

Rehabilitation for patients with rheumatic diseases: Patient experiences of a structured goal planning and tailored follow-up programme

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Abstract

Objective: To explore the significance of the content of rehabilitation in terms of achieving a personal outcome, and to understand the significance of tailored follow-up interventions for individual efforts to prolong health behaviour change after rehabilitation.

Design: Semi-structured interviews with patients who had received an extended rehabilitation programme. All interviews were transcribed verbatim. A thematic analysis was applied.

Subjects: A purposeful sample of 18 patients with rheumatic diseases who had attended specialized multidisciplinary rehabilitation with an extended programme consisting of a self-help booklet, structured goal-setting talks and tailored follow-up calls based on motivational interviewing.

Results: Four overarching and interrelated themes were identified. Experienced *Person-centred interventions* represented a basis for the patients' motivation and personal outcomes. *Confident self-management* describes a new confident approach to exercise and illness management after rehabilitation with person-centred interventions. For many, this included *reaching a different mindset*, a change of illness perception. *Continuity of the personal outcomes* describes the importance of follow-up telephone calls to maintain the focus on goals and continued efforts. Building on established relationships and practising person-centred communication were essential.

Conclusion: Tailoring of communication and rehabilitation interventions may be a premise for enhancing health behaviour, including a beneficial illness perception. Structured goal setting and follow-up telephone calls using motivational interviewing enhance motivation and may contribute to prolonged goal attainment.

Keywords

Rehabilitation, rheumatic diseases, person-centred, motivational interviewing, qualitative study

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Introduction

Improved medical treatment of rheumatic diseases prevents major functional limitations for many patients. However, adjusting to living with a chronic rheumatic disease may still be a complex and demanding process involving behavioural, cognitive and emotional aspects.^{1–5} From the early onset of the illness, multidisciplinary rehabilitation is a valuable adjunct to medical treatment in this process.^{6,7} Multidisciplinary rehabilitation in the context of a biopsychosocial model of illness has been shown to be beneficial for patients with rheumatic diseases.^{8–11} However, research also shows that rehabilitation outcomes tend to be short lived. After 6–12 months, most patients are back to their initial health status.⁹ This draws attention to the nature of rehabilitation outcomes and to factors and interventions that may help to increase the duration of positive outcomes.

Results from previous qualitative studies show that individual outcomes may include dimensions and experiences that are not easily captured in standardized instruments, such as increased dignity and self-respect.^{12–16}

Individual perspectives of illness challenges and health behaviour change represent the basis for tailoring rehabilitation goals and interventions.^{6,17–19} Collaborative, person-centred guidance to elicit and strengthen motivation for change may enhance the core focus of rehabilitation: enabling people to reach their optimal functional levels. Client-centred communication such as motivational interviewing (MI) is thus a suitable approach to enhance health behaviour change.^{20,21} A recent meta-analysis²² shows that the use of MI leads to improvement in levels of physical activity for people with chronic health conditions. MI does, however, not provide a theoretical framework for understanding how and why it can be effective. A general theory of human motivation, self-determination theory (SDT),²³ may deepen our understanding of the effects of MI^{24,25} and is increasingly used in areas of health behaviour.^{26–28} According to SDT, motivation varies in being experienced as autonomous or more controlled, with autonomously regulated motivation being more robust and lasting.²³ Both SDT and MI are person-centred, non-judgmental and supportive, information given to the patient is tailored according to individual needs, and both emphasize the principle of autonomy: the wish to change must come from within.

Rehabilitation often addresses health lifestyle changes that take a certain amount of time before becoming a new habit and is a process that commonly continues beyond the duration of the rehabilitation. Cognitive and behavioural strategies may still be vague and fragile upon completion of the rehabilitation stay and patients may not, for a variety of reasons, be motivated to continue daily involvement in necessary activities at home.^{29,30} More knowledge is therefore needed to understand how elements of rehabilitation set off individual processes of positive change and to help patients to develop sustainable strategies to maintain such changes after rehabilitation.

The purpose of the current qualitative article is twofold:

- To explore the significance of the content of rehabilitation in terms of achieving a personal outcome;
- To understand the significance of tailored follow-up interventions for individual efforts to prolong health behaviour change after rehabilitation.

Method

This study

This study is nested in a larger multicentre study where the main objective was to evaluate goal attainment, health effects and cost-effectiveness of an extended rehabilitation programme for people with rheumatic diseases.³¹ A total of six different rehabilitation institutions in the Health Region of South-East Norway participated. All rehabilitation was inpatient apart from a hospital-based programme, which followed a day care schedule. The centres had different original rehabilitation programmes, and the new extended rehabilitation programme represented a supplement to and an extension of these. It included four elements designed to enhance and support lifestyle changes introduced in the rehabilitation period. At both the outset and the end of the rehabilitation, the patients had *structured goal-setting talks* and decided on one or more personal goals. On the first or second day of the rehabilitation, all patients received a *self-management booklet*. The booklet was meant for use during the rehabilitation and at home and addressed topics relevant to the rehabilitation stay and for the first period after admission. The patients were encouraged to write down their goals and use the fields for reflections and taking notes. Furthermore, the patients received *four follow-up telephone calls*, at 1 week and 1, 3 and 5 months after discharge. The phone calls were, with a few exceptions, made by a rehabilitation care provider who met and got to know the patients during the rehabilitation and were directed at goal attainment and motivation for continued effort. The goal-setting talks and telephone follow-up calls were conducted with the use of *MI*, following a predefined structure and template. The interventions were administered by trained rehabilitation providers, in accordance with the study protocol.³¹ This study includes semi-structured interviews with 18 persons who had received the new extended rehabilitation programme at one of the participating centres and allows for a deeper understanding of the multidimensional phenomena of rehabilitation interventions and the individual continuity of rehabilitation outcomes. This study was approved by the Regional Committee for Medical and Health Research Ethics (2011/909).

Individual interviews

The informants were recruited by local project coordinators who were rehabilitation clinicians who knew the patients from the respective rehabilitation institutions. A purposive sampling strategy was applied, with sampling criteria selected

Table 1. List of informants.

Name	Gender	Diagnosis	Years since diagnosis	Age	Work situation	No. of follow-up calls	Previous rehabilitation
Ane	F	Ankylosing spondylitis	25	50	W	2	Yes
Helle	F	Juvenile idiopathic arthritis	20	23	W	4	No
Marita	F	Juvenile idiopathic arthritis	50	55	DB	2	Yes
Ina	F	Psoriatic arthritis	2	39	W	3	No
Berit	F	Osteoarthritis	10	56	W	3	Yes
Anine	F	Rheumatoid arthritis	20	53	W	3	Yes
Janne	F	Sjögren's syndrome	17	68	DB	2	Yes
Asta	F	Osteoarthritis	13	48	W	3	No
Sigrid	F	Osteoarthritis	3	56	DB	3	No
Astrid	F	Rheumatoid arthritis	2	67	W	2	No
Roar H	M	Rheumatoid arthritis	1	53	SL	2	No
Magnus	M	Ankylosing spondylitis	30	57	DB	2	Yes
Ole	M	Rheumatoid arthritis	9	57	W	3	No
Ottar	M	Polymyalgica rheumatica	7	63	W	3	No
		Osteoarthritis					
Mons	M	Ankylosing spondylitis	4	34	W	3	No
Bjørnar	M	Ankylosing spondylitis	3	26	W	2	No
Arnt R	M	Rheumatoid arthritis	2	58	DB	3	No
Lasse	M	Psoriatic arthritis	3	40	W	3	No
		Gout	0.3				

DB: disability benefits; SL: sick leave (full time).

on the basis of the research questions, to give a rich empirical material with sufficient variation. The criteria included rheumatic diagnosis, illness duration, gender, age and previous rehabilitation experience; both patients who had been to rehabilitation before and for those it was a first time experience. For a variation of patient experiences from all of the involved institutions, each institution recruited three patients. When 18 informants had been recruited at the involved rehabilitation institutions, the sample was regarded to contain sufficient variation of the selected criteria, and no further informants were invited to participate. The quality of the interviews was high, containing a high degree of variation, complexity and detailed descriptions of the explored experiences. The interviewer (T.N.D.) is a clinical psychologist with prior training in qualitative interviewing. The interviewer had no affiliation with the involved rehabilitation centres.

All the informants signed an informed consent. The names used in this article are fictional. The interviews were conducted when the patients had received at least two telephone follow-up calls (given 1 week and 1 month after rehabilitation). One patient had received all four follow-up calls. This was an intended time interval difference in order to capture information about the experienced significance of the timing of the follow-up intervention. The informants could choose the most suitable place for them to have the interview: at home, at the rehabilitation centre or at another convenient place. Most interviews lasted from 60 to 90 min, while five interviews lasted less than 60 min. All patients were living in the Health Region of South East Norway. The names used in this article are fictional.

The informants' ages ranged from 23 to 68 years. The sample included a variety of diagnoses. Most of the informants (12) were still in full- or part-time jobs, one was on sick leave, aiming to be back in full-time work after some months, and five patients were on permanent disability benefits or pensions. A description of the informants is presented in Table 1.

The interview guide

The interview commenced with an initial question asking the patients to describe their life situation at the time of referral. The interview guide further included topics such as experiences during the actual rehabilitation programme, experienced outcome, efforts to continue the rehabilitation process at home as well as the patient's life situation at the time of the interview. The significance of the supplementary rehabilitation interventions was specifically asked for. The interviews followed a natural progression of the topics according to the informant's emphasis and elaboration of specific themes. Towards the end of the interview, the interview guide was checked to ensure that all topics had been covered.

Data analysis

After each interview, general impressions and reflections were written down. The audio-recorded interviews were transcribed verbatim. This process was performed by a professional typist and the transcriptions were later checked against the sound files. A pragmatic approach, thematic analysis,³² was applied to identify patterns of meaning in the material.

All interviews were read and reread to get an overall impression and an initial marking of relevant themes and categories. The systematic coding of all interviews was done using the NVivo software programme. Condensed text within themes was then organized in matrices and further themes and subthemes emerged through the process of comparing within and across the interviews in cross-case analysis. The patterns of themes and subthemes were then described.

Because the evaluation of the supplementary interventions was of particular interest and a topic in the interview guide, they constituted predefined categories. The coding was performed by the first author (T.N.D.). Excerpts of transcripts together with initial codes, and later categories and themes, were discussed and developed further with a group of qualitative researchers. Preliminary analysis and patterns of theme structures were presented and discussed on several occasions with local project coordinators, who contributed to new perspectives and broadened analytic questions.

Findings

Four overarching and interrelated themes were identified: ‘person-centred interventions’, ‘confident self-management’, ‘reaching a different mindset’ and a fourth overarching theme related to the period after rehabilitation and individual efforts to maintain an achieved outcome: ‘continuity of personal outcomes’.

The interventions of the extended rehabilitation programme are nested in and contribute to these themes but each intervention does not represent one theme. In the following, the significance of the added interventions is described under the relevant overarching themes.

Person-centred interventions

The patients expressed high satisfaction with the rehabilitation programmes. Meeting health personnel with thorough knowledge of the treatment of their specific diagnosis, and with the time and interest to listen to individual perspectives and challenges was emphasized.

For Mons (34 years), the rehabilitation made him a more active caretaker of his own health. He was referred to rehabilitation after a long period of increasing stiffness and pain where he managed to do some exercise on his own, but daily life with a full-time job and two young children gradually became more challenging. He emphasized the significance of the individually adjusted approach:

What was important wasn't precisely what they were doing, but how they did it. I mean that an individual programme was made for each person who came in here. They followed us up in different ways and that was what was really good about it. (Mons, 34)

Individual tailoring was possible due to the high competence of the rehabilitation personnel and their ability to

capture personally meaningful themes and tailor interventions in accordance with the patients' illness perception and motivation. Magnus (57 years) had been to many previous rehabilitation stays, but had not been involved in individual goal setting. He pointed out the difference:

I thought that was a good thing, because then they found out what I needed and wanted in terms of the goal. It was a really big difference and a positive difference. So you can draw up a plan on the basis of that. (Magnus, 57)

The initial talks were also a natural context to establish a secure relationship and significant for the experience of person-centredness. The few meetings where the patients' concerns were not captured and interventions adjusted accordingly contrasted with most patients' positive experiences of person-centredness and indicated how essential this is.

Patient perspectives out of focus. In this study, dissatisfaction with the rehabilitation was related to meetings or interventions which were not experienced as person-centred. Janne (68 years) described going home with important issues left unaddressed. Rehabilitation increased her level of functioning, yet she worried about the progression of her illness and the discrepancy between what she wanted and actually managed each day. This was not captured and thus not addressed during rehabilitation, nor was her need for more help with daily living at home. The quickly fading rehabilitation effect was a major concern at the time of the interview. She somewhat sarcastically expressed how goals suggested by the rehabilitation personnel upon discharge were far from her own concerns:

I just wish they talked more about what you do about the practical things when you get home. There was more focus on what you want to do; do you want to meet a friend, or do you want to do this or that about some form or other, or a book or something like that. (Janne, 68)

Her experience illustrates how capturing the patients' concerns and perspectives on challenges is essential for reaching personally valuable goals. Personally important outcomes come from rehabilitation programmes with a focus on personally important issues. An experienced person-centred approach with tailored interventions forms the basis for the next theme: ‘confident self-management’.

Confident self-management

For many of the informants, the rehabilitation represented a turning point after which a new, more confident approach to exercise and management of the rheumatic disease was established. Without integrated knowledge about the disease, its symptoms, treatment and what patients can do themselves, uncertainty and ineffective self-management

strategies left many with a feeling of poor coping. Bjørnar (26 years) was diagnosed 3 years ago, yet had never become assured about exercises and adequate self-management strategies:

You trust them and you feel secure, very secure, and then you're not afraid to try things either. Here I got proper guidance, physiotherapy and we went through what the right things for me were, which exercises were suitable and which ones weren't. I used to just try everything, even things that aren't good. (Bjørnar, 26)

New knowledge and individualized training programmes provided by skilled personnel gave patients courage to take part in daily exercises and planned activities. Ina (39 years) had only had her rheumatic disease for 2 years and described the confusing and paralyzing knowledge gap that used to be. Through rehabilitation she moved from worry and uncertainty to secure belief and action. A securely based engagement in beneficial self-management was for many a primary rehabilitation outcome. The experiences of increased control and confidence also affected the patients' illness perception.

Reaching a different mindset

Rehabilitation for many was a rare opportunity to focus on living with a rheumatic disease at a distance from everyday challenges. This shift of perspectives facilitated a process of discovering new ways of thinking. Rehabilitation became a vantage point of the present situation and thus a means to change perceptions of illness and challenges. Ottar (63) had believed that there was little he could do to improve his situation. From the time when his illness was diagnosed 7 years ago, he had waited for the illness to 'burn out' without an active approach. The rehabilitation represented a turning point in this respect:

My stay here has made me realize that you don't need to just sit with your hands in your lap and hope you'll get better. You can exercise a bit for it, and that's what I do. (Ottar, 63)

An important and timely reassurance from the rheumatologist during the initial assessment represented a moment of change and was crucial for reaching a new approach to illness challenges.

The process of goal setting involved a valuable opportunity to reflect on the content of life at present, desired changes, subsequent personal goals and necessary strategies to achieve them. Ane (50 years) had lived with ankylosing spondylitis for 25 years and described how her way of thinking about her illness changed:

You think a bit differently about what you should do and what you actually do. Maybe even then you started thinking a bit long term almost unconsciously; it isn't just these 14 days, this is something more, a bit longer. I do think it was very useful and

very good in terms of awareness. You start to have thoughts you didn't have before and that makes you see things from a different angle. (Ane, 50)

The patients described a change of mindset related to living with a chronic illness, including a more supportive way of thinking about the present and future situation.

The self-help booklet became a valuable tool for some participants in the early process of deciding focus and goals for the rehabilitation period. The book's invitation to write down personal reflections and thoughts, resources, barriers and goals represented a way to increase awareness. The booklet expanded perspectives and action repertoires by providing beneficial ways to relate to concrete challenges. After the rehabilitation, however, only a few of the informants used the booklet actively. Some stated that the content and layout did not appeal to them, referring to the quotes and poems as well as the reflection notes. Its value as a source for inspiration seemed to fade after a while. This element of the extended rehabilitation intervention is therefore not included in the next theme, which focuses on the period after rehabilitation.

Reaching a different mindset shows that rehabilitation offered a way out of well-trodden thought paths. The following section presents the prolongation of the rehabilitation process: individual goals set at discharge and strategies to maintain the achieved outcome.

Continuity of the personal outcome

The main purpose of the additional elements of the extended rehabilitation programme was to prevent fading of rehabilitation outcomes. Many of the patients had integrated personally important strategies into their daily routines after rehabilitation. However, maintaining these was a vulnerable process as inspiration and input from rehabilitation faded. The interviews showed that the continuity of positive self-management strategies at home was challenged by factors such as illness exacerbation, daily workloads, daily demands and competing personal values. Having reached confident self-management and a comprehensive illness perception was a buffer against competing foci. The appreciation of new coping strategies included perspectives of what used to be, and for some, motivation to continue took the form of a fear of relapse. The positive changes strongly contrasted with the situation prior to rehabilitation, and the memory of what used to be became a driving force:

I was here and I got motivated and I've never felt like that before, so it was a sort of hallelujah feeling. [...] because I'm terrified of ending up where I was, you see? That's something you can't get out of your head. I don't want to go back there and it kind of whirls around in your head a bit, so it's really horrible. (Ina, 39)

The state she referred to was one before ‘confident self-management’. For Ina and many others, thinking back to the uncertainty of that stage became a motivating factor.

The main focus of the phone calls was to support goal achievement. The two subthemes are naturally intertwined and presented below.

The maintained focus on individual goals. The process of setting individual goals for the subsequent period was described as positive by all the informants. Most participants spontaneously talked about their specific personal goals. All had some goals in the area of physical exercise, but there were also other themes, such as experiencing less pain and increased movement and flexibility, and finding a better balance between activity and rest in daily living. Berit (56 years) was motivated by the experienced effect of physical training, and the concrete goals she set at discharge were a help to maintain a structure for the continuation:

Now you’ve given me so much motivation that when I get home I’m really motivated and really positive about everything. I have to keep it up, and then it was really nice to have something more specific, I must say. That’s when I took responsibility. When things are specific, it gets so much easier. (Berit, 56)

Specific goal formulations enabled her to take on the responsibility. Other patients described how goal achievement installed a useful future perspective and was helpful in order to give priority to specific activities. Some kept an exact record of goal attainments, marking off goals as they were achieved. When relapses or non-compliance with defined goals occurred, a certain generosity towards oneself seemed important. This non-judgmental attitude was an essential part of what was conveyed in the follow-up telephone calls.

The significance of receiving the follow-up telephone calls. The phone calls from a familiar person from the rehabilitation centre were perceived entirely positive and above expectations. During the calls the patients were asked about the process of maintaining focus on their goals, in a form they experienced as informal and friendly. The phone conversations contained the possibility to address both challenges and successes and gave a feeling of security. The supportive nature of the conversations was experienced as motivating. They promoted positive feelings and helped to redefine eventual relapses. Ane (50 years) was unable to remember the content of the phone calls, but remembered the feeling the phone call with her physiotherapist gave her:

I don’t remember exactly what she said, but what I’m left with is the feeling from that phone call, and then you’re left with a sense of being accepted. That’s the effect it had, and it makes you move on with a positive feeling that it’s working. (Ane, 50)

The residue of accept that Ane described after the phone call released energy and motivation to carry on towards goal

attainment. The content of the phone calls was integrated in thinking and self-talk about continued goal attainment. Anine (53 years) experienced the phone calls as reminders which brought her back on track towards goal achievement. The expected phone call made it easier to be attentive:

When I’ve been staying here now and I know he’ll ring me and ask how things are going, it makes me keep going more, I get more focused. If I’ve had a bit of a down period before he rings, well, it makes me more focused and I get going again, because I like exercising, I like feeling that my body’s fit, so that’s not the problem, it’s about finding time for it, when I have those boiling over periods. (Anine, 53)

When challenged to describe *why* the phone call made her intensify efforts, Anine mentioned how the focus of the call reminded her of her personal reasons for doing exercises. The follow-up calls represented a prolonged contact with the rehabilitation personnel: the patients’ important others in this context. The significance of experienced person-centredness and an established relationship with the person who made the call became particularly salient through contrasting experiences. Berit enjoyed the first phone call where she could proudly tell about the progress she had made. The second follow-up call was, however, from someone she had never met. In this case, the person who called strictly followed the questions in the template and did not manage to convey ‘the spirit of motivational interviewing’. The patients described well the demotivating effect of talking to someone who is not genuinely interested. Conveying achievements or challenges to someone with whom there is a positive relationship is crucial. The number of phone calls received before the interviews did not seem to reflect different experiences, and one specific follow-up time interval was not preferred to others.

Experiences conveyed by the participants in this study show that extended processes of rehabilitation and efforts to maintain positive outcomes may be strengthened by MI-based follow-up telephone calls from rehabilitation personnel.

Discussion

This article sets out to explore the significant elements of the content and outcome of rehabilitation from the perspective of the patients and to understand the significance of telephone follow-up calls to prolong health behaviour change after rehabilitation. This study shows that tailoring of communication and rehabilitation interventions may be a premise for reaching personally valuable outcomes. Confident self-management, namely knowing what to do, and doing it, is a primary rehabilitation outcome, for many involving a corresponding change of mindset. Having the confidence and knowledge of how to deal with illness challenges is essential for taking on the responsibility of self-management. Rehabilitation may represent a turning point in this respect. The structured goal-setting talks represented an arena for initiating person-centred interventions and establishing a secure

relationship. Efforts to prolong personal outcome were strengthened through goal-setting at discharge and the maintained focus on individual goals in the follow-up telephone calls.

The experienced confidence and wish to involve in new self-management approaches may be attributed to several elements of the rehabilitation. Many of the patients explicitly said that they felt *motivated* by the rehabilitation, and the individual experiences point to factors that are crucial for human growth and well-being: the need to feel capable of achieving desired outcomes, to be able to make autonomous choices based upon personal needs, and to experience positive relationships. According to SDT, these are basic psychological needs, and satisfying them in a given context is likely to elicit autonomously regulated behaviours relevant to the context.²³ Autonomous motivation was explored as a determinant of physical activity for patients with rheumatoid arthritis in a study by Hurkmans et al.³³ The results showed that higher levels of physical activity correlated with autonomously regulated motivation. For most patients in this study, the rehabilitation programme with structured goal planning and tailored follow-up interventions represented a need-supporting, or facilitating, context.²³ Communication style was a crucial component in this respect. The principles of MI represented an attitudinal core as well as a communication tool in the contact between the rehabilitation personnel and the patients. The three basic psychological needs of SDT are directly addressed by MI, and the communication style thus contributes to put the theoretical foundation of SDT into practice.^{24,27,34} The psychological need for autonomy is reflected particularly in the themes 'person-centred interventions' and 'change of mindset'. According to MI, the role of the therapist is to establish a facilitative, empathetic environment where the patient can discover the answers for himself.²⁴ This study shows that the emphasis on autonomous choice increased awareness of personal needs and wishes and thus facilitated making personally valuable goals and decisions. In a study exploring patient perspectives on a cognitive behavioural therapy (CBT) group programme for fatigue self-management in patients with rheumatoid arthritis, autonomous choice was similarly identified as a factor facilitating change.³⁵ The patients were encouraged to consider new ways of thinking through a guided discovery process, hence the title quote 'They didn't tell us, they made us work it out ourselves'. The evaluation of the programme showed improvements in fatigue impact, perceived severity, coping, mood and quality of life.³⁶

In our study, the psychological need for competence was met through several elements in the rehabilitation programme. 'Confident self-management' describes the significance of trying out exercises and self-management approaches within a secure framework and under the guidance of skilled personnel. Reassuring experiences with new health behaviour added to the feeling of competence, for some representing a significant turning point. Relatedness reflects the need to feel close to and understood by important others. According to SDT,

motivation will be interfered with when relational aspects are not sufficiently taken into account.²³ In this study, such demotivation was described with particular clarity in the few cases where patient perspectives were not captured or taken into account. The significance of relational factors is well known from psychotherapy research.³⁷⁻³⁹ Rehabilitation outcome research has primarily focused on the effect of specific interventions. However, a recent randomized controlled trial (RCT) study of rehabilitation for patients with Rheumatoid Arthritis (RA) and a high level of fatigue⁴⁰ focused on the partnership between the participant and the physical therapist, in a tailored 12-week programme of health-enhancing physical activity and balancing life activities. It showed a significant effect on the patients' level of fatigue at 6-month follow-up.

Need support may also be applicable when trying to understand the significance of the follow-up interventions. In addition, other perspectives may be relevant. In a recent meta-study,⁴¹ phone calls represented a monitoring of progress seen to positively affect goal attainment and served as reminders of personal goals and subsequent actions. Irrespective of the intention to change behaviour, action may be postponed, which is a discrepancy labelled the intention-behaviour gap.⁴² The contribution of follow-up telephone calls may thus bridge the possible gap between intended continuity and actual behaviour after rehabilitation. Procrastination is acknowledged as a factor associated with the intention-behaviour gap in other domains such as achievement and performance. Interestingly, it has also recently been explored as a perspective of health behaviour failure.⁴³ This perspective on adherence indicates that one purpose of follow-up calls may be to prevent procrastination of intended health behaviour. It draws attention to the need for clinicians to include relapse prevention as a theme in tailored communication about the continuity of rehabilitation outcomes.

Continuation of personal outcome may be facilitated by new insight and a change of mindset. Reaching a more beneficial illness perception may be a 'dynamo of volition'⁴⁴ and a solid basis for continued daily efforts towards continuation and goal achievement.⁴⁵ Adjusting to living with a chronic rheumatic disease may be delayed when patients lack adequate knowledge and efficient exercise and self-management strategies. Failing to equip patients with the knowledge and skill to take on efficient self-management strategies affects physical and psychological health. The findings of this study support the call to integrate rehabilitation as a service working in parallel with disease-focused services at all times.⁶

The study has some limitations. The informants were recruited by the rehabilitation coordinator who knew them in advance. Although all local coordinators recruited participants according to the sampling criteria and with a variety of experiences, this relational factor might have biased the sample. The structured goal-setting talks and follow-up phone calls were conducted by personnel trained in the principles of MI. There was, however, no monitoring of the adherence

to the MI attitude or techniques. A comprehensive template or check list, or video recordings, would have allowed us to monitor treatment fidelity more closely.

There is reason to believe that the significance of being met with a person-centred communication style has generalizability to patient consultations in other areas of rehabilitation and in the health care system. A carefully tuned talk contains the possibility to influence the patients' illness perception and mindset.

Patient experiences in this study show how rehabilitation with structured goal planning and tailored follow-up may represent a facilitating environment and provide patients with durable motivation and 'tools needed to attain independence and self-determination' (www.WHO.com).⁴⁶ Rehabilitation may represent a salient turning point, or less strikingly but nevertheless important, a source of motivation and inspiration to continue beneficial self-management. Considering rehabilitation with tailored interventions and communication based on MI as a facilitating environment²⁴ may explain the patients' experience of being motivated and their wish to involve in active self-management. This perspective draws attention to the significance of the meeting between the patient and health personnel and illuminates effective elements of individual and interpersonal processes involved in rehabilitation. Further research on the level of individual health behaviour change during and after rehabilitation is needed. In a clinical perspective, it is important to take into account need support²³ when planning rehabilitation programmes.

In conclusion, the study has shown that the potency of rehabilitation is related to uncovering and remaining close to the patients' own perspectives and understandings. When communication and interventions spring from a mutual vantage point, rehabilitation may move the patients towards new confident levels of managing and living well with their chronic rheumatic disease.

Clinical Messages

- Rehabilitation personnel should be encouraged to use a person-centred communication style in goal-setting talks.
- Follow-up telephone calls may be expedient to consider as a measure to extend the duration of the individual rehabilitation process and outcome.
- It is important that follow-up telephone calls are made by rehabilitation personnel with whom there is an established relation.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Ethical approval

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Informed consent

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