ADVERSE REACTIONS:

Decision clinical trials are currently under way to evaluate the potential for serious adverse reactions, including deaths, that may be observed in the absence of a vaccine. In addition, the vaccine may be required to be re-administered in the presence of a severe adverse reaction caused by the vaccine.

In clinical trials, the vaccine was administered to more than 20,000 people, including children and adults of all ages. In studies conducted in the United States, the vaccine was well-tolerated, with no serious adverse events reported.

In ongoing clinical trials, the vaccine has been studied in more than 20,000 people, including children and adults of all ages. In studies conducted in the United States, the vaccine was well-tolerated, with no serious adverse events reported.

Catalyst for change:
Motivational interviewing can help parents to help their kids.

Kenneth Tellerman, MD

For behavioral change to be successful, a collaborative relationship between clinician and patient is essential. Part 1 reviewed motivational interviewing for patients who are in the "No precontemplation or "Maybe" contemplation stages of change. Here, part 2 examines how clinicians can help patients in the "Yes" preparation stage to develop a viable plan to progress toward action.

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Catalyst for Change

Prepare the plan

The patient may choose the plan that provides the best balance of goals. Patients may choose plan A or B. The plan may include the following:

- Plan A: "Treat the patient's obesity with a structured behavioral intervention." (Indicate the plan chosen and confirm patient's understanding and consent.)
- Plan B: "Prescribe a low-calorie diet and encourage regular exercise." (Indicate the plan chosen and confirm patient's understanding and consent.)

Catalyst for Change

Keep it simple

Keep the plan simple, user-friendly, and flexible. Economists have coined the term "choice architecture" to refer to effective modes of change that are simple and comprehensible. Patients are more likely to implement a plan that is not overly taxing and complex. It is often better to implement a plan in small incremental steps and subsequently build on that foundation.

Set clear goals

Goals should be clear. Some of the interventions in brief solution-focused therapy emphasize the development of goals that are meaningful and tangible. The clinician may wish to use "nudge" questions such as, "If you were to change one thing about yourself, what would you change?"

Provide follow-up visits

- Encourage the patient to continue the plan. The patient may be contacted at the end of the month to discuss the plan's effectiveness.
- Schedule a follow-up visit to evaluate the plan's impact and make any necessary adjustments.

Motivational interviewing for the preparation and action stage of change.

Catalyst for Change

The clinician can stimulate brainstorming by asking questions such as, "What advice would you give to a friend who is trying to lose weight?" or "Have you done anything in the past to successfully lose weight?" or "What has someone you know done to lose weight?"

In addition, information framed positively may have more effect than information framed negatively. For example, a discussion of an approach that has an 80% success rate may be more effective than, emphasizing the 20% failure rate. Informing a patient that he or she will feel better after losing weight is more effective than highlighting the risk of developing hypertension if he or she continues to smoke.

Catalyst for Change

Tell a success story. People are very receptive to narratives, and by telling a story about a patient with a similar problem, the clinician can effectively impart information that is easy for patients to remember and remember.

Incorporate social connections

Recognize the importance of social connection and social influence when helping patients form an action plan. This plan may incorporate other family members or peers for support. A social support network may have a greater chance of success. For an overweight teenager, a plan that incorporates nutritional changes for the entire family—not just the patient—is likely to be more successful. A plan that involves a close friend or family for support or aims for the patient and his or her peers to lose weight or stop smoking together may also be effective strategies.

Statements that highlight what other patients are doing, or not doing, may have an influential effect, particularly for teenagers. A smoking advertising campaign in Montana helped to reduce smoking with the message: "Most of Montana Teens Are Tobacco Free!"

At the end of the 8-month campaign, 10% of teens living within the targeted area had started smoking compared with 17% of teens who lived outside the targeted area—a 37% difference in the proportion of teens in the campaign area who started smoking compared with those in the rest of the state. The clinician may wish to replicate this effect by stating, "Although some teenagers in my practice smoke, most do not.""
This kind of proactive planning for interim setbacks can help to keep patients from feeling guilty and reinforce that the stated goals are still worth pursuing even if there are episodic slipups. Clinicians should also reassure patients that plans are often difficult to implement at the beginning but become easier over time and with practice. It may also require repeated attempts and revisions before "getting it right."

Assess readiness for action
The preparation of a plan does not always translate into action. The anticipation of beginning a new behavior can be anxiety provoking. Patients may react by delaying action. The clinician can help patients articulate these feelings and assess their level of commitment by asking, "How ready are you to begin?" This question can also help to distinguish between patients who are in the stage of preparation versus action. An encouraging and nurturing attitude on the part of the clinician can help patients make the jump from preparation to action. A numeric rating scale can be used to gauge the patient's degree of readiness. The clinician might ask, "On a scale of 1 to 10, how ready are you to put your plan into action?" Further discussion can be generated by asking, "Why did you give yourself a 5 and not a 9?" This can be followed up with, "What do you think it will take to move from a 5 to a 9?"

Keeping a record of the patient's numeric ratings is useful for reviewing and analyzing how the patient's readiness for action is changing over subsequent visits.

Some patients, after wrestling with a decision, experience a flush of anxiety when setting on an action. This phenomenon is known as cognitive dissonance. For example, a parent who has decided to immunize her child or start her child on an attention deficit hyperactivity disorder medication may suddenly feel doubtful and worried about her decision. Reassurance at this time by the clinician can be particularly helpful.

Establish a time frame
Initially, the clinician should help lay the groundwork for the plan by asking the patient, "What is your time frame?" or "When or how soon will you begin?" or "When do you want to start?"

The momentum of the plan is often sustained by encouraging the patient to set short-term goals and to implement the plan in the near future while he or she is engaged rather than delaying. Waiting too long to begin may result in early enthusiasm being overridden by the inclination to "default to zero." A plan that is set to begin in the next 2 weeks is more likely to be implemented than a plan set to begin in 2 months.

Conclude the discussion
The clinician can conclude the encounter by having the patient summarize the plan and review strategies for any slipups. The patient can then be asked when he or she would like to return for follow-up.

At the conclusion of the visit, the clinician should also consider how this and follow-up counseling

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The Power of Language

Language is a powerful mediator of change. The clinician should always attend to the subtleties of language and its influence on behavior.Clinicians can use language to gently nudge patients toward healthy change.

Elicit change language. Listen carefully for and try to reinforce patient-change language such as, "I wish I could . . . " or "I really should . . . " or "I am going to . . . " or "I will . . . " If the patient says, "I really should lose weight," the clinician can provide positive reinforcement by responding, "That's great. It sounds like you are giving some serious thought to your weight." Challenge overgeneralizations. Some patients overgeneralize their lives and may arrive at self-defeating, erroneous conclusions such as, "I can't lose weight," "I will never lose weight," or "I always mess up." The clinician can challenge such thinking by asking, "What evidence do you have that you can't lose weight? Do you have any evidence to the contrary that you can do things to lose weight?" The clinician may also ask, "Can you think of a time when you really did change something about yourself?" These types of questions can help patients recognize and counter negative "automatic thoughts" such as overgeneralization, leading patients toward healthier behaviors.

Use commitment language. For patients in the action stage, the clinician can use commitment language such as, "What are you going to do?" Instead of "What do you think you might do next?" The clinician may also wish to use "when" versus "if" statements when talking with patients in the action stage. For example, the clinician can convey an expectation of success by saying, "When you lose 2 pounds . . . " instead of "If you lose 2 pounds . . . " Similarly, when seeing a patient in follow-up, the clinician can refer to recent behaviors in the past tense. For example, the clinician might say, "It is great to hear about the changes you have made in your diet compared with how you used to overeat," or "It sounds like you don't cough as much now compared with when you used to smoke.

Use priming language. Priming is a way to use language to instill a subtle message of change. Studies have found that asking questions about intention can lead to changes in behavior. People who are simply asked whether they intend to consume fatty foods in the next week were found to actually consume less fatty food in the following week. Another priming approach makes use of positive self-fulfilling prophecy. The clinician, for example, can express an expectation for successful change with a statement such as, "I know you are a caring parent and want to do the best for your child, so I am sure that you will make the right decisions about your child's diet.

Similarly, use of the word "yet" can set an expectation of success. The clinician might say, "It sounds like you plan to cut back on fast food, but you just have not been able to do it yet." When given a choice between two extreme alternatives, people will often opt for what they perceive as the less extreme option. Clinicians can also use this tendency to help promote change behavior. For example, the clinician might ask a parent, "Your baby is due for 4 vaccines today, and I know that you are nervous about giving multiple vaccines. Would you consider giving 2 vaccines today and 2 more in a few weeks?" To the overweight patient, the clinician might say, "Do you think you can stop going to fast food restaurants for 2 months? How about 2 weeks?"

A suggestion for change can also be planted through the use of anchoring. The clinician can give a specific example of what other people have done in a similar situation. For example, the clinician may say, "A lot of people find it reasonable to eliminate fries from their diet for a month; how long do you think you can do it?" or "Many people find that 3 hours per week is a reasonable amount of time to devote to exercise; how many hours per week will work for you?"

Encourage self-talk. Clinicians can encourage patients to learn to use self-talk. For example, a patient reaching for junk food from the pantry or refrigerator can be advised to slow down and engage in a self-dialogue such as, "I have spent so much time trying to drop this weight, do I really want to be eating this now? Interacting this type of self-talk can be helpful in mediating impulsive counterproductive behaviors.

Follow-up and maintenance: Staying on course

Follow-up visits provide the motivation that helps keep the patient in motion and allow the clinician to assess how the plan is proceeding. Some patients find it helpful to keep a log of their progress, such as a food, exercise, or cigarette diary. These logs can be reviewed during follow-up encounters. Numeric rating scales can be reassessed to evaluate how the patient is moving through change. Clinicians can use follow-up sessions to provide encouragement and positive feedback for those elements of the plan that are going smoothly. Conversely, follow-up visits are also a time to evaluate and help modify aspects of the plan that are not going as intended and to help expand the plan in small increments if indicated. In order to assess ongoing commitment, clinicians can ask the patient, “How prepared are you to continue?”

The maintenance stage of change can be quite challenging and requires perseverance. Clinicians can recognize patients in the maintenance stage by their ability to repeatedly practice and engage in their chosen alternative behaviors. Patients in the maintenance stage are also successful in reminding themselves of the work they’ve done so far and in developing contingency plans for handling potential lapses and setbacks. For patients in the maintenance stage, intermittent follow-up visits can be very reinforcing. However, some patients may wish to defer follow-up visits because they feel that they can progress independently. Other patients may defer follow-up visits because they are not fully committed to taking action. Clinicians should respect the patient’s wishes.

When to refer

Patients at the preparation or action stage may require assistance that is outside the clinician’s knowledge base or comfort level. For example, an extremely overweight patient may require the help of a nutritionist and/or a mental health consultant in order to achieve his goals. Adolescents who are involved in substance abuse, particularly if engaging in dangerous risk-taking behaviors such as drunk driving, may also require a referral to a counselor with expertise in these areas. These patients pose a challenge because they are frequently not ready to make any changes in their behavior. In such cases, parents may need to assume control even if the patient is not amenable to counseling. The primary care clinician, however, may be helpful in using certain approaches (see, “The Power of Language,” page 52-53), and some of the approaches reviewed in part II to guide the patient toward the action steps of receiving help rather than focusing directly on changing the specific drug or alcohol abuse behaviors.

Success

Patients who are ready to change can continue to benefit from a collaborative partnership with the clinician. Clinicians can motivate these patients to act on their readiness for change by helping them create an individualized plan of action that is realistic, simple, and user friendly. Evaluating patients’ commitment to proceed with the plan, and encouraging them to start by setting a time frame, and providing follow-up and ongoing encouragement are the keys to successful intervention that can lead to change.

References