

Legal Documents to Familiarize Yourself

Informed consent: Informed consent to medical treatment is fundamental in both ethics and law [7]. Informed consent means that the physician or provider has communicated thoroughly with the patient about their medical options, and signed a document as such.

Patient choice of providers: Federal law mandates that Medicaid beneficiaries and all patients get the freedom of choice for their health care providers and provider companies [8].

Advanced directives for health care: An advance directive is a document by which a person/patient makes advanced or pre-determined health care decisions in the event that, in the future, he/she becomes unable to make those decisions [9]. A patient is still allowed to change their mind on these decisions if in a state of mind to do so when the change is requested.

Advanced directives for mental health care: This is the same as the aforementioned Advanced Directives; however, this document applies to mental health care. If your health agency is unable to provide any of these documents, you may find forms by searching the internet, or having a lawyer draft a version.

Release of information: Release of Information form is signed by the patient, allowing a provider or agency to send your private information to another party. This document will notate to whom the information is to be sent, what items are to be sent, and the date range of service information to be sent.

Competency or capacity screening: This is a decision-making capacity screening, for the purpose of determining need for use of a health care proxy that the patient assigned per their directive documents. It is imperative to let patients make their own decisions for as long as possible. An unaffiliated/unbiased person who is trained in screening assessment [10] will conduct this determination of competency or capacity. Such an unbiased person may confer with family or friends as to the best mental awareness state the patient has been in for the last several months.

Financial power of attorney: Power of Attorney refers to the person(s) whom the patient has declared will be the manager, in this case, of their finances, once they are unable to do it themselves.

Health care power of attorney: Health Care Power of Attorney refers to the person(s) whom the patient has declared with be the manager of their health matters, if they are unable to make decisions.

Motivational Interviewing and the Multi-Disciplinary Care Team

During discussion of the patient's need to make changes to manage their disease, the practitioner must assess what factors are prohibiting the patient from making changes, and then work with the patient to address those issues. Motivational Interviewing is a complex and multi-faceted counseling or coaching process, which is done over a period of time. Because it is difficult to determine the amount of

time it will take to elicit pro-life, proactive, and positive life change; the health care team and primary doctor and counselor, should act with prudence, fortitude, and temperance to encourage and save life, yet also be patient and paced in their work.

The multidisciplinary team of care providers in the pro-life palliative care process should all be aligned and educated in the motivational interviewing framework. While the role of motivational interviewer or coach is primarily the duty of the social worker or counselor in the palliative team, all of the care providers should speak and act in a complementary manner. The primary physician should strictly be of the pro-life cause and lead medical efforts to sustain life and increase morale. For the other providers, such as the physical or occupational therapist, nurse aid, nurse, and chaplain, the rule of less is more in speech with the patient, allows for the social worker or counselor to take the lead in patient coaching. A warm, caring, and helpful demeanor is the most effective personality style to accompany the respective services provided by the broader multidisciplinary pro-life palliative team.

Pro-life palliative counseling should begin by establishing dedication, empathy, and a trusting relationship between the primary providers and patient/family. The process of change is achieved in small increments as the therapeutic relationship develops, and the patient begins to create internal motivations for life and flourishing.

Such an invested, secure and concerned therapeutic relationship for a patient's life and well-being will begin the internal healing process of hope for the patient.

Theories in Motivational Interviewing

The approach of Motivational Interviewing began in the 1980's with William R. Miller, PhD. This counseling modality is well explained in Motivational Interviewing, 3rd Edition: Helping People Change, by William R. Miller and Stephen Rollnick. Motivational Interviewing has been described as "a way to individualize care for patients [11]".

The motivational counselor should be aware that the suffering of the patient may cause feelings of ambivalence and indifference to their care and health management, when the patient was prior more decisive and ambitious. The patient may even experience such lethargy that they are unable or unwilling to take steps forward. Ambivalence should be handled in a gentle paternalistic manner in which the clinician knows that life and living is primary.

If the patient and/or family have declared in their Advanced Directives that they want health interventions, and they are of the pro-life mentality, then proceeding with Motivational Interviewing is a best practice.

Motivational Interviewing recognizes theories that support its approach, including: cognitive dissonance theory and self-perception theory. Cognitive Dissonance Theory [12] was established by Leon Festinger in the 1950's. Dissonance occurs most often in situations where an individual must choose between two incompatible beliefs or actions (life and death). The greatest dissonance is created when the two alternatives are equally attractive. Furthermore, attitude change is more likely in the direction of less incentive since these results in lower dissonance. This is especially relevant to decision-making and problem-solving. Dissonance can be eliminated by reducing the importance of the conflicting beliefs, acquiring new beliefs that change the balance, or removing the conflicting attitude or behavior. A simple example of removing the conflicting idea, is for the patient to be educated on their health options and to know who can help them.

The theory of Self-Perception [13] was recorded by Daryl Bem in the 1960's. According to this theory, when people are unsure of their own attitudes, one way to infer them is by looking at others' behaviors. Bem argued that people sometimes analyze their own behavior in the same fashion as they would analyze someone else's behavior. Self-perception theory provides a similar explanation for emotion by suggesting that people infer their emotions by observing their bodies and their behaviors. According to self-perception theory, people undergo an over-justification effect when their actions can no longer be attributed to their intrinsic motivation but, rather, to the anticipation of an extrinsic reward (e.g. suffering-free eternity in death). A person in such a state is weak and ambiguous, and not able to visualize managing a healthier life.

A clinician who is working with a patient through motivational interviewing must recognize the level of motivation the patient holds and must be willing to work through possible resistance to change, in order to foster goal setting and to move forward [14]. Motivational Interviewing can be successfully implemented into appointments or interactions between the health care clinician and patient.

The social worker or counselor in the palliative care team who is the primary motivational interviewer, may be required to travel with the patient to hospitals and other settings of care, and speak with insurance companies and various providers. Such a role would be to mediate and direct communications, educate, and advocate for the patient and their family, in light of the motivational interviewing approach to pro-life palliative care [15].

Assessing Readiness to Change

The Motivational Interviewer should be aware of the Stages of Change Model. This model describes five stages that people go through on their way to change: Pre-contemplation, Contemplation, Preparation-Determination, Action, and Maintenance [eventually followed by a 6th stage of Termination]. The Stages of Change Model or Transtheoretical Model was developed by J. Prochaska and also then added onto with C. DiClemente in the late 1970's.

During the pre-contemplation stage, a patient is resistant to change because he/she does not understand its necessity. The clinician will express empathy and good care for the patient, reminding the patient that they enjoy their time together. The contemplation stage is when the patient recognizes that a change needs to happen; and this is often at the stage where motivational interviewing begins. The health care team should be aware that patients can be in the contemplation stage for a long time, even for years. The clinician may begin by educating the patient and family on health options, and allow them time to process and understand goals. In the preparation stage, patients may still be ambivalent about what to do, but they are planning to change. The patient may be uncertain what plans are best for solving their situation and so may still be somewhat ambivalent about making choices toward change. It is a good idea for the clinician to begin clear goal writing with the direct steps that must be accomplished to get there. It is unhelpful for a clinician to act irritated when a goal is not progressing, but instead, it is a good idea for the clinician to review the

goals regularly, and the progress made toward reaching them. In the action stage, the patient does a lot of activity that demonstrates working toward change. Others can see accomplishment in the patient, and should recognize, compliment, and reward such change and good work as motivation to continue. Loved ones and caregivers should thank the patient for their time together, and express how much the patient means to them. Writer Henry David Thoreau is quoted to say, Things do not change. We change.

The maintenance stage of change for the patient is ongoing and is the stage in which the patient will likely remain for their lifetime, making every effort to prolong their life with counsel and health management and interventions.

Communication Styling in Motivational Interviewing

Motivational Interviewing consists of four main principles that guide the counseling process.

These include empathy, discrepancy, 'rolling' with resistance, and supporting self-efficacy.

In their motivational interviewing book, Miller & Rollnick suggest that good listener's take an interest in what another has to say, seek to understand, and at least temporarily, refrain from offering advice. Henri Nouwen said, "Anyone who willing enters into the pain of a stranger [empathy] is truly a remarkable person." Sometimes the best course of action for a counselor clinician is also to be silent, and just exist with the patient in contemplation.

The motivational interviewer should seek to learn what inspires each patient to hope and optimism, or what triggers their rationales for thought and action. This can be a very effective communication strategy to incorporate into the counseling process.

The patient needs empathy from the clinician in order to feel as if he/she is not alone in the process and to feel that someone truly understands their suffering. This empathy can reduce feelings of isolation and can create change ideas. The goal of empathy is to help the patient to feel that he/she can open up. Through the clinician providing a non-judgmental attitude that conveys warmth and a gentle demeanor while engaging the patient, it thus expresses,

"*I can image what you are going through; and I care about what happens to you.*"

Discrepancy and resistance describe the patient's current mindset as compared to where the patient needs to be. The clinician works through the motivational interview to help the patient see not only the current status, but to gently and patiently remind the patient of proper health goals and gain momentum. The clinician can passively accept where they patient is now, but with a broader presence of approach, that a better life is ahead. The process of counsel in motivational interviewing is one of *guiding* the patient.

It can be helpful to site examples from the patient's life in which they have overcome challenges. This is a part of the process of kindly engaging and getting to know your patient as a person. Overcoming past challenges creates great confidence and a feeling of respect in the patient, thus increasing their strength to meet new challenges. It is very important for the motivational interviewer to always speak in a supportive, calm, and concerned tone, and smile with gratitude for their time together. Examples of supportive and non-threatening statements may be:

"That must be very difficult for you; I cannot imagine how you are suffering."

"It sounds as if you want to consider other options before tackling this choice."

Self-efficacy defines how individuals feel about their abilities. Similar to overcoming past challenges, you want to make the patient recognize that they will get through their struggles with great strength and ability. People naturally want to live, and since the beginning of time, have feared the approach of death. Perhaps your patient has a fear of a procedure, but that is hidden behind resistance to managing their illness and prolonging life. It is good counseling to find the core thought or trigger. The pro-life clinician will inspire and integrate the self-efficacy naturally to live and flourish as best the patient can. Suffering is a part of every life to some extent, and the more suffering an ill patient endures, the stronger their character and resilience in the end.

A patient who is going through a crisis or other health situation may feel judged or criticized by others. This is a prominent reason for a clinician to be trustworthy and steadfast in their belief in the patient's life.

There are good methods to transition into hopeful, pro-life thinking in a patient's decision making. The clinician may approach an educational opportunity by saying:

"Would it be all right if I shared with you…"
"I have seen this experience in the past. Can I tell you about it?"
or, "Tell me what your thoughts are on this, and I will share with you mine."

The multi-disciplinary team of practitioners should be aware of any barriers or special needs. Universal learning pedagogies include visual and auditory materials as needed. Some patients and families may even require an interpreter of their native language to get the full detail and complexity of a situation.

Non-verbal communication refers to the posture, attitude, gestures, and unspoken communication that both the patient and the clinician engage in. The clinician who is conducting the interview must be very cautious of his or her non-verbal communication. Non-verbal communication can convey certain messages all on its own, sometimes contrary to their intent. Facial expressions, eye contact, posture and gestures are types of non-verbal communication.

The motivational interviewer should practice mindfulness of their verbal and non-verbal performance when with a patient and their family or other providers.

Active listening ties to the patient the appropriate signals that show the patient that the clinician is attentive and concerned to what they are expressing. By actively listening to the patient, the clinician not only hears the words with their ears, but demonstrates to the patient that he/she is being listened to, such as by leaning forward, making eye contact, and nodding the head. Use of timely Socratic [16] questioning may prompt the patient to think in a different way about a point of controversy or unhelpful perspective.

If the patient is demonstrating strong feelings, such as telling a sad story, or describing their pain, it is necessary for the clinician to mirror the patient. The clinician should focus on the patient, lean in or sit closely, and nod as the patient talks. A clinician is allowed to cry, which shows empathy and relation to the patient's story. However, the clinician should always be able to then regulate and resume communication appropriately as prior.

Through collaborative empowerment, the motivational interviewer sets up the direction in which the conversations will proceed. This is an important method process in the communication with your patient. The clinician will be the emotional and directional regulator in counseling, and is to act with prudence and wisdom in speaking. The motivational interviewer will be the lead contact in provider discussions and relay of information. It is crucial that the clinician always involve the patient, family, and primary decision makers, and to accurately represent information.

Treatment Planning in Motivational Interviewing

At the center of motivational interviewing, the clinician will work toward evoking and eliciting change in the patient. It is important for the clinician to know how to write treatment plans [17], and work with the patient and family in developing measurable or identifiable treatment goals. The patient and clinician will work together throughout the health change and maintenance process to continuously re-evaluate how well the patient is working toward set goals and ideas for change.

The patient remains accountable toward the interviewer to keep updated about the work completed toward goals (e.g. speaking with their doctor or minister about prolonging life), the achievement of smaller goals set along the way (e.g. compliance with exercises as determined), and what resources have been utilized in the process (e.g. medical procedure or medication regimen).

Accountability is also required from the clinician toward the patient. The clinician must follow through with a very organized presentation and coaching, and dedication to the patient and family. This involves structuring conversations; contact with patients and their providers, allowing adequate time for each; and following up as promised, at the most suitable times.

Conversation in Motivational Interviewing

Authors Miller & Rollnick [18] emphasize that the service of motivational interviewers exist to benefit the people they serve (patients, families, system of providers), and that change is fundamentally a self-change in the patient. The services of pro-life motivational interviewing in palliative care facilitate natural change in the patient for a better and longer life ahead.

Prayer is an acceptable component of the counseling process. You may find that patients appreciate beginning or ending your meeting with a prayer. Perhaps they may even enjoy leading the prayer at times.

The structure of motivational interviewing is traditionally in two phases of four techniques18:

Phases

1. Building Motivation
2. Consolidating Commitment

Techniques

1. Engaging
2. Focusing
3. Evoking
4. Planning

With regards to how you present information to a patient and their family, consider that there are different levels of understanding and comprehension, based on the technicality of wording. You can covey information first in everyday language, then in professional terms and finally in a realistic and practical upfront explanation, and with the outlook of good things on the other end.

It is useful for the motivational interviewer to apply both open and closed-ended questions in conversations with the patient and family. A closed-ended question only requires a yes, no, or maybe response. But an open-ended question requires a more lengthy and thought-out reflection. As part of any interviewing process, a clinician should provide reflection feedback and summary. This will be done for the purpose of clarifying important information, asking additional questions, summarizing what has been said, and allowing for additional change of opinion in future days ahead.

A clinician may allow for future conversations about a topic by saying, *"I want to get back to this idea next week when we meet again."*

Core Interviewing Skills

Following the getting to know you process between the clinician and patient/family, which will likely take a few visits; you should continue to focus on skilled interviewing. Motivational Interviewing is considered a person-centered therapeutic approach in order to identify and develop intrinsic strengths in each person.

There are various interview techniques that make up motivational interviewing and can be utilized effectively to support the different aspects of the counseling approach. These include OARS, the 5 A's of Motivational Interviewing, DARN CAT, Elicit-Provide-Elicit, FRAMES and Pros and Cons.

As Miller & Rollnick (2013) explain in their motivational interviewing book, OARS methods promotes communications, as the acronym stands for Open-Ended Questions – Affirmations – Reflection - Summaries. Open-ended questions will propel conversations forward, with such questions as, *"Tell me about…"* and *"Help me understand…"* Repeating and rephrasing, paraphrasing, and feeling reflection, will secure the conversation in honesty and trust.

Affirmations are positive statements, such as *"I am glad that you told me about this…"* When the clinician recognizes a problem and deciphers a concern, then the patient has optimism for effective intervention and change.

Reflective listening or reflective feedback helps the clinician to fully understand what the patient is saying so that none of the information will be misinterpreted. Reflection also helps the patient to think about what they themselves are saying, consider its truth or inconsistency, and clarify ideas that might have been misunderstood.

It is ethically vital that the interviewer accurately represent the patient's voice. This requires humility and insight into deep feelings and thoughts.

Motivational interviewing can incorporate the well-known brief intervention 5 A's. This requires a strict awareness in the clinician to their tone, inflection, and feeling transference and countertransference. The 5 A's include 1) Ask, 2) Advise, 3) Assess, 4) Assist, and 5) Arrange. The 5A's should be acted in accord with the pace of the situation or conversation currently evolving. It is not to be pushed through in an authoritative manner, but instead as a collaborative effort.

DARN CAT is a mneumonic which stands for Desire - Ability - Reason - Need – Commitment - Activation - Taking Steps. This phrase helps the clinician to easily remember how best to build motivation in the patient. If you are working with a patient and family, then the desire to prolong life exists. Ability is the collaboration and goal-setting therapeutic tasks. Reason and Need may swap places in description, depending on the personality on the patient, but the end motive of reason-need is always to effectively manage and prolong life. Commitment and Activation are in circular momentum or joint forces to tackle a situation. In the patient's motion to care commitment, have them repeat their strength statement, *"I am ready for this, I can do this."* Now, Take Steps to move forward.

Remember to 'roll' with resistance, and as such, if a patient puts up a front of anger, poor progress, or wanting to change providers for an unclear reason; then there is a uniquely paradoxical appearance of the patient's wish for death, which is contrary to their seeking pro-life care. This appearance makes the perfect case for assisted suicide in giving up in an unmanaged or severe health condition. Patients have a right to self-determination, which is equal to a right to life. The clinician must develop the skills be able to 'wind-in' or patiently walk-beside the patient's resistance until progress is gained.

The elicit-provide-elicit technique is similar to the technique in child rearing of serve-and-return. Many patients like the philosophical exchange with a clinician as, at the least, showing interest in their needs and making them feel worthwhile as thinking and feeling human being. This technique should never sound condemning or patronizing, but rather remain candid and esoteric in inquiry. *Patient-Clinician-Patient* dialogue. These methods are proven to build pleasant cooperation and understanding, partnered with an unwavering, dedicated clinician.

Another guide to solicit change is FRAMES, or Feedback – Responsibility – Advice - Menu of Options – Empathy - Self-Efficacy. The most important aspect of motivational interviewing is to foster success for the patient. FRAMES can be viewed from the perspective of guided meditation and visualization of the best life the patient can live in their circumstances. What does your patient envision in a better life? Dealing with setbacks is a duty of the clinician to address should it be anticipated or unexpectedly occur. Setbacks are never a reason to give up.

Pros and Cons methodology is a no-fail technique in the long term success of a patient. In the short term, patients can easily feel and see bumps in the journey, but the greater good in the long term is that the patient made every effort to improve and live.

Age & Cultural Considerations

Motivational Interviewing has been found effective with children, teens and adults who are battling disabling conditions.

Children and teens are always under the final decisions of a parent or legal guardian, who should be included in counseling, as appropriate to the parental style and needs of the minor. Similarly, handicapped or older adults may also have a legal guardian where no family exists to assist them, and the guardian should be regularly contacted and visited.

It is helpful to incorporate family and loved ones into the proactive work of motivational interviewing, to better find resilience and joy in life. On the other side of that joy, is the practical task for patients who wish to have a blessing or anointing from their priest or minister because of the severity of their illness and possible death. Such a ministry can occur at any time in health or sickness, and is not indicative of an immediate end to life by any means.

The multi-disciplinary team and other staff are very helpful in gaining resources and community supports. The team is also great at building rapport in the proactive approaches of finding resilience and joy in life. Complimentary and complementary care is an invaluable team approach.

Group support has been utilized interim individual motivational interviewing, especially if the patient is mobile and verbal. The clinician can establish a support group at any point in treatment, or even after treatment has slowed upon improvement. The clinician might find it useful to keep in mind patients with similar conditions, personalities or needs, and thoughtfully arrange a group session at a convenient location. Group work follows the same structures in motivational and cognitive-behavioral therapies, while allowing the patients to speak in turn and freely. Support groups can also incorporate fun activities such as painting and art, or meditation and prayer into their programs.

Termination

A patient in chronic disease management may achieve sustainable success to the point of infrequent visits with the palliative care team. It is best practice to say to the patient that they are welcome back into treatment at any time in the future. It is also good to keep them informed of support groups and other local resources that may be of benefit to their morale and self-care. Upon ending long treatment, clinicians want to have a lengthy enough closing session to review the positive outcomes of all the patient's work, as well as how they should specifically proceed to maintain their progress. Providing the patient with a list of provider contact numbers or even national foundation support alliances are all helpful continuation resources. If there is a special conversation, symbol, or item that became a comforting part of the pro-life care that you developed with your patient, it would be a nice gesture to offer that as a reminder of the patient's joy, accomplishments and strengths.

For the patient who has passed or transferred to hospice care, there are bereavement counselors, groups, and supportive services. Losing a patient, friend, family member, or loved one is always devastating, and presents many lingering feelings, from relief to sadness to traumatic loss. It is important to provide families with links to supportive outlets on their road to healing. Some outreach bereavement networks

sew blankets, bears, and other home items from the pieces of a loved one's garments. This is a warm and loving reminder of good memories that were shared. A motivational clinician should also seek support from their team, agency managers, supervisors, mentors or any systems of support.

Signs and Symptoms of Death and Differential Diagnosis

Weakness, disorientation, irregular breathing or heart beat, difficulty swallowing, fluid retention, and even recurrent hospital visits, are all symptoms that usually allow for continued care and medical intervention. This is why it is always good practice to communicate your symptoms and needs to your pro-life health care providers, who best know you, and be able to best intervene and assist, and keep you at only a necessary level of health care restriction.

In the days and hours before a true natural death, blood circulation draws back from the body, arms, and legs as vital organs work hard to retain circulation. Mottling of the skin to a purplish coloring, when accompanied by other end-of-life symptoms, are an indicator of lack of blood flow throughout the body. Mechanisms that control the body's ability to maintain its even temperature will start failing, and their temperature will drop below normal. The patient's exhalation or out-breath will be longer than the inhalation or in-breath. For some patients, a distinctive pattern of breathing, known as Cheyne-Stokes [19] respirations, occurs. Cheyne-Stokes respirations consist of loud, deep, and rapid respirations (up to 30-50 per minute), followed by a pause in breathing (apnea) for a period of approximately five seconds to as long as a full minute. The real signs of natural death at the end will eventually present itself, after every intervention has been comfortably implemented, and every goal assessed and collaboratively approached.

Closure

As often as we sigh, may be as regularly as a patient may need reassurance and coaching toward better health. Do not give up on a patient who can live longer. If there is life, there is reason to live.

The fragility of life and death compels us to value each life and prolong life until at the very end or natural death. There is never a justifiable reason to hasten death and shorten life, when the virtues and morals of living are truly realized. All pro-life practitioners and people should make every last effort to save and prolong life.

Entrust your care to an established pro-life practitioner, one who is dedicated to the cause, genuine in their care, charismatic in their skill, and educated and experienced in their field.

Motivational interviewing can well provide the guidance in pro-life palliative care to those with loss of hope and motivation through both early disease course to late stage disease course.

Verified training can be found online through (MINT) Motivational Interviewing Network of Trainers. https://motivationalinterviewing.org/. MINT is an international organization committed to promoting high-quality Motivational Interviewing practice and training.

References

1. https://www.nih.gov/
2. https://www.nia.nih.gov/
3. Capone RA, Stevens KR, Grimstad J, Panzer R (2013) The Rise of Stealth Euthanasia 38: 6.
4. Catechism of the Catholic Church (2013) Those whose lives are diminished or weakened deserve special respect. Pg no: 2276-2277.
5. Garcia B, Brind'Amour K (2007) Evangelium Vitae (1995), by Pope John Paul II. Arizona State University, Arizona, USA.
6. http://www.uffl.org/
7. https://www.ama-assn.org/
8. https://www.cms.gov/
9. http://www.patientrightscouncil.org/
10. https://fpnotebook.com/Neuro/Exam/CrvsCpctyAssmntTl.htm
11. Hohman M (2012) Motivational Interviewing in Social Work Practice. The Guilford Press, New York, USA.
12. Festinger L (1962) A Theory of Cognitive Dissonance. Stanford. Stanford University Press, California, USA.
13. Bem DJ (1967) Self-perception: An alternative interpretation of cognitive dissonance phenomena. Psychology Rev 74: 183-200.
14. Barrowclough C, Haddock G, Wykes T, Beardmore R, Conrod P, et al. (2010) Integrated motivational interviewing and cognitive behavioural therapy for people with psychosis and comorbid substance misuse: Randomised controlled trial. BMJ 341: 6325.
15. Prochaska JO, Norcross JC, DiClemente CC (2007) Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. William Morrow Paperbacks, New York, USA.
16. Paul R, Elder L (2006) The Thinkers Guide to the Art of Socratic Questioning. Foundation for Critical Thinking, California, USA.
17. Jongsma AE, Peterson LM (1999) The Complete Adult Psychotherapy Treatment Planner, (2nd Edn). Wiley, New Jersey, USA.
18. Miller WR, Rollnick S (2012) Motivational Interviewing, (3rd Edn) Helping People Change. Guilford Press, New York, USA.
19. Cheyne J, Stokes W, Who first described in the 1800's the Cheyne-Stokes breathing pattern at death. StatPerls NCBI, Maryland, USA.

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