Goals Set After Completing a Teleconference-Delivered Program for Managing Multiple Sclerosis Fatigue

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MeSH Terms

- fatigue
- goals
- multiple sclerosis
- self-care
- telecommunications

Setting goals can be a valuable skill to self-manage multiple sclerosis (MS) fatigue. A better understanding of the goals set by people with MS after completing a fatigue management program can assist health care professionals with tailoring interventions for clients. This study aimed to describe the focus of goals set by people with MS after a teleconference-delivered fatigue management program and to evaluate the extent to which participants were able to achieve their goals over time. In total, 485 goals were set by 81 participants. Over a follow-up period, 64 participants rated 284 goals regarding progress made toward goal achievement. Approximately 50% of the rated goals were considered achieved. The most common type of goal achieved was that of instrumental activities of daily living. Short-term goals were more likely to be achieved. This study highlights the need for and importance of promoting and teaching goal-setting skills to people with MS.

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People with multiple sclerosis (MS) experience a wide range of unpredictable symptoms that may fluctuate daily and progress over time. Developing self-management skills can be an important approach for people with MS to cope with their unique and changing needs (Fraser, Johnson, Ehde, & Bishop, 2009).

Fatigue is one of the most common symptoms of MS (Bakshi, 2003; Larocca, 2011; Minden et al., 2006). Upward of 60% of people with MS who report fatigue state that it is the most disabling symptom (Janardhan & Bakshi, 2002; Smith & Arnett, 2005). MS fatigue can interfere with daily functioning and routines and with quality of life. It is not surprising, therefore, that fatigue management is the most common topic addressed in self-management interventions for adults with MS (Plow, Finlayson, & Rezac, 2011).

Self-management of MS fatigue requires behavioral changes such as modifying routines and activity patterns. Goal setting is a technique that is often taught during self-management programs for people with chronic illness to facilitate such behavioral changes (Von Korff, Gruman, Schaefer, Curry, & Wagner, 1997). Goal setting has been examined in previous MS-specific studies based in inpatient rehabilitation settings (Bloom et al., 2006; Khan, Pallant, & Turner-Stokes, 2008) and in community-based self-management programs (Barlow, Edwards, & Turner, 2009; Stuifbergen, Becker, Timmerman, & Kullberg, 2003). In inpatient rehabilitation studies, goal setting is often directed by clinicians and commonly focuses on symptom management (Bloom et al., 2006; Khan et al., 2008). In comparison, goal setting in community-based MS self-management programs is directed by people with MS and tends to focus on lifestyle and behavioral changes (Stuifbergen et al., 2003). In studies in both settings, goals were set either before commencing an intervention or at an early intervention phase, and goal achievement was used as an intervention outcome.

Participants in one community-based MS self-management study found goal setting to be helpful in achieving their goals during intervention because of improved feelings of empowerment and confidence gained through the process (Barlow et al., 2009). In addition, realistic goal setting was linked to the successful planning and performing of activities that participants had avoided in the past (Barlow et al., 2009). Similarly, women with MS in another self-management study reported that setting goals with incremental steps helped them formulate their goals and monitor achievement over time (Stuifbergen et al., 2003).

The self-management literature suggests that goal setting provides an impetus to make and maintain health-related behavior change and that success in achieving goals increases self-efficacy (Scobbie, Wyke, & Dixon, 2009). An increase in self-efficacy in turn provides people with the confidence to set and pursue more ambitious goals (Scobbie et al., 2009). Although previous studies have supported the use of goal setting, we have limited knowledge of what people with MS hope to accomplish in their daily life after an intervention is complete. A better understanding of the goals set by people with MS after intervention can assist health care professionals with revising and continuing to strengthen interventions and developing content for future applications. Therefore, we examined the goals set by people with MS after they completed a teleconference-delivered fatigue management program. The objectives of this study were (1) to describe the focus of short-, intermediate-, and long-term goals set by people with MS who participated in a teleconference-delivered fatigue management program and (2) to evaluate the extent to which participants were able to achieve these goals over time.

Method

The data used in this study were collected as part of a randomized controlled trial (RCT) that evaluated the efficacy and effectiveness of a teleconference-delivered fatigue management program for adults with MS (Finlayson, Preissner, Cho, & Plow, 2011). As part of the final session of the 6-wk intervention, the participants set short-, intermediate-, and long-term goals. Once the final session was complete, the participants were asked to refine their goals and mail back their setting goals worksheet to the study office. These goals and the participants' self-reported ratings of goal achievement over time were the data analyzed for this study.

Participants

Participants were recruited by advertising through the local chapter of the National Multiple Sclerosis Society

and the North American Research Committee on Multiple Sclerosis Registry, which is a database of voluntary information from people with MS. People interested in participating in the study contacted the study office. During the contact, a trained research assistant explained the study (i.e., purposes, procedures, risks, and benefits) to the potential participants, and if they agreed to continue, the research assistant evaluated their eligibility.

Inclusion criteria included living within the state of Illinois, self-reported diagnosis of MS, 18 yr of age or older, able to read course materials and carry on telephone conversations in English, a Fatigue Severity Scale (FSS; Krupp, LaRocca, Muir-Nash, & Steinberg, 1989) score of ≥ 4 (i.e., moderate to severe fatigue), and a weighted score of ≤ 12 (i.e., no severe cognitive impairment) on the short version of the Blessed Orientation–Memory–Concentration Test (Katzman et al., 1983).

We sent a study information sheet, informed consent documents, and a demographics form by mail to 190 people who met the criteria. When a participant returned a signed consent form to the office, the research assistant contacted him or her for allocation (to either the immediate or the delayed intervention group as part of the RCT). Participants in the immediate intervention group began their teleconference-delivered fatigue management program soon after the allocation, whereas those in the delayed intervention group waited 6 wk after the allocation to begin their program. Nine people could not be contacted. Therefore, the original data were obtained from 181 participants (refer to the original study for details: Finlayson et al., 2011). Of those, 81 participants (44.8% of 181) submitted their setting goals worksheet with their short-, intermediate-, and long-term goals.

Intervention

The intervention involved weekly 70-min group-based teleconference calls for 6 wk, facilitated by a licensed occupational therapist. Each group consisted of 4–7 participants to optimize opportunities for interaction, social learning, peer support, and development of self-management skills (e.g., problem solving, self-monitoring, active decision making; Finlayson et al., 2011).

Across the six sessions, a total of 14 energy management strategies were addressed through teaching, peer discussion, and practice activities that the participants completed at home between sessions. The first session included discussion of fatigue, the impact of fatigue on life, the fatigue cycle, and an overview of major fatigue management principles. The second session addressed the role of communication (e.g., how communication skills

can be used to elicit useful support from others to manage fatigue). The third session provided participants with knowledge and skills to make adaptations to use energy more efficiently. The fourth session introduced activity analysis and the importance of making active choices and setting priorities. The fifth session focused on using the skills of analyzing, modifying, and planning days to manage fatigue and live a balanced life. The final session focused on a review of the program material and a teaching session about goal setting to continue incorporating change into the participants' lifestyle (Finlayson et al., 2011).

Measures

During the final session, participants learned about key concepts of goal setting (e.g., rationale, examples, procedure for setting goals). A facilitator defined short-term goals as changes that could occur in about 2–3 wk, intermediate-term goals as changes that could occur in about 3 mo, and long-term goals as changes that could be achieved in about 6 mo. The facilitator provided the participants with the following background information to set goals:

Setting short- and long-term goals will help you to continue incorporating change into your lifestyle. Goals will help you use the information from the program and continue to apply it. It is important that your goals are realistic and achievable and that they are not dependent on other people. Your goals should include a plan for achievement and have a clearly defined endpoint.

Each participant was asked to identify two short-term, two intermediate-term, and two long-term personal goals using a setting goals worksheet and received feedback from the facilitator and peers. The worksheet included a simple instruction: "Use the space below to set goals for yourself." Participants were asked to refine their goals, after the session while at home, and mail their completed worksheet to the research office.

To assess goal achievement, participants were asked to rate their progress toward set goals using a Likert-type rating scale ranging from 1 (*haven't started working on the goal yet*) to 10 (*fully achieved the goal*). This rating scale was created for the study. For the purpose of this analysis, goals with a score ≥ 8 were considered achieved. During three follow-up phone calls, participants reported their scores. Short-term goals were rated at 6 wk after intervention, intermediate-term goals at 3 mo after intervention, and long-term goals at 6 mo after intervention as part of follow-up data collection points for the main study.

Information on demographics, MS, and fatigue were also collected from participants for the purposes of describing their characteristics. Variables included age, years since diagnosis, the Patient-Determined Disease Steps (PDDS; Hohol, Orav, & Weiner, 1995; Marrie & Goldman, 2007) score and the FSS score, gender, education level, living arrangement, MS type, use of fatigue medication, and involvement in any other rehabilitation programs. The PDDS is a self-reported measure of ambulatory disability in MS. Participants were asked to select one of nine categories that described their ambulatory situation the closest using a scale ranging from 0 (*normal*) to 8 (*bedridden*). Higher scores indicate more severe ambulatory disability (Hohol et al., 1995; Marrie & Goldman, 2007). The FSS is a self-reported questionnaire that consists of nine questions. Participants were asked to rate each question using a Likert scale ranging from 0 (*completely disagree*) to 7 (*completely agree*). Higher average scores indicate more severe fatigue (Krupp et al., 1989).

Data Coding and Analysis

At the beginning of the data analysis process, the second through fifth authors (Preissner, Duffy, Meixell, and Finlayson) completed open coding on a selection of setting goals worksheets. Open coding is an initial phase of the qualitative coding process and is performed to break down the data into segments so that data content and meaning can be uncovered (Benaquisto, 2008). During the process, the authors independently read an assigned set of setting goals worksheets and identified categories within which to organize the goals. When discussing the emerging codes, the team realized that the codes were consistent with the occupations described in the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; American Occupational Therapy Association [AOTA], 2014). The *Framework* identifies eight occupations: (1) Activities of Daily Living (ADLs), (2) Instrumental Activities of Daily Living (IADLs), (3) Rest and Sleep, (4) Education, (5) Work, (6) Play, (7) Leisure, and (8) Social Participation.

Once this discovery was made, the third and fourth authors (Duffy and Meixell) used the occupation categories from the *Framework* to code all of the goals that were submitted, under the supervision of the second and fifth authors (Preissner and Finlayson). Good to excellent interrater reliability among the two coders was found (Cohen's κ s = .71–.86). The research team met regularly to discuss coding challenges and reach consensus when there was uncertainty about how to code a particular goal. It was through these meetings that the team realized that the IADL code provided inadequate differentiation.

Therefore, this category was further divided into IADLs–Home, IADLs–Health, and IADLs–Other. The occupation of Play was not used because the goals were more consistent with the definitions of Leisure or Social Participation provided in the *Framework*. In addition, when goals did not fit into one of the occupation categories, they were coded as Uncodeable. The final 10 categories used to code the goals were (1) ADLs, (2) IADLs–Health, (3) IADLs–Home, (4) IADLs–Other, (5) Rest and Sleep, (6) Education, (7) Work, (8) Leisure, (9) Social Participation, and (10) Uncodeable. Table 1 summarizes definitions for each occupation category and provides sample goals set by the participants.

Results

Participants

Table 2 summarizes characteristics of the 81 participants who submitted their goals to the study office. We descriptively examined the quantitative data obtained from the baseline demographic forms and the goal achievement ratings. The table describes continuous variables (i.e., age, years since diagnosis, and PDDS and FSS scores) using means and standard deviations (*SDs*) and categorical variables (e.g., gender, education, MS type) using numbers

and percentages. The mean age of the participants was 57.4 yr (*SD* = 8.0). The majority were women (*n* = 68; 84.0%); were diagnosed with relapsing-remitting MS (*n* = 43; 53.1%); and had a mean PDDS score of 3.8 (*SD* = 1.6), which means that on average the participants reported mild to moderate ambulatory disability that interfered with their activities.

Of the 81 participants with goals, 64 (79.0%) rated at least one goal achievement over the three follow-up periods. Participants who submitted their goals (*n* = 81; 44.8%) did not differ from the other participants who did not submit any goals (*n* = 100; 55.2%) regarding their baseline characteristics (e.g., age, sex, education), MS status (e.g., type of MS, years since diagnosis, PDDS score), and levels of fatigue severity. In addition, no notable differences were found in these characteristics between the participants who rated at least one goal achievement (*n* = 64; 79.0%) and those who did not rate any goal achievement (*n* = 17; 21.0%).

Goal Categories

Table 3 summarizes the number and percentage of occupation categories chosen, from most to least selected, by participants for their short-, intermediate-, and long-term goals. A total of 485 goals (162 short-, 162 intermediate-, and 161 long-term goals) were submitted by

Table 1. Occupation Categories, Framework Definitions, and Sample Goals

Occupation Category	Framework Definition	Sample Goal
ADLs	Activities that are oriented toward taking care of one's own body	Within 3 mo, I will schedule my day, balancing self-care, productivity, leisure, and rest.
IADLs–Home	Activities to support daily life within the home and community that often require more complex interactions than self-care used in ADLs	I will clean and organize my garage in preparation for my intended move.
IADLs–Health	Activities to support daily life within the home and community that often require more complex interactions than self-care used in ADLs	Within 3 wk, I will participate in a 1-hr water exercise class, 2 days weekly.
IADLs–Other	Activities to support daily life within the home and community that often require more complex interactions than self-care used in ADLs	I will apply for Social Security Disability.
Rest and Sleep	Activities related to obtaining restorative rest and sleep that support healthy active engagement in other areas of occupation	I will rest 2 times a day for 30 min each instead of 1 hr only.
Education	Activities needed for learning and participating in the environment	I will learn some Spanish.
Work	Activities needed for engaging in remunerative employment or volunteer activities	I will finish the monthly church newsletter by the end of the month and not be overwhelmed or stressed by procrastinating.
Leisure	Nonobligatory activities that are intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep	Within 6 mo, I will scrapbook our Disney Christmas vacation pictures.
Social Participation	Organized patterns of behavior that are characteristic and expected of a person or a given position within a social system	I will talk with my daughter about my fatigue and my expectations of her while she's home for the summer.
Uncodeable		From day to day, my body fatigue and back problems keep me from doing things.

Note. ADLs = activities of daily living; IADLs = instrumental activities of daily living. Framework refers to the *Occupational Therapy Practice Framework: Domain and Process* (3rd ed.; AOTA, 2014).

Table 2. Participant Characteristics (*N* = 81)

Characteristic	<i>M</i> (<i>SD</i>) or <i>n</i> (%)
Age, yr	57.4 (8.0)
Time since diagnosis, yr	15.0 (8.7)
PDDS score	3.8 (1.6)
FSS score	5.5 (1.0)
Gender	
Male	13 (16.0)
Female	68 (84.0)
Education level, yr	
≤15	39 (48.1)
>15	42 (51.9)
Living with other adults	
Yes	59 (72.8)
No	22 (27.2)
MS type	
Relapsing-remitting	43 (53.1)
Progressive	29 (35.8)
Unknown	9 (11.1)
Taking medication for fatigue	
Yes	27 (33.3)
No	54 (66.7)
Receiving any rehabilitation services	
Yes	10 (12.3)
No	71 (87.7)
Allocation	
Immediate intervention group	50 (61.7)
Delayed intervention group	31 (38.3)

Note. FSS = Fatigue Severity Scale; *M* = mean; MS = multiple sclerosis; PDDS = Patient-Determined Disease Steps; *SD* = standard deviation.

the 81 participants. All participants except 1 set 2 goals per time period.

The most common type of goals set by participants was IADLs–Home (*n* = 136; 28.0%). The second and third most common goals were IADLs–Health (*n* = 96; 19.8%) and IADLs–Other (*n* = 48; 9.9%). The least common goals were ADLs (*n* = 2; 0.4%) and Education

(*n* = 7; 1.4%). These least common goals were mostly set for the long term. In addition, a total of 80 goals (16.5%) were Uncodeable.

Goal Achievement

Table 4 summarizes the number of goals rated by participants regarding progress toward achievement, the number of goals rated as achieved by participants, and the mean scores for goal achievement for all rated goals. Out of 485 goals submitted by 81 participants, 284 (58.5%) were rated by 64 participants. Approximately 15% of the goals were found to be no longer applicable and therefore they were unrated at the time of the follow-ups, and 27% of the goals were unrated for unknown reasons.

Overall, 53.5% (*n* = 152) of rated goals were considered achieved (i.e., a score ≥8). The mean goal achievement score for all the rated goals combined was 7.0 (*SD* = 3.1). Leisure and IADLs–Other goals had the two highest mean goal achievement scores (7.9 and 7.4, respectively), whereas Education and Uncodeable goals had the two lowest scores (5.8 and 4.3, respectively). Short-term goals were more likely to be achieved (66.3%) than intermediate- (47.5%) or long-term (43.6%) goals.

Discussion

A person's values and choices in behavioral change interventions may play an important role in achieving an intended or desired change. However, most health and behavioral change interventions are commonly developed with goals selected by investigators or health care providers, which often fail to capture participants' or clients' values and choices regarding specific and desired changes (Stuifbergen et al., 2003).

Table 3. Short-, Intermediate- and Long-Term Goals From Most to Least Selected Occupation Category

Occupation Category	Goal			Total, <i>n</i> (%)
	Short Term, <i>n</i> (%)	Intermediate Term, <i>n</i> (%)	Long Term, <i>n</i> (%)	
IADLs–Home	43 (26.5)	52 (32.1)	41 (25.5)	136 (28.0)
IADLs–Health	32 (19.8)	30 (18.5)	34 (21.1)	96 (19.8)
IADLs–Other	22 (13.6)	14 (8.6)	12 (7.5)	48 (9.9)
Work	13 (8.0)	14 (8.6)	14 (8.7)	41 (8.5)
Leisure	10 (6.2)	12 (7.4)	13 (8.1)	35 (7.2)
Rest and Sleep	13 (8.0)	3 (1.9)	4 (2.5)	20 (4.1)
Social Participation	8 (4.9)	8 (4.9)	4 (2.5)	20 (4.1)
Education	1 (0.6)	2 (1.2)	4 (2.5)	7 (1.4)
ADLs	0 (0.0)	1 (0.6)	1 (0.6)	2 (0.4)
Uncodeable	20 (12.3)	26 (16.0)	34 (21.1)	80 (16.5)
Total ^a	162	162	161	485

Note. ADLs = activities of daily living; IADLs = instrumental activities of daily living.

^aPercentages may not total 100 due to rounding.

Table 4. Goal Evaluation and Achievement by Time Period

Time Period	Goals Submitted, <i>n</i>	Goals Rated, <i>n</i> (%)	Goals Achieved, ^a <i>n</i> (%)	Goal Achievement Score, <i>M</i> (<i>SD</i>)
Short term	162	107 (66.0)	71 (66.3)	7.7 (2.9)
Intermediate term	162	99 (61.1)	47 (47.5)	6.7 (3.1)
Long term	161	78 (48.4)	34 (43.6)	6.3 (3.3)
Total	485	284 (58.5)	152 (53.5)	7.0 (3.1)

Note. *M* = mean; *SD* = standard deviation.

^aGoal achievement score ≥ 8 .

All the participants in this study completed a teleconference-delivered fatigue management program aimed at reducing the impact and severity of fatigue and at improving health-related quality of life (HRQoL; Finlayson et al., 2011). The results of the RCT support the positive intervention effects on self-reported MS fatigue, HRQoL, and the use of fatigue management strategies taught in the program (Finlayson et al., 2011). The current study makes a unique contribution to the existing literature by documenting the nature of goals set by people with MS after completing the fatigue management program, potentially as a result of their improved fatigue management.

In an acute or clinical setting, rehabilitation therapy such as occupational therapy often focuses on optimizing a person's ability to perform ADLs (Baum & Law, 1997). Our study, however, identified that <1% of goals set by the participants were in the area of ADLs, placing ADLs as the least desired type of goal. In comparison, the most common type of goal set by the participants was in the area of IADLs (home, health, and other). Agreeing with Radomski (1995), our results indicate that accomplishing ADLs may not be a priority for adults managing MS fatigue on a daily basis. Our findings therefore suggest that rehabilitation therapy and existing fatigue management programs should place greater emphasis on strategies for people with MS to perform IADLs.

Alternatively, the popularity of IADL goals in this study may be related to the fact that two exemplar goals introduced to the participants just before writing their goals were both in the area of IADLs. This possibility suggests that the current intervention may require some refinements so that a wider variety of relevant example goals are introduced to participants, either in future studies or in clinical practice.

Successful goal achievement has been linked to a person's level of confidence and motivation to reach desired goals (Bandura, 1977; Strecher et al., 1995). There were 10 occupation categories (including Uncodeable) identified across the goals set by the participants in this study. The most common occupation addressed in the participants' goals, IADLs–Home, had the fifth highest mean goal achievement score. In contrast, the fifth most common occupation category for the goals set, Leisure,

had the highest mean achievement score. It is possible that Leisure goals provided greater motivation to the participants than IADL goals, which in turn led to a higher Leisure goal achievement score.

The importance of setting realistic yet meaningful goals is recognized to optimize successful outcomes (Locke & Latham, 1990, 2002). Participants in this study were not asked to rate characteristics of their goals (i.e., how realistic, meaningful, or measurable their goals were), which may be considered a limitation of the study. A lack of understanding of why participants chose not to submit their setting goals worksheet or not to rate their submitted goals may be considered an additional limitation of the study.

In this study, we were not able to code 80 goals (16.5% of 485 goals set) using the defined areas of occupation in the *Framework*; therefore, they were classified as Uncodeable. These goals had a mean goal achievement score of 4.3, which was lowest of all. A wellness intervention study of women with MS that used goal setting found that they were able to identify behaviors that they wished to change; however, they needed substantial assistance from the facilitators to write goals that were clear, measurable, and achievable (Stuifbergen et al., 2003). It is possible that these Uncodeable goals were neither clear nor measurable for the participants to assess their goal achievement. Alternatively, it may be possible that the occupations described in the *Framework* are insufficient in capturing all areas that are important to occupational therapy clients (Nelson, 2006).

In a group telephone intervention setting, such as our fatigue management program, it may prove challenging for a facilitator to assist each participant with his or her goal-setting process in depth. A dedicated goal-setting session or an individual follow-up call for monitoring and revising goals may prove useful and worthy of consideration for a future study. A lack of such approaches in the current program may be considered a limitation of the study.

MS is a chronic, progressive disease accompanied by a wide range of unpredictable symptoms. As a result, longer term goals may become inapplicable or difficult to achieve over time, especially for people who have experienced some change in their disease progression after

intervention. This possibility may explain why the intermediate- or long-term goals showed a lower rate of goal achievement (47.5% and 43.6%, respectively) than the short-term goals (66.3%) and why participants chose not to rate approximately 42% of the submitted goals at the time of the follow-ups. In a wellness intervention study, the participants with MS found biweekly follow-up calls up to 3 mo after intervention to be a critical part of successful behavior changes (Stuifbergen et al., 2003).

The results of our study may be an indication that longer term goals require a different or incremental strategy to optimize successful outcomes. Future research may consider introducing goal setting in the early phase of an intervention and addressing goals within each individual session so that participants apply the new content immediately and have more time to develop and practice goal-setting skills and receive sufficient feedback from facilitators and peers (e.g., if a session addresses the role of communication for managing fatigue, goals would be set related to communication). Participants may also benefit from follow-up and booster sessions that help them remember, monitor, or revise their long-term goals. Because these sessions were not a part of our current fatigue management program, their potential effects are unknown.

Conclusion

This study identified a wide range of goals that people with MS hope to accomplish after completing a teleconference-delivered fatigue management program. The most common area of occupation for the goals set by people with MS who completed the program was IADLs–Home. Approximately 50% of set goals were achieved (i.e., a goal achievement score of ≥ 8 out of 10). The short-term goals were more likely to be achieved than the intermediate- and long-term goals.

The findings of the study suggest the potential need for and the importance of promoting and teaching goal-setting skills among people with MS. Researchers testing similar interventions and health care professionals working with people with MS may consider goal-setting tutorials to help clients set clear, measurable, and realistic goals. In addition, offering follow-ups to monitor progress over time and to improve goal achievement should be considered as part of a future fatigue management program.

Implications for Occupational Therapy Practice

After this fatigue management intervention, people with MS planned to use their acquired knowledge and skills to address a wide range of occupational goals. The majority

of these goals were related to IADLs, followed by Work and Leisure. Intermediate- and long-term goals were achieved less often than short-term goals. Together, these findings have the following implications for occupational therapy practice:

- Occupational therapy practitioners need to focus on the application of fatigue management strategies to IADLs rather than ADLs.
- Occupational therapy practitioners need to develop mechanisms that would enable long-term follow-up and periodic support for clients after intervention. ▲

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