



CLINICAL EXERCISE SPECIALIST MANUAL

A Fitness Professional's Guide
to Training People with
CHRONIC DISEASE

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**A FITNESS PROFESSIONAL'S GUIDE TO
EXERCISE AND CHRONIC DISEASE**

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CHAPTER 3

RAPPORT AND PSYCHOLOGY

By the end of this chapter you will understand:

- Psychological factors associated with chronic disease
- Stress
- Self-efficacy
- Models of behavior change
- The significance of building rapport with clients
- Client education
- SMART goal setting
- Shaping

As chronic disease becomes more prevalent, patients dealing with the stigma of chronic disease are seeking normalization (Joachim & Acorn, 2000). These conflicting concepts, stigma and normalization, have created a unique space in healthcare offering a proactive approach to reframe the social perspective. Accordingly, integrating behavior care into other forms of less stigmatizing health services is gaining attention as patients with chronic diseases seek allied providers to assist with lifestyle and disease management behaviors, and self-management support (Fisher & Dickinson, 2014). By understanding a client's perspective, a CXS can provide the support and a positive environment for clients to overcome or manage a chronic disease.

Understanding Stress

Up to 75% of Americans experience some type of stress in any given month (Clay, 2011). Stress can result in headaches, stomach problems, sleep disorders, anxiety, depression, weight disorders, irritability, cardiovascular disease, and much more. Dr. Hans Selye (1950) described the stages of stress as a predictable, universal pattern, and termed the process the *General Adaptation Syndrome*. Pleasant or unpleasant experiences can trigger stress. Pleasant stressors are termed *eustress*, and unpleasant stress is termed *distress*; the physical response to eustress and distress is the same.

- The first stage is alarm. The alarm stage is in response to the fight-or-flight reaction. Individuals in the alarm stage can experience physical and mental symptoms such as indigestion, headaches, depression, anxiety, weight gain, and sleep disorders.
- The second stage is resistance. During the resistance stage, the body learns to deal with stress, and can adapt to new levels of stress as it builds resistance.
- The final stage is exhaustion. As stress persists, life threatening exhaustion develops, that negatively affects physical and mental well-being.

Long term personality changes such as decreased extroversion, openness to experience, and conscientiousness have been associated with chronic disease (Jokela, Hakulinen, Singh-Manoux, & Kivimaki, 2014). Accordingly, as chronic disease persists, many individuals affected are stigmatized as they perceive themselves as damaged and discriminated against (Joachim & Acorn, 2000). However, individuals who find ways to adapt, and in many cases overcome chronic disease, begin the process of normalization as they resume previous responsibilities and duties. Normalization is the act of creating a positive attitude toward living with a chronic disease (Joachim & Acorn, 2000). As discussed, it is known exercise can help prevent (primary, secondary, and tertiary) of over 35 chronic conditions (Boothe, Roberts, & Laye, 2012).

Self-efficacy

Self-efficacy is the self-belief an individual is capable of executing behaviors necessary to achieve a goal (Carey & Forsyth, 2019). Clients who have strong self-efficacy will think of a new challenge as something to overcome, recover quickly from failure, and are committed. Clients with a low level of self-efficacy avoid new challenges and dwell on failures. Self-efficacy can be thought of as a cycle in behavior change, with past performance as the strongest predictor of success. Therefore, clients in the early stages of behavior change will naturally have a lower level of self-efficacy, and in later stages, self-efficacy will facilitate participation, and greater participation will, in turn, increase self-efficacy (Marcus, Selby, Niaura, & Rossi, 1992).

The pattern of attrition from exercise is similar to the relapse curve of heroin, alcohol, and tobacco use (Marcus et al., 1992). Accordingly, clients who feel they have not yet mastered an activity or exercise program, or are struggling with staying on schedule or experiencing disruptions, are at a greater risk for relapse than those in later stages of behavior change. Unfortunately, relapse will happen, and most likely within the first 6 months. Understanding how behavior change is facilitated and taking measures to overcome barriers that may cause relapse will ensure continuation and continuity of a new client's exercise program.

Models of Behavior Change

When we talk with prospective clients it is important to understand their perspectives on their current behavioral patterns. Understanding will provide insights into how a CXS can prompt change in those patterns. Clients who are suffering from one or more chronic diseases may have a low level of self-esteem and self-confidence, they may suffer from depression and anxiety, as well as addiction or other negative coping mechanisms. The strategies and stages of the transtheoretical model of behavior change, the health belief model, and the self-determination theory may be useful to understand behavior change, and provide insights to overcome obstacles to client apprehension and to begin or continue an exercise program.

Transtheoretical Model

The transtheoretical model of behavior change provides strategies, based on stages of change, to determine readiness to make a change; accordingly, a program designed for an individual in one stage will not be effective for an individual in a different stage (Marcus et al., 1992; Prochaska & DiClemente, 2005; Rogers, 2015). The stages of the model are:

1. Precontemplation indicates an individual is unaware a problem can be solved. The goal is to help clients be mindful that the risk of doing nothing is greater than the risk of change by making the solution relevant to them. To accomplish this, there needs to be validation of a clients' circumstances, and clients need to be encouraged to seek information regarding their condition.
2. Contemplation occurs when a client is aware of a problem but does not know how to initiate change. In this stage, clients need to be informed of the options and provided some minimal direction. Clients need to understand the choice to change is theirs to make, be encouraged a positive outcome is possible and beneficial, and offered opportunities to begin the process.
3. Preparation is the stage when a client is ready to make a change and seeks opportunities to begin or increase activities related to change. Goals and priorities are established, and a structured program implemented. During preparation, clients need to receive positive feedback and reinforcement regarding the decision to change a behavior, and need to know if a problem arises, they are not alone.
4. Action indicates a client is acting autonomously, gaining a sense of self-liberation, and desiring opportunities to participate. The main goal in the action phase is to ensure changes become habit through emphasis on self-efficacy and long-term benefits. This is also the stage where a relapse is most likely to occur, therefore continual positive feedback and support are necessary.
5. Maintenance builds on the tools acquired during the first four stages. Plans are in place to overcome obstacles, and the client is capable of dealing with relapse. It is understood that maintenance requires fewer resources than building, and to avoid burn out, program variety should be encouraged.

Health Belief Model

The health belief model is predicated on variables of perception (Carpenter, 2010). The first is the belief people will begin healthy behaviors if they perceive that not doing so will have a negative effect; the stronger the belief, the greater the likelihood of initiating change. For behavior change to occur it

is necessary to believe the change will bring about a drastic or strong positive result. Last, perceived barriers will prevent the adoption of the new behaviors. Barriers can include the seriousness of illness or injury, a lack of time, or a poor financial situation. Regardless, a client must perceive the benefits of an exercise program outweigh the barriers.

Self-determination Theory

The self-determination theory suggests there are three psychological needs, autonomy, competency, and relatedness, which facilitate behavior change (American College of Sports Medicine, 2018; Graham & Whitehead, 2018). Autonomy is the belief the decision to participate was made freely by choice and without undue influence. Competence occurs when an individual successfully completes or masters an activity or exercise. Relatedness is defined as when an individual is connected to, or senses a belonging with, others. The extent to which these three psychological needs are met determines the level of motivation.

Motivation is described as intrinsic or extrinsic (Sebire, Standage, & Vansteenkiste, 2009). Extrinsic motivation is centered on achieving outward goals such as awards, respect of others, and money. Intrinsic goals are focused inward and may include moral achievements, values, and personal interests. For exercise, activity, and fitness, an extrinsically motivated client would be focused on losing weight or building muscle, while an intrinsically motivated client would be concerned with skill development, or health and wellness factors. Although the goals of each client need to be addressed, a client suffering from one or more chronic conditions is likely concerned with health and wellness, and therefore motivated by intrinsic factors. Additionally, the psychological needs described in the self-determination theory are considered intrinsic and need to be considered when developing an exercise program for a client with a chronic disease. Furthermore, while extrinsic feedback such as verbal cues are important during the initial stages of an exercise program, intrinsic feedback, based on experience, is provided by a client's internal voice, and is crucial for long-term commitment.

Rapport

A good client-CXS relationship begins with good communication. Unfortunately, communicating is not always easy, and can be more difficult for a client suffering from chronic disease as extroversion decreases, and irritability and interpersonal conflicts increase (Jokela et al., 2014). The first few minutes with a client are the most crucial time to build rapport, with the goal of fostering trust, and then compliance (Barkley, 2017). Rogers (2015) describes rapport as a mutual understanding and trust in a relationship, and is paramount to facilitate behavioral change. Initially, rapport can be established by spending a few, uninterrupted minutes focused completely on a client's needs. By understanding what is important to a client and discussing a program plan that addresses client concerns, the foundations of a positive environment of collaboration and teamwork can be built (Barkley, 2017).

Client concerns can include a lack of time, financial insecurity, or aches, pains, and failing physical ability. However, assuming the concerns of a client indicate a closed mind, and can lead to miscommunication and the failure to understand a client's needs or abilities, and ultimately failure due to false expectations. Allowing clients to explain, in their own words, and then reiterating their concerns back to them, displays empathy and provides a CXS an opportunity to address and clarify any foreseeable obstacles. It is best to do this in a quiet place with minimal distractions where focus can be placed on the client, and eye contact assured.

Educate Your Client

Recreation and fitness leaders lead by emphasizing skill instruction, educating for understanding, and facilitating change (Little & Watkins, 2004). Skill instruction involves leading by doing. An instructor shows how something can be done and encourages followers to imitate. Educating for understanding builds confidence by explaining the components of an activity, why it is performed, and how it benefits performers. The focus is on performers and their needs. Leading to facilitate change encompasses skill instruction and understanding, but the focus should be on personal change rather than a specific activity. The emphasis is on empowering clients to take the lessons and victories from an activity into other aspects of their lives. By using a combination of these leadership approaches, clients can get what they need, as well as what they want.

A method to ensure a client understands material is the teach-back method. With the teach-back method, sometimes called the show-me method, clients are asked to explain in their words what they need to know or do (Agency for Healthcare Research and Quality, 2015). The teach-back method has been demonstrated to improve understanding and adherence, reduce cancelled appointments, and improve satisfaction and outcomes.

Be SMART

Goal setting is a proven method to achieve behavior change (Bovend'Eerd, Botell, & Wade, 2009); however, if expectations are too challenging or goals are too difficult, failure will most likely follow. The SMART method of goal setting allows for achieving realistic goals in a timely manner. The acronym SMART stands for:

- **Specific goals**—Setting a time or distance goal for cardiovascular exercise, eliminating unhealthy foods, or performing resistance weight training twice a week are examples of specific goals.
- **Measurable goals**—Setting a continuous 20-minute time goal for cardiovascular exercise, only eating pastry desserts on weekends, or bench pressing a certain weight are examples of measurable goals.
- **Attainable goals**—The goals should be within control. For example, running a marathon, or bench pressing 300 pounds may not be attainable goals for someone new to exercise.
- **Relevant goals**—Are the goals relevant to an individual? Does a client with arthritic knees need to run a marathon, or does a shoulder replacement client need to bench press twice their body weight?
- **Time frame**—A reasonable and realistic length of time should be allowed for goal achievement. For example, setting a time frame of 6 weeks to run a marathon is not a reasonable or realistic goal for a sedentary individual.

Shaping

Hope and fear are powerful motivators. Whereas fear is negative and leads to anxiety, hope is positive and leads to aspiration, and subsequently, long-term adherence. One way to convey hope is through shaping. Shaping is simply exercise progression via behavior change and affirmation (Rogers, 2015). Starting with achievable movements, based on assessments, a client slowly progresses to the ultimate

goal. By beginning with an achievable exercise, a client is not overwhelmed or anxious, but gains hope and confidence. Shaping can then be used to slowly challenge a client to build new skills and develop new behaviors. Shaping is ideal for large goals that may take longer to achieve but can be divided into manageable segments. For example, running a marathon can be divided into the smaller goals of running a mile in 6 weeks, increasing to 3 miles in 6 months, and a marathon in 24-36 months.

A written contract is another powerful motivator to ensure long-term adherence. A contract is a voluntary and deliberate, binding agreement between two parties, or a self-agreement where expectations are written down, and mutually agreed upon. Using SMART goals to define the parameters of the contract may be a good place to start, but the agreement should be flexible enough to allow for adjustments as expectations and goals change. Regardless, to achieve goals, progress should be tracked, and the goals should be revised as needed.

Discussion and application

1. Why is rapport considered to be the foundation of any fitness program?
2. Taking into account the stigma and psychosocial effects of chronic disease, how would you encourage someone with a chronic condition to start an exercise program? If possible, use a real-life example of success and/or failure.

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