

7. Reflective listening
8. Simple reflection
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Case-based learning activities and case examples

The case examples on the following pages were contributed by members of the curriculum planning group for this toolkit. These cases are based on actual clients seen in a variety of clinical practice settings, but names and identifying information have been changed to preserve client anonymity.

HOW TO USE THE CASES

Case examples can be a very helpful way to engage groups and individual practitioners. They ground the material being covered in a workshop by demonstrating:

- the relevance of MI as a practice approach, especially with people who are ambivalent about changing their behaviour
- avenues for reflection on specific micro-skills or the overall spirit of MI
- ways to practise the skills with diverse clients, and problem areas for intervention.

You can select cases based on your audience and your understanding of their practice context and the kinds of presenting issues they commonly encounter, and on the particular skills you would like the group to practise. Note that the resources in this toolkit emphasize your autonomy as a trainer to substitute or expand on learning activities. These cases provide a menu of options and instructional strategies to help you to customize the learning experience for diverse settings and learners.

All of the cases lend themselves to a variety of instructional strategies. Below is a list of suggested activities that you can incorporate in your own trainings and workshops, using one or more of the cases. In addition, we encourage you to adapt these cases and/or to use your own case examples to illustrate and augment the workshops you facilitate.

SUGGESTED ACTIVITIES FOR USE WITH CASE EXAMPLES

Start out with a case: Introduce a section or a skill

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Starting the workshop or a specific section of the workshop with a case is a nice way to capture the group's interest and attention. You can use the brief description of the client on a slide as a jumping-off point for discussion and learning.

Enhancing practitioner empathy

The following exercise can be a powerful way for participants to directly experience the spirit of MI, and can be done as an individual reflective activity or in pairs, dyads, triads or small groups. Have the participants re-write the case from the perspective of the client, then ask them to reflect on how the exercise of re-writing the case impacted their empathic understanding of the person's unique situation and concerns. Debrief by asking the group to reflect on how they would respond to the person and work to engage them in treatment with this new and enhanced understanding. Emphasize that this empathic understanding and compassionate stance is at the heart of the MI approach.

Case discussion

Ask the group to reflect on the case and discuss the following questions. Note that you can do this activity in dyads, triads, small groups or a large group.

- How might Motivational Interviewing be useful with this client?
- What are the barriers to change? What are the strengths or enablers of change for this person?
- What specific skills could you try (for example, OARS skills, agenda-mapping)?
- What kind of treatment plan might be optimal for this person? How could you introduce this in a way that is consistent with MI spirit?

Clinical demonstration

Select a case and ask for a volunteer from the audience to play the role of the client. The facilitator takes the role of the practitioner, demonstrating MI skills to the group. Note that this can be a "high-risk" activity for facilitators (e.g., "What if I do a poor job demonstrating the skills?" "What if the 'client' is too resistant or challenging?" "What if I choke and don't know what to say next?"). Here are some tips to help the demonstration go more smoothly and reduce your performance anxiety in the practitioner role:

- Emphasize that there is no such thing as a perfect motivational interview—we are all learning and striving to improve, and that includes MI trainers!
- Periodically stop the role play and ask the group what they see as possible avenues for intervention, or possible skills to try.
- Ask the group for help if the "client" is extremely difficult or resistant, by stopping the role play and inviting feedback ("If you were in my seat, what might you say next? OK—let's try that and see what happens").

- Encourage an atmosphere of experimentation: “We are going to try different strategies and approaches, and the client’s response will be feedback as to whether we are on the right track.”
- Beware of the “Righting Reflex.” If you find yourself struggling, it may be because you have stepped out of the spirit of MI, and are trying to get the person to change. If you notice this happening, mentally regroup and remember that MI is a guiding (not directing) style to explore ambivalence and facilitate change.
- Remember P-A-C-E: Partnership, Acceptance, Compassion, Evocation. This means emphasizing that the client alone must decide to make this change or not, and you are there to help regardless of what he or she decides. Evoke the person’s reasons for change as well as roadblocks or barriers.
- Try to use all of the OARS skills (Open questions, Affirmations, Reflective listening and Summary statements). Sometimes when we’re anxious we tend to default to the skill that feels most comfortable for us, which is often questioning. Remember to use affirmations, reflections and summary statements.
- Finally, if all else fails, don’t be afraid to admit defeat and clearly state that MI is not a panacea—this approach is neither appropriate nor effective with every client, and the reality is that some people will decide not to change, despite our best efforts to assist them. However, if we can establish rapport and engagement, then the person may be more likely to return when he or she is ready to make a change.

In debriefing the clinical demonstration, start by asking the “client” what the conversation was like for him or her, and what was helpful or less helpful. Then invite the large group to comment and give feedback. The value in clinical demonstrations—aside from their utility as a group learning activity—is that they model risk-taking and willingness to practise, and make it more likely that participants will also be willing to take risks, experiment, and practise MI skills in the workshop.

Practising specific MI skills

Choose one or more cases and provide them as handouts to participants. Use the case example(s) as a starting point for asking participants to practise specific MI skills. Ask participants to read the case and respond to the challenging client statement(s) with:

- an open-ended question
- an affirmation
- a simple reflection
- a complex reflection
- a summary statement.

This is a lower-risk activity than a role play, as participants have some time to reflect and formulate their response rather than having to come up with a response in the moment. Yet this exercise still provides a valuable opportunity to practise the skills. Participants can also be given one of the more complex cases and asked to

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practise agenda-mapping, using the agenda-mapping worksheet in the PowerPoint slides.

Group role play and practice

Ask participants to form dyads, triads or small groups. Provide the case you have chosen as a handout, and ask one person to volunteer to be the client, and another person to volunteer to be the practitioner. Other group members may act as coaches, or you can ask group members to “tag team” as practitioners (i.e., to take turns responding to the client).

This exercise works best if you ask the “client” to start by reading the “challenging client statement” included with the case description as a prompt for the practitioner to respond. It is also useful to instruct the “clients” to not role-play the most resistant and difficult person that they have ever encountered in their practice career. The objective is to provide an opportunity to practise.

After the groups have had a chance to complete the role play, debrief as a large group.

We hope that these suggestions are helpful, and encourage you to adapt and add to the many possible ways to integrate case examples and practical learning activities into your workshops. The cases can be found on the following pages, arranged by age (in descending order).

CASE EXAMPLES

Allan (male, 70)

BRIEF DESCRIPTION OF THE PATIENT

Allan is a 70-year-old man discharged from the hospital two weeks ago after his first admission with Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD). He is retired, married and living with his wife, and is a long time heavy smoker (50 pack years). Allan's wife has never smoked.

PRESENTING ISSUES

- Allan has never had spirometry screening to diagnose COPD.
- He has symptoms of shortness of breath on exertion (SOBOE) and chronic productive cough.
- As a result of his SOBOE, he has decreased his activity level.
- He has been newly prescribed albuterol, Advair (fluticasone/salmeterol), and tiotropium bromide capsules for inhalation; he may have issues with medication compliance.

MOTIVATIONAL ISSUES

- What is Allan's understanding of his COPD diagnosis? Until very recently, he had never even heard of COPD.
- Is medication compliance an issue? Does he know how to take his new medications?
- Allan is still smoking, but has reduced the number of cigarettes per day.
- Allan is motivated to change his smoking; still, he is ambivalent about a goal of total abstinence. He would like to be able to smoke just 1 or 2 cigarettes per day.

A CHALLENGING STATEMENT TO THE PRACTITIONER

"I can't believe this has happened to me so suddenly. I was fine until last month, and now the doctor tells me I have a chronic lung disease that is going to kill me."

Billy and Betty (male, 64, and female, 68)

BRIEF DESCRIPTION OF THE PATIENT

Billy and Betty, 64 and 68-years-old respectively, are a retired couple who have come to the clinic for smoking cessation counseling. Both are long-time smokers (40-plus years). Spirometry screening reveals that Betty has very severe Chronic Obstructive Pulmonary Disease (COPD) with 27% lung function. Billy reports a hacking cough with a lot of phlegm. They both know they need to quit, and they say, “We really want to quit.” Neither has ever tried to quit before. They do quite well at being smoke-free when they are apart, but are struggling when together; both tend to smoke when around each other.

PRESENTING ISSUES

- Betty and Billy are two heavily nicotine-dependent people with lengthy smoking histories.
- When together as a couple, they act as “triggers” for each other; they tend to have less success abstaining from smoking when together.
- Betty has severe COPD—poor lung function.
- Billy also has respiratory symptoms.
- This is the first quit attempt for both individuals.

MOTIVATIONAL ISSUES

- Billy and Betty are motivated by their respiratory symptoms (COPD diagnosis, impact of smoking on their health).
- Their goals are aligned; they both “want” and “desire” to be smoke-free.
- What is their level of understanding around the impact of second-hand smoke on COPD?
- How can their support of each other be enhanced?

CHALLENGING STATEMENT TO THE PRACTITIONER

“We do fine not smoking when we’re busy and not together, but we smoke whenever we’re together.”

Then, during their second visit, with sighs of relief: “We were afraid you were going to give us heck for not doing well, since we haven’t quit yet.”

Khalid (male, 65)

BRIEF DESCRIPTION OF THE PATIENT

A 65-year-old male, Khalid has smoked since age 19. He has tried to quit, but relapsed. He is depressed and has little hope. He has a Medical Research Council Breathlessness Scale of 4 (“Stops for breath after walking about 100 yards, or after a few minutes on level ground”). Recent pulmonary function tests show severe Chronic Obstructive Pulmonary Disease (COPD). He lives with his wife; she is a non-smoker but he smokes in their home. Khalid was recently prescribed oxygen 24 hours a day; however, he wears it only 6–8 hours a day, when he is really short of breath.

PRESENTING ISSUES

- Khalid is smoking in his home with oxygen (a safety issue).
- He has a history of depression, but is not taking any medications.
- His limitation of his activities has led to increased dyspnea (“air hunger”).
- He has compliance issues.

MOTIVATIONAL ISSUES

- Khalid is smoking in his home with oxygen due to a lack of education and information.
- Khalid feels quitting smoking now is pointless, no longer a relevant issue. His lung damage is done already, and his disease is progressive—so why bother?
- His beliefs and understanding around medications present issues. He does not like the idea of taking more medications, such as medications for depression; he feels that he is “on too many medications already.”

CHALLENGING STATEMENTS TO THE PRACTITIONER

“My lung disease is going to worsen, no matter what I do! I have little to enjoy now, so I am going to enjoy my cigarettes.”

“I don’t wear my oxygen when I smoke.”

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Bob (male, 65)

BRIEF DESCRIPTION OF THE PATIENT

Bob is a 65-year-old client with Chronic Obstructive Pulmonary Disease (COPD). His primary care practitioner has recommended that he attend the Pulmonary Rehabilitation Program. Bob is quite sedentary but is fairly adherent to his medication regime. He has had two exacerbations in the last year, one of which hospitalized him for three days.

PRESENTING ISSUES

- Bob sits in his apartment for days on end. His wife cannot get him to accompany her on outings—shopping, visiting or socializing.
- He is becoming weaker, with decreased muscle mass. His shortness of breath (SOB) is increasing, which makes him more anxious, leading to more SOB (vicious cycle).
- Bob is becoming increasingly depressed as he grows more dependent on his wife to do things for him.

MOTIVATIONAL ISSUES

- Bob realizes that his isolation is increasing his loneliness.
- He realizes that each hospitalization leaves him weaker (decreased lung function).
- He realizes that the less active he is, the more he suffers from SOB.

CHALLENGING STATEMENT TO THE PRACTITIONER

“You want me to attend the Pulmonary Rehabilitation Program? Do you have any idea how difficult it is for me to leave my apartment, with my breathing problems?”

Tommy (male, 54)

BRIEF DESCRIPTION OF THE PATIENT

Tommy is a 54-year-old male with severe shortness of breath (SOB) and cough. He is married, has a 16-year-old daughter, and owns his own construction company. He has no pets, smokes 30–40 cigarettes per day, and drinks one bottle of wine (five standard drinks) per day. He started smoking at age 12. His last visit for health care was three years earlier, for pneumonia.

PRESENTING ISSUES

- Tommy wants to know if he has pneumonia again.
- He is a long term, heavy smoker, and has undiagnosed SOB and a cough.
- Alcohol use is an issue—he is drinking more than the safe drinking guidelines recommend.
- There may be a relationship between his alcohol use and his smoking.
- He is under business and financial stress.

MOTIVATIONAL ISSUES

- Tommy has never made a quit attempt or considered quitting smoking.
- He does not believe smoking is related to his symptoms, or at least believes it is not an “important” factor.
- He says he smokes and drinks to “wind down” and deal with stress.
- It is unknown how he feels about his present alcohol use.
- What are the good things, and are there any “not-so good” things, about his daily drinking?
- His wife and daughter’s respect and love are important to him. He does not smoke in the home out of respect for his family.

CHALLENGING STATEMENT TO THE PRACTITIONER

“The only reason I would stop smoking is if you told me it was life or death.”

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Carly (female, 52)

BRIEF DESCRIPTION OF THE PATIENT

Carly is a 52-year-old woman with a diagnosis of anxiety and severe Chronic Obstructive Pulmonary Disease (COPD)/asthma. She is unable to work because of her COPD/disability. She has smoked 1.5 packs per day (30 cigarettes per day) for over 40 years. Her recent pulmonary function tests (PFT) show severe deterioration (forced expiratory volume 29%). PFT comments include that she may now need arterial blood gas measurements (ABGs) to determine oxygen criteria. Her partner also smokes in the home.

PRESENTING ISSUES

- Carly has an anxiety disorder.
- Her COPD is severe and deteriorating.
- She has a lengthy smoking history and is heavily nicotine dependent (30+ cigarettes per day).
- She is unable to work.
- Her partner smokes in the home and has no plans to quit.

MOTIVATIONAL ISSUES

- Carly does not want oxygen.
- Her COPD medication has been maximized.
- She is highly ambivalent about quitting smoking; she has been told by health care practitioners that she needs to quit smoking for her breathing prognosis to improve, but she worries that quitting smoking will worsen her anxiety symptoms and it will be too difficult.
- Her partner has no plans to quit, and Carly does not feel comfortable telling her partner that she must smoke outside of their home.

CHALLENGING STATEMENT TO THE PRACTITIONER

“Can’t you just give me more breathing medicine?”

“Trying to quit smoking will make me more stressed.”

Helen (female, 49)

BRIEF DESCRIPTION OF THE PATIENT

Helen is a 49-year-old widowed female who sees you during a community visit. She tells you that she wishes she had never started smoking as a teenager. She states that she has tried to quit a few times over the years but has never even been able to last more than one day without cigarettes; on her most recent try, she only lasted until lunchtime. She is currently taking the following medications: tiotropium bromide one capsule per day; Advair (fluticasone/salmeterol); ventolin 1–2 puffs every 4 to 6 hours as needed; venlafaxine 150 mg; vitamin D 400 IU per day; lorazepam 1.0 mg every night as needed.

PRESENTING ISSUES

- Helen is a foster parent to her two grandchildren, as her daughter is in treatment for alcohol addiction. Her Chronic Obstructive Pulmonary Disease (COPD) is getting worse, making it harder to cope with the demands of caring for her grandchildren.
- She is on social assistance and stays home all day.
- She suffers from depression. It took many trials to find the current combination of antidepressants that is working for her.
- She smokes 40 cigarettes per day and starts smoking before she gets out of bed in the morning. She smokes in the house, despite knowing that it will affect her grandchildren; no one else can watch her grandchildren if she smokes outside.
- Her cravings are so strong that she smokes constantly, all day long. She said that she tried stopping “cold turkey” but got “very cranky and irritable” after not smoking for half the day, so she resumed.

MOTIVATIONAL ISSUES

- Helen is compliant with her current medication regime.
- She has very low self-confidence around her ability to quit smoking and is unsure if she is willing to try again.
- She is ambivalent about quitting; she knows it’s important, but doubts it’s possible.
- She has little information about or understanding of smoking cessation medication options, how they work, access, other treatment options, and accessing support.
- She loves caring for her grandchildren, but is very concerned about her ability to do this much longer because of her health and breathing difficulties.
- What are some of the motivating factors that could lead to Helen making health behaviour changes?

CHALLENGING STATEMENT TO THE PRACTITIONER

“In a perfect world I would be a non-smoker, but it’s just too hard, I’ve tried to quit a thousand times and I guess I just don’t have the will power that some people do.”

Todd (male, 48)

BRIEF DESCRIPTION OF THE PATIENT

Todd is a 48-year-old male, single with no girlfriend, never married, and an eldest child. He lives with his parents and younger siblings on a rural farm. He admits he feels depressed. He has never been in a hospital for respiratory problems. He admits that he is very short of breath, and states he wants to die of “natural causes” so the insurance will pay off the farm. Todd says he wants to speed up his inevitable death from Chronic Obstructive Pulmonary Disease (COPD) so he has increased number of cigarettes smoked; when questioned, he says that he will not (cannot) commit suicide due to religious beliefs. Spirometry screening shows moderate COPD. Todd reports extreme financial pressure and works seven days a week on the farm.

PRESENTING ISSUES

- Todd’s COPD is undertreated.
- His smoking has increased from 25 to 35 cigarettes per day.
- He has financial stressors.
- He shows signs of depression and hopelessness.

MOTIVATIONAL ISSUES

- Todd has become increasingly depressed since he was diagnosed with COPD last year.
- He has not told his doctor about his increasing feelings of depression or sought treatment for it.
- He works seven days a week on the farm to support his family; his father suffered a serious injury a few years ago and is now unable to run the farm, and Todd’s mother also has poor health.
- Todd does not go out socially; he is too broke and too exhausted.

CHALLENGING STATEMENT TO THE PRACTITIONER

“Why would I want to take inhalers, or quit smoking? I have no life, I am trying to die sooner.”

John (male, 46)

BRIEF DESCRIPTION OF THE PATIENT

John is a 46-year-old man with opioid addiction, depression and anger issues. He is single, does not work, is on social assistance, has smoked since age 15, and lives in a rooming house with four other smokers. John smokes about 20–30 cigarettes per day, purchased in baggies from a contact; he pays \$12 per baggie, and each baggie contains 200 cigarettes.

PRESENTING ISSUES

- John has a hoarse voice and chronic bronchitis, and complains of chest pain and shortness of breath.
- He attends a methadone program to manage his opioid addiction, and he is stable.

MOTIVATIONAL ISSUES

- John does not want to see a doctor, because he will just be told to quit smoking, and he is very resistant to this idea.
- He shuts down the conversation when smoking is discussed.
- There is a relationship between his smoking and his mental health. He smokes more when he is stressed and/or angry; he uses cigarettes to help calm himself down.
- There is also a relationship between his smoking and his opioid addiction and methadone treatment. He says his favorite cigarette is the one that he has right after he drinks his methadone dose.

CHALLENGING STATEMENT TO THE PRACTITIONER

“Do not even talk to me about smoking. I love my cigarettes, they’re all I have.”

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Anne (female, 26)

BRIEF DESCRIPTION OF THE PATIENT

Anne is a 26-year-old woman who has been referred to a smoking cessation specialist. She is divorced with two young children, currently in the custody of their father. Anne has been told by Child Protection Services that she has to stop her marijuana use before she will be allowed access to her children. Anne smokes approximately 20 cigarettes per day as well as one to two joints per day, typically in the evening before bed.

PRESENTING ISSUES

- Anne’s smoking cessation counsellor has no particular expertise in cannabis addiction, and Anne’s tobacco use is not a priority for Anne.
- Anne has a number of mental health diagnoses, including depression, anxiety, borderline personality disorder, and posttraumatic stress disorder.
- She reports having no community supports in place for her mental health concerns, and states that cannabis is the only thing that “keeps her sane.”

MOTIVATIONAL ISSUES

- She is willing to seek further support for her mental health issues.
- She is ambivalent about changing cannabis use; she feels that she needs it to stay sane, yet it prevents her from accessing her children.
- She wants joint custody of her children.
- She just got a new child protection worker; she is pleased with this change and she describes this worker as very supportive.

CHALLENGING STATEMENTS TO THE PRACTITIONER

“The joints are medicinal—they help me sleep and cope with my anxiety. I don’t smoke very much but I need them, nothing else works.”

“Why should I have to quit completely when I know for a fact that my ex is still smoking up and the kids are with him?”

Zach (male, 18)

BRIEF DESCRIPTION OF THE PATIENT

Zach is an 18-year-old male, brought to a primary care practitioner by his father because he is “blue” in the mornings around his mouth. Diagnosed with asthma at age 6, Zach is not using inhaled corticosteroids (ICS) therapy. He does not attend school, sleeps until noon, smokes 3–4 joints per day, wants to be a tattoo artist and does tattooing out of the family basement with his parents’ support. He hopes to have his own tattoo business one day.

PRESENTING ISSUES

- Zach has uncontrolled asthma and is not adherent to therapy.
- He is a regular marijuana user and smokes in the home, in the basement.
- The dyes and solvents he is exposed to when he does his tattooing may be an environmental trigger.
- His irregular daily schedule is not structured to support regular twice-daily ICS therapy.

MOTIVATIONAL ISSUES

- Zach wants to have his own tattoo business one day.
- He does not regard his daily marijuana use as harmful—he grows his own, it’s organic, and he doesn’t roll it with tobacco.
- Zach’s father was not initially concerned about Zach’s marijuana use; however, he was not aware that it had increased from occasional use to 3–4 joints per day.

CHALLENGING STATEMENT TO THE PRACTITIONER

Zach: “It’s no big deal. Mom and Dad worry too much.”

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Tyrone (male, 15) and his mother

BRIEF DESCRIPTION OF THE PATIENT

Tyrone is a 15-year-old male who came to see the asthma educator with his mom. He was recently seen in the emergency room and put on prednisone. According to his mother, Tyrone has not had any problems with his asthma since he was five years old. (He has had no inhalers since.) But recently the problem has recurred. His mother is very upset, as she thought he was fine for the past 10 years. She is visibly shaken. Tyrone says he “feels fine.”

PRESENTING ISSUES

- Tyrone’s chronically poor asthma control has led to fixed obstruction.
- He is a poor perceiver of his asthma symptoms.
- He treats acute episodes, but there are risks of poor control.
- His mother feels intense guilt and distress.

MOTIVATIONAL ISSUES

- Tyrone reports feeling “fine” and having no real problems with asthma.
- Tyrone and his mom are at very dissimilar stages in the change process. His mom is upset, but is taking action—she brought him to see the asthma educator. Tyrone feels this issue is resolved, and no further action is required.
- Tyrone was given no choice in attending this appointment with his mom. He is hesitant to engage in treatment. How can you increase his motivation around treatment engagement?
- In working to improve Tyrone’s management of asthma, self-care, and medication compliance, consider the developmental tasks of teenagers (developing autonomy, identity and role formation).

CHALLENGING STATEMENTS TO THE PRACTITIONER

Mother: “He’s been fine for 10 years! I haven’t given him any puffers since he was five”

Tyrone: “I am fine now. I can do everything I want. It [the asthma] doesn’t stop me from doing anything.”

Andrew (male, 14)

BRIEF DESCRIPTION OF THE PATIENT

Andrew, a 14-year-old Grade 9 student with a new group of friends, was diagnosed two years ago with asthma, but doesn't like to take inhalers because "it's not cool." He has been experiencing worsening breathing, waking at night and feeling tired during the day. Andrew has a six-year-old sister who is very attached to the family dog. Andrew comes to the appointment with his mother, who is very concerned about his worsening breathing. His mother is also concerned about the crowd he has been hanging around with at school, as these youth have a reputation for using drugs and alcohol.

PRESENTING ISSUES

- Andrew's non-compliance with medication is an issue. He used to be compliant on inhalers, but is not any more.
- Andrew's mother's agenda is at odds with his own agenda.
- There is a dog in his home, to which his six-year-old sister is very attached.
- Andrew may be smoking cigarettes and/or marijuana.
- He experienced one exacerbation of asthma symptoms two years ago, and needed hospitalization.
- He has anaphylaxis to LTRA-montelukast (leukotriene receptor antagonist used for maintenance treatment of asthma).

MOTIVATIONAL ISSUES

- Teenage development involves mastering the task of autonomous decision making; at the same time, social acceptance by peers is of key importance.
- Explore Andrew's relationship with both his family and his peers, and the impact this has on his self-care (medication compliance).
- Explore Andrew's understanding of his asthma and the recommended treatment regime. Explore the same issue with his mother.
- Does this case require primarily individual behaviour change, or is it potentially a "whole-family" behaviour change issue? (For example, are there triggers in the home, in addition to the dog?)
- Are the parents also ready to look at making some changes related to this problem, or are they ambivalent themselves?

CHALLENGING STATEMENTS TO THE PRACTITIONER

Mother: "I need you to make Andrew take his medications because he won't listen to me!"

Andrew: "None of my friends need inhalers, why do I?"

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Cody (male, 11) and his mother

BRIEF DESCRIPTION OF THE PATIENT

Cody is an 11-year-old male with moderate to severe asthma. His primary caregiver is his mother, who travels a lot for her job. His grandmother takes care of Cody when his mom is not around. Grandma is a “cat lady” with 3 cats; she is a heavy smoker and lives in the basement of the family’s bungalow. Grandma loves to cook and smoke.

PRESENTING ISSUES

- Cody’s asthma is poorly managed.
- His mother is in denial and doesn’t believe in inhaled corticosteroids (ICS) use, although Cody is becoming a “frequent flyer” (he has had over four emergency room visits for asthma attacks).
- Asthma attacks mess up Cody’s hockey games. He loves hockey but it usually gets interrupted.

MOTIVATIONAL ISSUES

- Cody’s goals and values motivate him. He would like to be able to progress beyond house league hockey to play “Triple A” one day.
- Cody’s mom misses work every time Cody is sick.
- Grandma has brought many triggers into the home environment.
- Cody has little to no control over many factors that contribute to the management of his asthma.
- This case requires that the entire family engage in the change process. There is a need to align the values and behaviour of Cody, his mother and his grandmother to facilitate change.
- How does the family’s current living situation—which permits and promotes many environmental triggers—fit with the mother’s core values and her wish to change Cody’s asthma management?

CHALLENGING STATEMENT TO THE PRACTITIONER

Cody’s mother: “Steroids will stunt my child’s growth!”

Paul (male, 8) and his father

BRIEF DESCRIPTION OF THE PATIENT

Paul is an eight-year-old boy diagnosed with asthma. He is atopic to many things: cats, dogs, dust mites, pollen. His parents are divorced, with shared custody. Paul stays with his mother during most of the week and his father on the weekends and Mondays. His father smokes in the home and has a dog.

PRESENTING ISSUES

- Paul has had multiple, recent emergency room visits with uncontrolled asthma. He shows improvement since he was put on an inhaled steroid; however, spirometry shows >12% & 200 mL change in post bronchodilator spirometry, and he still has a nighttime cough.
- Paul's mother works on trigger avoidance and giving medication, but his father doesn't understand that he needs to do so as well. The two don't get along or communicate.

MOTIVATIONAL ISSUES

- Paul, a child, has no control around presenting issues that require change.
- His mother and father are at very different stages in the change process around Paul's medication regime and trigger avoidance.
- His father appears highly ambivalent about changing his smoking behaviour (i.e., not smoking while Paul is in his care and home). It's unclear if this issue is related to his motivation to change his smoking behaviour, or to his understanding of the importance of making this change. What is his understanding of the impact of second-hand smoke on Paul's asthma and on his children's health in general?
- The father has come in twice for separate visits, and seemed to be on board, but now it seems nothing has changed. There is a discrepancy between his statements during his sessions with you, and his actions.

CHALLENGING STATEMENT TO THE PRACTITIONER

Paul's father: "I don't believe my son has any problem with his breathing."

Ahmed (male, 4) and Zarah, his mother

BRIEF DESCRIPTION OF THE PATIENT

Ahmed is a four-year-old male who has asthma. Zarah is his young single mother. Ahmed has had two emergency room visits in the past six months and wakes up at night occasionally because of his cough. He is on several puffers but Zarah is reluctant to give them to him consistently; she is concerned about the side-effects. Zarah has missed work on several occasions when Ahmed's asthma flared up.

PRESENTING ISSUES

- Ahmed has had two recent emergency room visits.
- He wakes up at night with a cough.
- Zarah is not compliant around Ahmed's medication, because of a steroid "phobia."
- Zarah faces financial implications if her repeated work absences due to Ahmed's condition lead to the loss of her job.

MOTIVATIONAL ISSUES

- Ahmed's symptoms are intermittent.
- Zarah is highly ambivalent about the prescribed treatment regime because of her perceptions about the medications.
- What are Zarah's beliefs and values, and how do her current actions of not complying with Ahmed's medication regime fit with these values and beliefs?
- What are the pros and cons of treating Ahmed's asthma intermittently with medications?

CHALLENGING STATEMENTS TO THE PRACTITIONER

Zarah: "The long term side-effects of steroids have not been well documented."

Zarah: "I've heard that steroids will stunt growth."

David (male, 49)

BRIEF DESCRIPTION OF THE PATIENT

David is a 49-year-old male, married with 2 children, and works as an engineer. He has smoked 20-30 cigarettes per day for the last twenty years. He has tried quitting five times: once with the nicotine patch which was effective and his other trials were “cold turkey”. His longest abstinence period was 5 months. David felt exercise-induced shortness of breath and was diagnosed with Chronic Obstructive Pulmonary Disease (COPD) 2 years ago. One of his children has also been diagnosed with asthma. He knows he should quit smoking, however finds smoking rewarding. He especially finds it rewarding when he smokes and drinks with his wife every evening at home, after reading bedtime stories to his children. His respirologist had encouraged him to consult with you.

PRESENTING ISSUES

- David is a heavy smoker with significant nicotine dependence symptoms.
- He suffers from COPD and was prescribed COPD medications.
- He regards himself as rather healthy.
- David drinks alcohol daily.
- David’s wife is a daily smoker.
- David’s children are exposed to second-hand smoking and one of them has asthma.

MOTIVATIONAL ISSUES

- David had several past quitting attempts and tolerated NRT well.
- David arrived today after his respirologist persuaded him to come.
- David devotes a lot of time to care for his children.
- Smoking plays a significant role in David’s relationship with his wife.
- David’s older son has told that him he has a bad smell after smoking.

CHALLENGING STATEMENTS TO THE PRACTITIONER

“I enjoy smoking so how about reducing to 10 cigarettes per day? The medications will help my COPD.”

“No one would give-up spending this quality time with his most significant other, so why should I?”

“I had tried quitting smoking with patches and I am still smoking.”

Jennifer (female, 30)

BRIEF DESCRIPTION OF THE PATIENT

Jennifer is a 30-year-old single female. She has no children, lives alone and works as a journalist. Since the age of 17, Jennifer has been smoking 15-20 cigarettes per day and 1-2 “joints” per week. She has a partner who also smokes marijuana. Jennifer was diagnosed with asthma as a child. She avoids medical check-ups but has agreed to use bronchodilators. Last winter, her family physician recommended steroids, which she prefers not to use. Jennifer also suffers from anxiety, resulting in monthly panic attacks that interfere with daily working. She was referred by the family physician to learn more about the harms of smoking and cessation options. She claims the marijuana helps her asthma.

“I’ve had asthma since I was a kid. I’m not crazy about using steroids – that’s some awful medication. My doctor wants me to quit smoking but I don’t see the point. I know so many people with worse things and they continue to smoke. Anyhow, my real issue is my anxiety. If I can get my anxiety under control, my asthma attacks wouldn’t be so bad. I get panic attacks every month and it affects my work. I have to do something. I can’t continue like this.”

PRESENTING ISSUES

- Jennifer is a heavy cigarette smoker with significant nicotine dependence symptoms.
- She has never attempted to quit smoking.
- Jennifer suffers from persistent asthma with recent evidence of deterioration.
- There are issues of medication nonadherence.
- She suffers from a debilitating anxiety disorder; some symptoms may be attributed to nicotine withdrawal and marijuana smoking.

MOTIVATIONAL ISSUES

- Jennifer had agreed with her family physician to learn more about the harms of smoking but is not interested in cessation at the present time.
- Jennifer believes her asthma is worsening, not because of her smoking, but because of her anxiety attacks.
- Jennifer enjoys smoking daily with her partner.

CHALLENGING STATEMENT TO THE PRACTITIONER

“No one will tell me what to do with my cigarettes”

“My main mission is to get over my panic attacks first”

“I have a friend with asthma who smokes daily and he looks fine to me”

Jacob (male, 50)

BRIEF DESCRIPTION OF THE PATIENT

Jacob is a 50-year-old man recently diagnosed with Chronic Obstructive Pulmonary Disease (COPD). Jacob has been smoking for 40 years and cannot imagine life without cigarettes. Jacob usually smokes 25 cigarettes per day but if he consumes alcohol his smoking increases. Jacob drinks within the low risk drinking guidelines (see below for a description) except on the weekend. Jacob lives with his wife who does not smoke but according to Jacob seems more, “sickly.” Jacob explained his wife is often coughing and has problems with congestion.

“I’m so freaked out about being diagnosed with COPD. I can’t believe this is happening to me. I know that smoking is making it worse. But how can I quit smoking? I started smoking when I was 10 years old. That’s who I am. What’s the point now anyway? This is going to kill me. But my wife....she’s my life. What if my smoking is making her sick? I don’t want to do that. I love her.”

PRESENTING ISSUES

- Jacob is ambivalent about quitting because smoking is, “a part of my life.”
- Jacob experiences shortness of breath and since his decrease in activity he has taken to drinking more alcohol.
- Jacob really enjoys smoking at home away from “judging eyes.”
- Jacob’s wife is becoming less tolerant of Jacob’s indoor smoking.

MOTIVATIONAL ISSUES

- Jacob believes his diagnosis of COPD is a “death sentence.”
- Jacob’s cognitions are often all or nothing.
- Jacob loves his wife and is worried about her health.

CHALLENGING STATEMENTS TO THE PRACTITIONER

“I’ve been told I need to quit smoking and I don’t know if I can because I really enjoy it.”
“Now with this diagnosis what’s the point as it’s going to kill me anyways.”

Canada’s Low-Risk Alcohol Drinking Guidelines

Reduce your long-term health risks by drinking no more than:

10 drinks a week for women, with no more than 2 drinks a day most days;

15 drinks a week for men, with no more than 3 drinks a day most days.

Reduce your risk of injury and harm by drinking no more than 3 drinks for women and 4 drinks for men on any single occasion.

Please visit the Canadian Centre on Substance Abuse (CCSA) website (www.ccsa.ca) to view the complete guideline.

Butt, P., Beirness, D., Cesa, F., Gliksman, L., Paradis, C., & Stockwell, T. (2011). *Alcohol and health in Canada: A summary of evidence and guidelines for low-risk drinking*. Ottawa, ON: Canadian Centre on Substance Abuse.

Abby (female, 58)

BRIEF DESCRIPTION OF THE PATIENT

Abby is a 58-year-old woman who has been approached by her daughter to quit smoking. Abby was smoking 40 cigarettes per day but over the last year she has reduced to 30 cigarettes per day. Abby reduced by moving her smoking outdoors when her granddaughter, Mandy, was diagnosed with asthma. Abby heard that smoking could exacerbate Mandy's symptoms.

Abby feels she is "doing her part" as she no longer exposes her grandchildren to second hand smoke. Abby also feels her daughter is "out of line" as she has given her a place to stay after her "nasty" divorce.

Abby loves having her family around especially her grandson who just turned 8 months old. Abby's husband died 2 years ago from lung cancer and she has not felt the same. Abby often feels tired and unmotivated.

"I've had such a hard time. My husband died just two years ago. I miss him terribly. I can't seem to enjoy anything anymore. I'm not sure what my daughter expects. I've cut down a lot and that was so hard. And I even decided to not smoke in the house anymore as I know it's bad for Mandy. I've done a lot to protect my grandkids. I'm not exposing them to tobacco smoke anymore. So I don't see why I shouldn't be able to smoke a bit. It helps me."

PRESENTING ISSUES

- Abby is unaware of second and third hand smoke and how this could affect her grandson and granddaughter.
- Abby has a past history of depression and her mood has been low since her husband died.
- Abby feels smoking gives her energy and helps with her concentration.

MOTIVATIONAL ISSUES

- Abby loves her grandchildren.
- Abby has received treatment for depression in the past.
- Abby has been able to reduce her cigarette consumption.

CHALLENGING STATEMENT TO THE PRACTITIONER

"I'm smoking outside, what's the big deal? Isn't that good enough?"