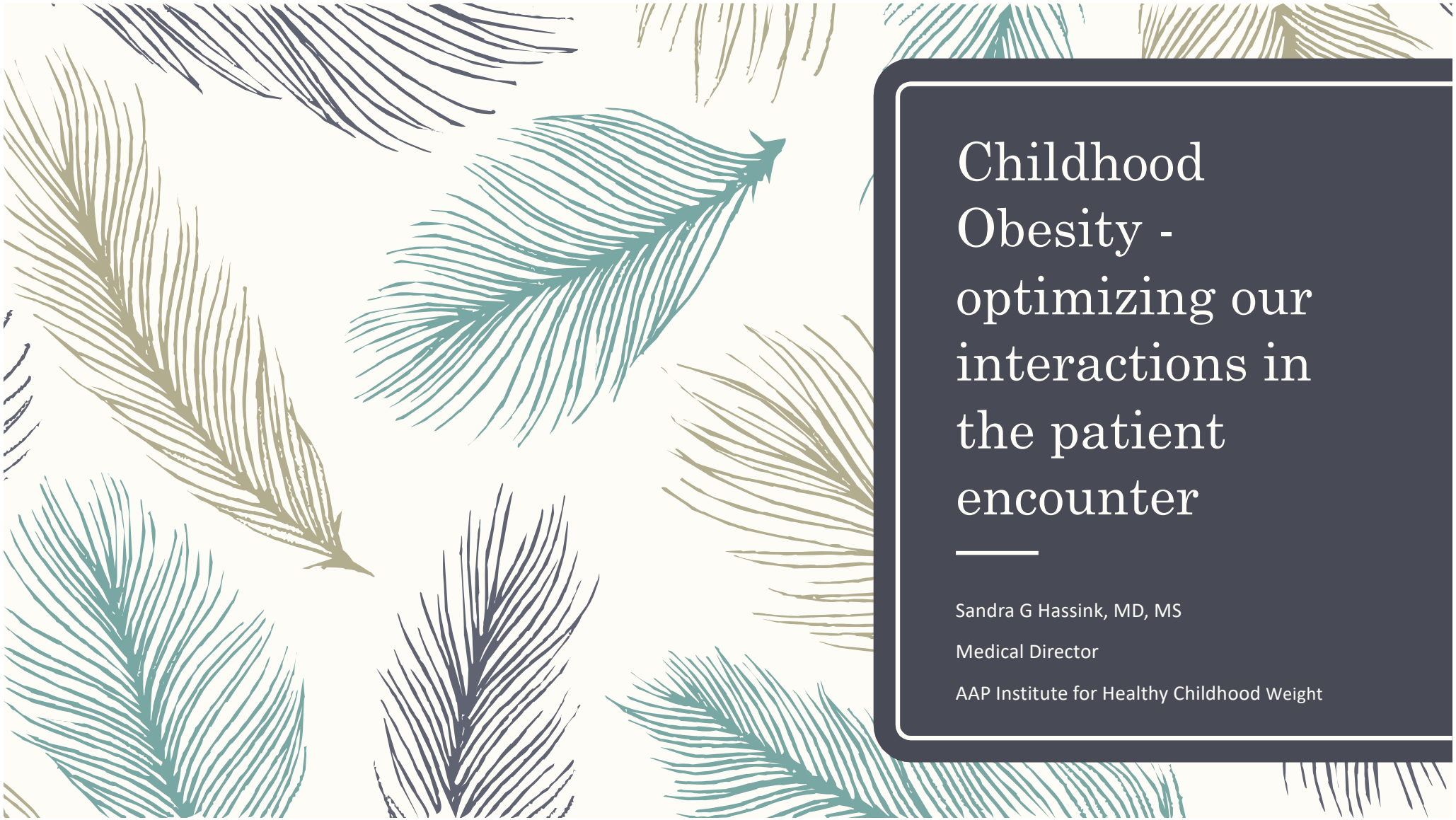


Childhood Obesity - optimizing our interactions in the patient encounter

Sandra G Hassink, MD, MS

Medical Director

AAP Institute for Healthy Childhood Weight

Faculty Disclosure

I do not have a significant financial relationship with the manufacturers of commercial products and/or providers of commercial services discussed in this CME activity.

I do not intend to discuss use of a commercial product/service.

I do not intend to discuss an unapproved/ off-label use of a commercial product/device in my presentation.

Learning Objectives

- Understanding the role of weight bias in the patient encounter
- Develop familiarity with Motivational Interviewing and its role in obesity prevention and treatment
- Explore the role of mindfulness within the patient encounter

The Patient Encounter

Every encounter is an opportunity.
If we always do what we've always done
we'll always get what we've always got.
Life is all about change.

https://allauthor.com/quotes/13635/

Importance of the Encounter

"In an age where relational and social determinants of health are at the root of so much childhood and adult morbidity the possibility of the encounter to reveal and hold these experiences in a safe space, to foster healing and hope is incalculable."

Hassink SG. Reclaiming the Patient Encounter. Acad Pediatr. 17;17(7S):S12-S13. doi:10.1016/j.acap.2016.08.008

The Patient Encounter

Actions

- Patient Concerns
- Patient's history
- Review of Symptoms
- Physical examination
- Guidelines
- Quality
- Documentation
- Diagnosis
- Prescription of Treatment

Roles

- Expert
- Treatment provider
- Link to the health system
- Diagnostician
- Partner
- Agent of change
- Healer

The Patient Encounter: The "place" where our most important "work" occurs.

- What are the characteristics of an optimal/excellent patient encounter?
- What influences the quality of a patient encounter?
- What are the outcomes of an excellent patient encounter?
- How can we make the patient encounter more meaningful?
- How can we move the patient toward healing and health?

The Patient Encounter: Descriptions

- Provides a safe place in which patients can regain a sense of integrity and wholeness is part of the health care mandate.
- More than a hospital corridor or an examining room; it encompasses the space in which expressions of doubts, dread, and hope can be heard.
  - *Kearney M. A Place of Healing: Working with Suffering in Living and Dying. Oxford, U.K: Oxford University Press; 2000.*
- Importance of inviting a meaningful exchange between two equal individuals, one who happens to be a doctor, and the other, a patient
  - *Mount BM. Existential suffering and the determinants of healing. Eur J Palliat Care. 2003;10(suppl):40–2.*

The Patient Encounter: What it Requires

- Link between effective physician–patient communication and patient health outcomes (emotional health, symptom resolution, functional status, and pain control).
- For optimal communication to occur, physicians must be “mindful” of themselves, the patient, and the context
  - *Stewart MA. Effective physician–patient communication and health outcomes: a review. CMAJ. 1995;152:1423–33.*
- Requires openness, courage, immediate presence, availability
  - *Ford JS. Caring encounters. Scand J Caring Sci 1990; 4: 157–62*
  - *Takman CAS, Severinsson E. A description of health care professionals’ experiences of encounters with patients in clinical settings. J Adv Nurs 1999; 30: 1368–74.*

Weight Bias:
Barrier to an Optimal Patient Encounter

- Affects the clinical environment
- Affects the child's feelings about themselves, health care providers and influences their approach to care
- Affects child's own health
- Affects families and their approach to their child
- Affects providers and their delivery of care

AAP Policy
Stigma Experienced by Children and Adolescents With Obesity

Stephen J. Pont, Rebecca Puhl, Stephen R. Cook, Wendelin Slusser, SECTION ON OBESITY, THE OBESITY SOCIETY Pediatrics Nov 2017, e20173034; DOI: 10.1542/peds.2017-3034

- For children and adolescents with overweight or obesity, weight stigma is primarily expressed as weight based victimization, teasing, and bullying.
- Research documents weight stigma by parents and other family members, teachers, health care professionals, and society at large, including the popular media.

- *Vitolins MZ, Crandall S, Miller D, Ip E, Marion G, Spangler JG. Obesity educational interventions in U.S. medical schools: a systematic review and identified gaps. Teach Learn Med 2012;24(3):267–272*
- *Puhl RM, Heuer CA. The stigma of obesity: a review and update. Obesity (Silver Spring). 2009;17(5):941–964 9.*
- *Puhl RM, Peterson JL, Luedicke J. Weight-based victimization: bullying experiences of weight loss treatment seeking youth. Pediatrics 2013;131(1) Available at:*

AAP Policy
Stigma Experienced by Children and Adolescents With Obesity

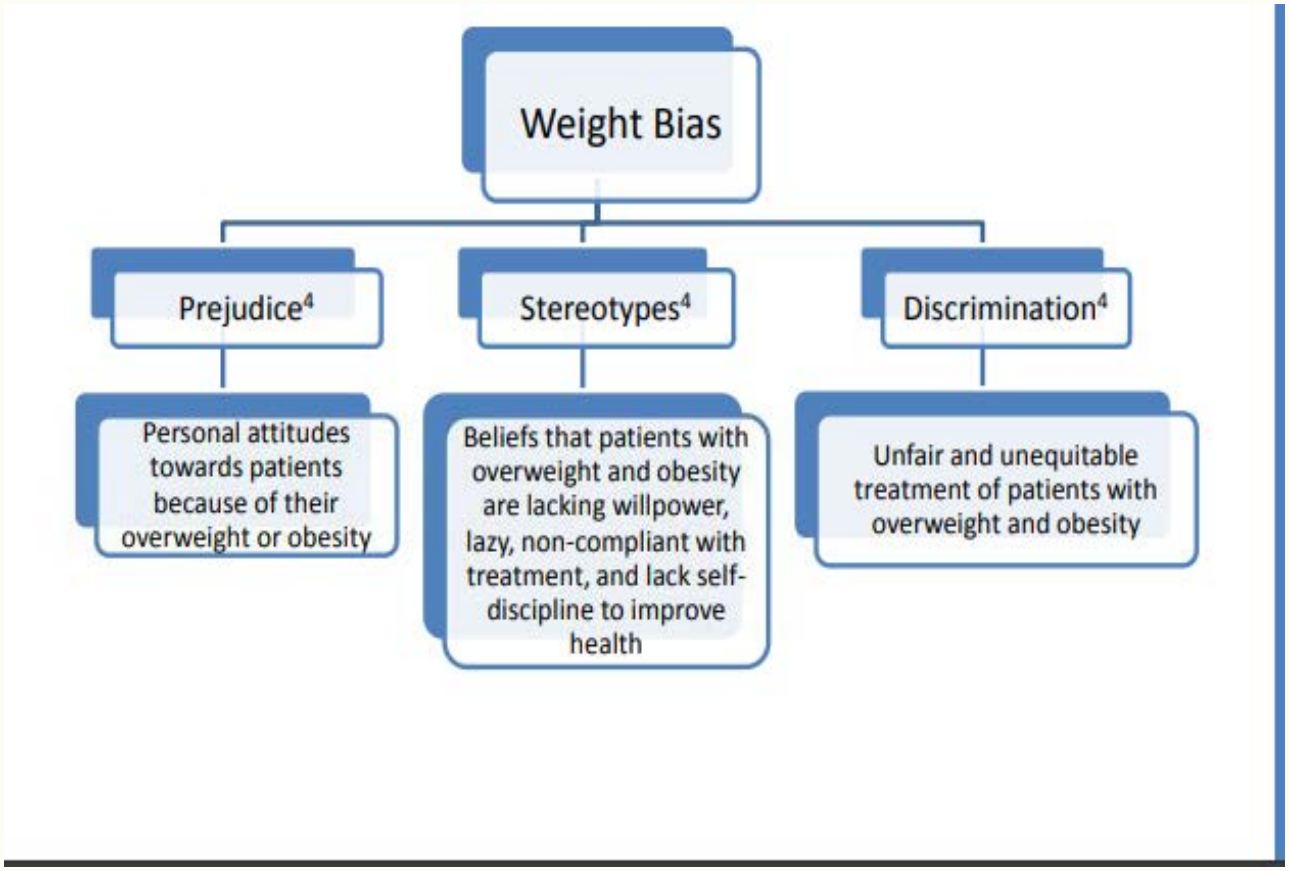
Stephen J. Pont, Rebecca Puhl, Stephen R. Cook, Wendelin Slusser, SECTION ON OBESITY, THE OBESITY SOCIETY Pediatrics Nov 2017, e20173034; DOI: 10.1542/peds.2017-3034

- Negative weight based stereotypes toward children with overweight emerge as young as 3 years old.
  - Andreyeva T, Puhl RM, Brownell KD. Changes in perceived weight discrimination among Americans, 1995-1996 through 2004-2006. Obesity (Silver Spring). 2008;16(5):1129–1134
- Adolescents report the primary reason their peers are teased or bullied at school is because of their weight.
  - Puhl RM, Luedicke J, Heuer C. Weight-based victimization toward overweight adolescents: observations and reactions of peers. J Sch Health. 2011;81(11):696–703
- 71% of adolescents seeking weight treatment reported being bullied about their weight in the past year, and more than 1/3 indicated that the bullying had persisted for >5 years.
  - Puhl RM, Peterson JL, Luedicke J. Weight-based victimization: bullying experiences of weight loss treatment seeking youth. Pediatrics. 2013;131(1)

AAP Policy
Stigma Experienced by Children and Adolescents With Obesity

Stephen J. Pont, Rebecca Puhl, Stephen R. Cook, Wendelin Slusser, SECTION ON OBESITY, THE OBESITY SOCIETY Pediatrics Nov 2017, e20173034; DOI: 10.1542/peds.2017-3034

- Increased vulnerability to depression, anxiety, substance use, low self-esteem, and poor body image among youth who are teased or bullied about their weight.
  - Bucchianeri MM, Eisenberg ME Wall MM, Piran N, Neumark-Sztainer D. Multiple types of harassment associations with emotional wellbeing and unhealthy behaviors in adolescents. J Adolesc Health. 2014;54(6):724–72959.
  - Eisenberg ME, Neumark-Sztainer D,Haines J, Wall M. Weight-teasing andemotional well-being in adolescents: longitudinal findings from Project EAT.J Adolesc Health. 2006;38(6):675–683
  - Hayden-Wade HA, Stein RI, GhaderiA, Saelens BE, Zabinski MF, WilfleyDE. Prevalence, characteristics, and correlates of teasing experiences among overweight children vs. non-overweight peers. Obes Res.2005;13(8):1381–139261.
  - Jensen CD, Steele RG. Bodydisstisfaction, weight criticism,and self-reported physical activity in preadolescent children. J Pediatr Psychol. 2009;34(8):822–82662.
  - Puhl RM, Latner JD. Stigma, obesity, and the health of the nation's children.Psychol Bull. 2007;133(4):557–58063
- Self-harm behaviors and suicidality are higher among youth who have been teased or bullied about their weight compared with same-weight peers who have not been teased.
  - Eaton DK, Lowry R, Brener ND, GaluskaDA, Crosby AE. Associations of bodymass index and perceived weight with suicide ideation and suicide attempts among US high school students. Arch Pediatr Adolesc Med.2005;159(6):513–51964.
  - Eisenberg ME, Neumark-Sztainer D,Story M. Associations of weight-based teasing and emotional well-being among adolescents. Arch PediatrAdolesc Med. 2003;157(8):733–738



Weight Bias

"negative weight-related attitudes, beliefs, assumptions and judgments toward individuals who are overweight and obese"

Washington RL. Childhood obesity: issues of weight bias. Prev Chronic Dis. 2011;8(5):A94. http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

Weight Bias in Clinical Care

Studies show that physicians hold negative attitudes and stereotypes about patients with obesity and view them as,[1,8,15,16,18,20,31-35]

Less compliant
Less motivated

→ *Most commonly reported by physicians to be their frustrations for treating patients with obesity*

Less disciplined
Less adherent to medications
Less trustworthy
More annoying

Additionally, as patients' BMI *increases*, physicians report,[17,36]

Less patience
Less desire to help the patient
Less respect for patients
Greater perception of patient as a waste of time

- Weight bias is common in health care settings/comparable to weight bias in the general population
  - Independent of the doctors own weight and gender
- Weight bias can effect the delivery and quality of care for patients with overweight and obesity

http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

Weight Bias in Clinical Care

- Weight bias has negative effects on patients
  - Discouraged from making positive lifestyle changes
  - Avoid seeking routine or preventive care
  - Engage in unhealthy eating and weight control behaviors, and avoiding physical activity in response to stigma
  - Experience negative psychological consequences

- Weight bias can be reduced and patient's quality of care optimized by
  - Increased self-awareness of personal attitudes about body weight
  - Implementing appropriate and sensitive communication strategies with patients with overweight and obesity

http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

How Weight Bias is Expressed in Clinical Care

- Negative weight based assumptions
  - such as obesity is an issue of self discipline
- Negative stereotypes about individuals with obesity
  - such as they are lazy or lacking willpower
- Judgements that patients with obesity are non compliant with treatment
- Insensitive language about excess body weight (i.e. referring to a patient as “fat”)
- Insensitive remarks or jokes that make the person with obesity the target of humor or ridicule

- http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

Weight Bias in Clinical Care

Patients with obesity report...[10,12-18]

- Feeling judged about their weight, thus becoming less trusting of their doctors
- Being blamed for their weight and related problems
- Feeling upset by comments about their weight
- Perceiving a lack of empathy from providers
- Receiving negative judgment by providers because of their weight
- Feeling as if they will not be taken seriously
- Being reluctant to discuss their weight concerns

3

http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

Weight Bias can be reduced

http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

AAP Policy Recommendations for Pediatricians

Stephen J. Pont, Rebecca Puhl, Stephen R. Cook, Wendelin Slusser, SECTION ON OBESITY, THE OBESITY SOCIETY
Pediatrics Nov 2017, e20173034; DOI: 10.1542/peds.2017-3034

- **Role Modeling**
  - Supportive and nonbiased
  - Recognize and acknowledge complex etiology of obesity
  - Dispel common assumptions and stereotypes that place blame and judgment solely on individuals
- **Language and Word Choice**
  - Use appropriate, sensitive, and nonstigmatizing
    - *"weight" and "body mass index" preferred by adolescents with overweight and obesity*
    - *"obese," "extremely obese," "fat," or "weight problem" induce feelings of sadness, embarrassment, and shame if parents use these words to describe their children's body*
  - Using people-first language such as "a child with obesity" rather than an "obese child."
- **Advocating Against Weight Stigma**
  - Pediatricians can be important advocates to reduce weight stigma in multiple settings.

AAP Policy
Recommendations for Pediatricians

Stephen J. Pont, Rebecca Puhl, Stephen R. Cook, Wendelin Slusser, SECTION ON OBESITY, THE OBESITY SOCIETY Pediatrics Nov 2017, e20173034; DOI: 10.1542/peds.2017-3034

- **Clinical Environment**
  - Create a safe, welcoming, and non stigmatizing clinic space that accommodates patients of diverse body sizes, from the clinic entrance to the examination room.
- **Behavioral Health Screening**
  - Assess patients not only for physical but also emotional comorbidities and negative exposures associated with obesity, including bullying, low self-esteem, poor school performance, depression, and anxiety

AAP Policy Recommendations for Pediatricians

Stephen J. Pont, Rebecca Puhl, Stephen R. Cook, Wendelin Slusser, SECTION ON OBESITY, THE OBESITY SOCIETY
Pediatrics Nov 2017, e20173034; DOI: 10.1542/peds.2017-3034

- **Clinical Documentation**
  - Obesity is a medical diagnosis
  - Using more neutral terms, such as “unhealthy weight and “very unhealthy weight.”
- **Behavior Change Counseling**
  - Use patient-centered, empathetic behavior change approaches, such as motivational interviewing.
  - Collaboratively engage the patient and/or parents in determining their goals and addressing barriers to how they will achieve sustained health behavior change.

Modeling in the office

- **Waiting room**
  - Books, posters, videos promoting healthy lifestyle
- **Staff role models**
  - Drinking water, healthy snacks, physical activity
- **Equipment**
  - Appropriate gowns, seating and equipment
- **Procedures**
  - Sensitive procedures for checking and documenting weight
- **Communication**
  - Consistent messages, involvement with community

Stigma Experienced by Children and Adolescents with Obesity

Society believes weight stigma and shame can **motivate people to lose weight.**

But, weight stigma is **harmful** to both **emotional** and **physical health.**

Health Consequences of Weight Stigma

- Decreased Exercise and Physical Activity
- Social Isolation and Academic Outcomes
- Emotional and Psychological Effects
- Unhealthy Eating Behaviors
- Worsening Obesity

Although pediatricians focus their efforts on improving weight-related health of youth, there should also be a **focus on weight stigma.**

The American Academy of Pediatrics Section on Obesity and The Obesity Society offers the following **recommendations** for pediatricians **to address weight stigma** in different settings.

Improving Clinical Practice

- Be a role model - share best practices for nonbiased behaviors.
- Could we talk about your weight today? — **Pay attention to language.**
- Use an empathetic approach for clinical documentation.
- Use patient-centered empowering counseling techniques.
- Create a supportive clinical environment.
- Perform behavioral health screening.

Advocate Against Weight Stigma

Schools
Promote antibullying policies to protect vulnerable students.

Youth-Targeted Media
Portray individuals with obesity responsibly and respectfully.

Provider Training
Address weight stigma in ongoing training and education for medical students, residents, and practicing physicians.

Parents
Empower families and patients to manage and address weight-related health issues in schools, communities, and homes.

Find the new AAP digital and print Pediatric Collections at collections.aap.org

Source: Pont SJ, Puhl R, Cook SR, Slusser W, SECTION ON OBESITY, THE OBESITY SOCIETY. **Stigma Experienced by Children and Adolescents With Obesity.** *Pediatrics.* 2017;140(6):e20173034. doi: 10.1542/peds.2017-3034

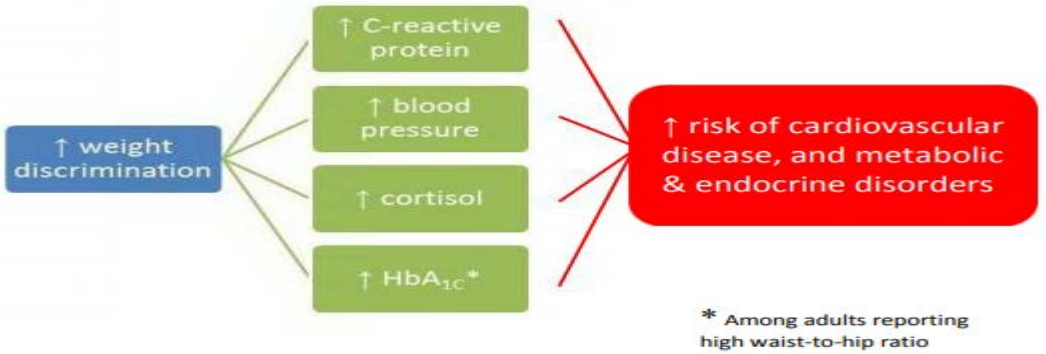
Link: pediatrics.org/content/140/6/e20173034

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

PEDIATRICS

Physiologic Effects of Weight Stigma

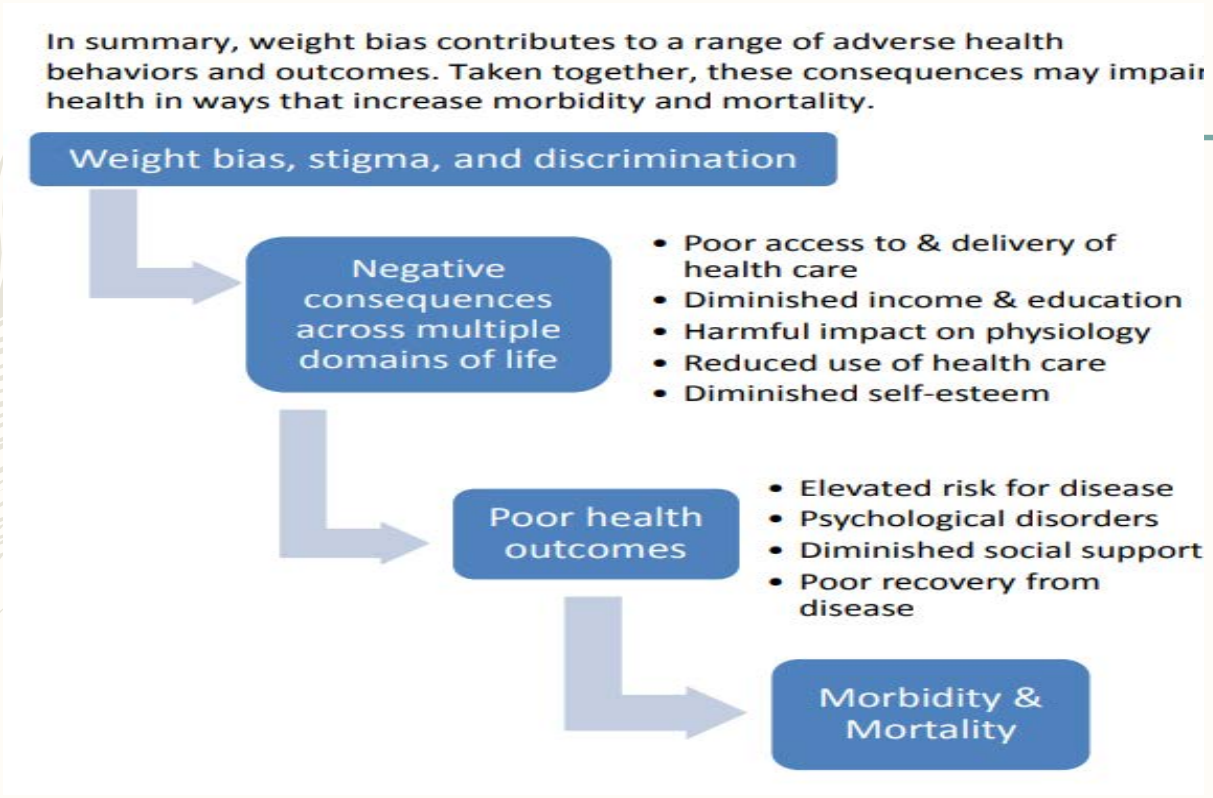
Research has recently begun to substantiate the physiological effect of experiences of weight stigma.



Experiments have documented the effect of weight stigmatization on blood pressure[90,91] and cortisol reactivity.[92,93] In a 2014 experiment, 123 women viewed either a weight stigmatizing or neutral video.[92] Findings showed that compared to the neutral video, the stigmatizing content elicited greater cortisol reactivity for women across the weight spectrum. Similar findings evidence the detrimental impact of stigma on C-reactive protein[94] and glycemic control (indexed by HbA_{1C}).[95]

http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

Effects of Weight Bias



http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

Implicit Weight Bias in Clinical Care

Please ask yourself the following questions:

1. *What are my views about the causes of obesity?*
2. *Do I believe common stereotypes about obesity (e.g., eating too much or lack of motivation) to be true or false?*
3. *Do I make assumptions about an individual's character, intelligence, abilities, health status, or lifestyle behaviors based only on his or her weight?*
4. *How do my views and assumptions about obesity affect my attitude towards individuals of higher weight status?*
5. *How do I feel when I work with patients of different body sizes?*
6. *Could my attitude about obesity impact my ability to help my patients?*
7. *Do I consider all of a patient's presenting problems, in addition to weight?*
8. *What kind of feedback do I give to patients with obesity?*
   - *Do I encourage healthy behavioral changes?*
   - *Am I sensitive to the needs and concerns of my patients?*
9. *What barriers do I face in addressing weight with my patients with obesity?*

http://uconnruddcenter.org/files/Pdfs/CME%20Complete%20with%20links.pdf

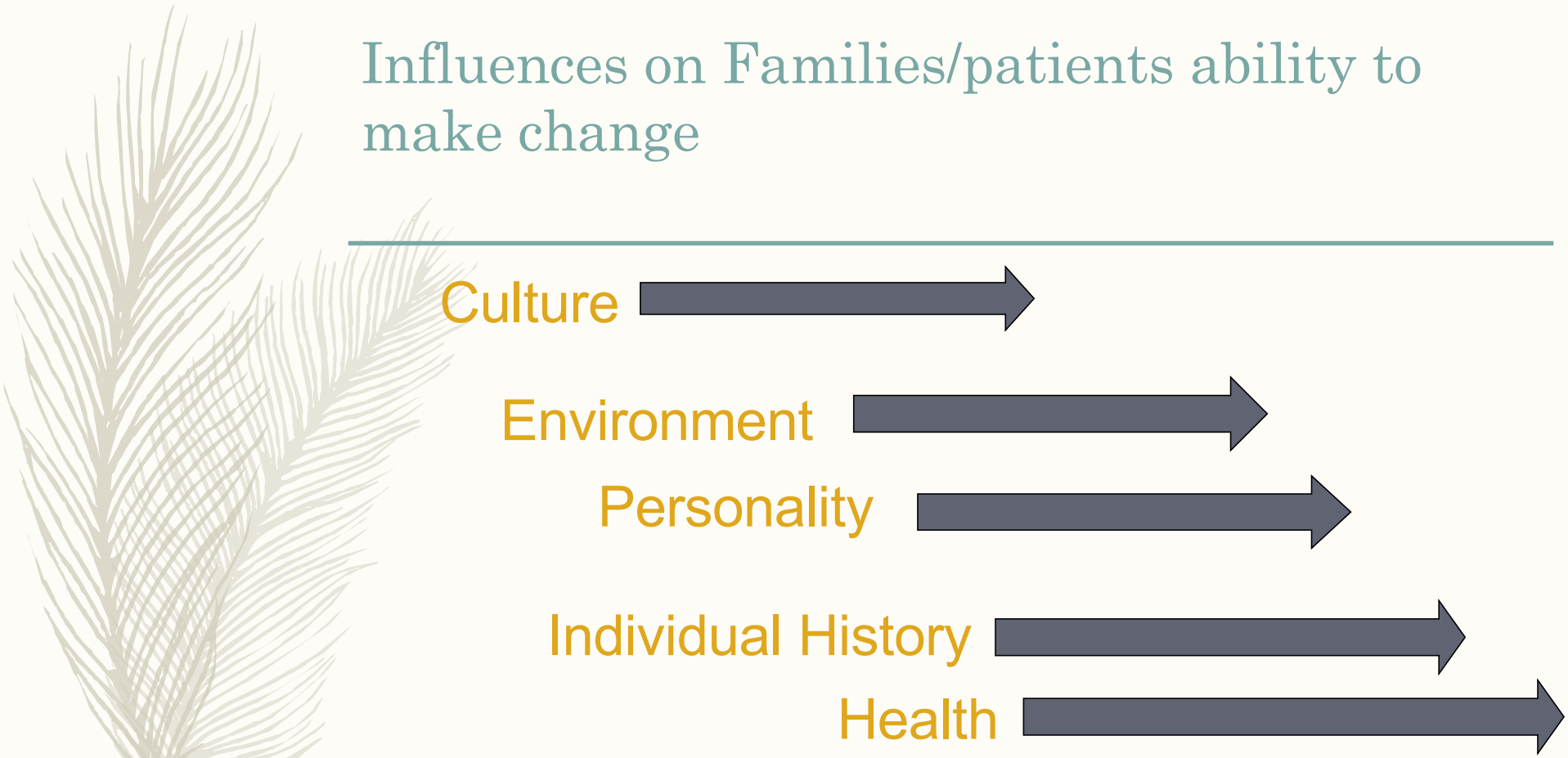
Motivational Interviewing- Working with Families in the Patient Encounter

Sandra G. Hassink, MD, FAAP

Medical Director, AAP Institute for Healthy Childhood Weight

Past President AAP

Influences on Families/patients ability to make change



Families

- Families have a critical role in influencing a child's health
  - *Cohen RY et al Health Educ Q 1989;16;245-253*
- Effective interaction with families is the cornerstone of lifestyle change

Parent–Child dynamic
Evolution of clinical intervention

- Traditional psychotherapeutic techniques
  - Physician driven
- Direct coaching of parents
  - Physician driven with parent participation
- Social learning theory
  - Changing a parents behavior leads to a change in child's behavior
    - *Johnson G et al Child Care Health Dev 2005;31;25-32*
  - Adult education model, parents as active participants
    - *Positive results in child weight control*
      - *Epstein LH Health Psychol 1994;13;373-383*

Health Care Professionals are taught to….

- Give advice regarding medical implications of behavior
- Suggestions about what families can do to help their overweight child lose weight
- Share information

What should health care professional do when the family is ambivalent about changing behavior?

Problems With Standard Practice when applied to Behavioral Change

- Unwelcome advice elicits resistance
- Knowledge weakly correlated with behavior
- There is variability in personal motivation
- Provider advice must match motivation

Ambivalence

- Ambivalence is considered a normal phase in the behavior change process rather than an obstacle to change
- Patients encouraged to express ambivalence while clinician serves as guide to potential benefits of change
- Non judgmental, empathic, encouraging

Motivational Interviewing

Motivational Interviewing

- Patient centered directive method for enhancing motivation to change by exploring and resolving ambivalence
  - *Miller WR, Rollnick S. Motivational Interviewing: Preparing People for Change. 2nd Ed. New York: Guilford Press; 2002.*

Motivational Interviewing

- Traditional counseling
  - Therapist insight
- Traditional nutritional and activity counseling
  - Information exchange
- Motivational interviewing
  - Interactive, patients do most of the work of change
  - Assumes behavioral change is driven more by motivation than information
  - Information necessary but not sufficient

What It's Not

- Not arguing that a person has a problem and needs to change
- Not offering advice without patient's permission
- Not taking an expert "stance"
- Not doing most of talking

Principles of MI

- **Express empathy**
  - Establish rapport with the family
  - “I understand that you must feel hurt when the children complain about having a healthy meal”
- **Develop discrepancy**
  - A discrepancy between present behavior and important goals will motivate change
  - “Sam enjoys extra snacks before bedtime, but his sleep apnea is getting worse because of his extra weight.”

Principles of MI

- **Avoid argumentation**
  - Arguments are counterproductive
  - Defending breeds defensiveness
- **Resistance is a signal to change strategies**

  "Having your child inside and playing video games works well for your family. Do you see any negative outcomes of this behavior?"
- **Support self-efficacy**
  - "It's great that you and your family made a plan that worked to limit screen time!"
  - Reinforce the completed goals every time!

Motivational Interviewing

- **Four essential skills**
  - Asking
  - Informing
  - Advising
  - Listening
- **Three styles of communication**
  - Following – information gathering
  - Guiding- clarification of values, confidence, importance
  - Directing – post decisional planning
    - *Rollnick S et al BMJ 2005;331;961-963*

The MI Process and Tools of the Trade

- Establish rapport
- Set the agenda
- Getting permission
- Open ended questions
- Reflective listening
- Summarizing – pros and cons
- Elicit self motivational statements
- Menus vs. single solutions
- You provide information, patient interprets it.

Establishing Rapport. How to?

- Body Language
- Non stigmatizing language around weight
- Listening
- Empathy
- Not hurrying
- Genuine interest

Setting the agenda: Your work

- Gathering background information
  - History
  - Social Determinants of Health
  - ROS/Family History
  - Physical Examination

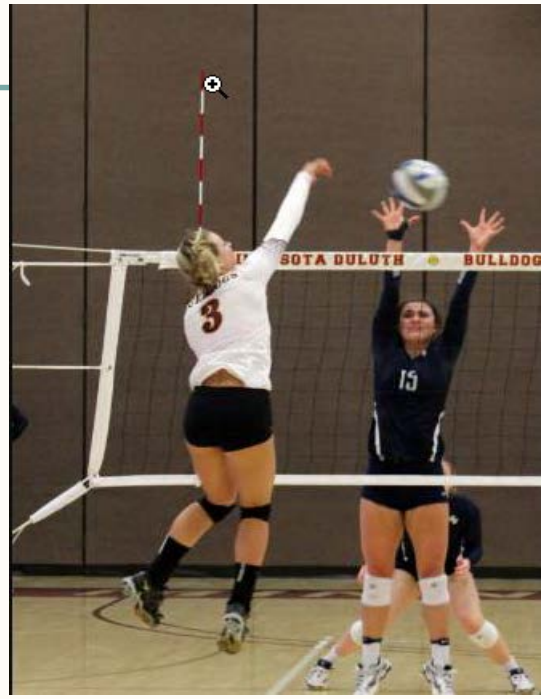
- Risk based priorities

Getting Permission to Go On: Joint work

- **Establishing a partnership of care**
  - "Can we talk about some ways to help Kim with her concerns about her weight?"
- **Joining forces**
  - "Would you like to hear about some ways other families have tried to limit screen time?"
- **Moving on**
  - "Can we talk about John's reluctance to exercise on his next visit?"

Open-Ended Questions (putting the ball in motion)

- Can’t be answered yes/no
- Use patient’s own words
- Not biased or judgmental



Establishing a partnership: Open Ended Starters

- **Open**
  - To what extent…
  - How often…
  - Why…
  - Tell me… about
  - Help me …understand.
  - What, if….
  - What else…

Closed

Did you…

Will you…

Can you.

Is it…

Open Ended Questions

- Are you comfortable not asking your child to finish what's on her plate?
- Will not buying sodas increase the amount of stress in your house?
- Do you think you will be able to reduce the amount of TV your son watches?
- Will your husband go along with these changes?
- Can you start to make these changes in the next week?

Reflective Listening (keep the ball rolling)

- Restate and rephrase
- Statement of understanding (clarifies meaning)
- Builds rapport and keeps patient talking

Sample Reflections

- It sounds like you are feeling……..
- It sounds like you are not happy with….
- It sounds like you are having trouble with…..

As you improve, you can truncate the reflection…

- You're not ready to….
- You're having a problem with….
- You're feeling that….
- It's been difficult for you….

"I Want My Son to Lose Weight Because I Don't Want Him to Have My Health Problems"

- Content reflection
  - "You see a connection between weight gain and health problems"
- Feeling reflection
  - You are afraid that your son might have health problems as a result of his weight
- Meaning reflection
  - Your son is very important to you and you want him to be healthy

I know TV is bad for Jimmy, but I need some peace and quiet in the house. I am a single mom. I don't have a lot of help. Having him watch TV let's me get my housework and schoolwork done. He is happy, content, and frankly, I don't have to worry about entertaining him.

REFLECTION

Which “reflection” would you choose in responding to Jimmy’s mother?

A. Letting him watch TV gives you time to get your work done.

B. It can be exhausting having to entertain him all the time.

C. You would like for him to watch less TV.

D. You don’t have to worry about him when he is watching TV.

E. On one hand you need some free time to get things done. On the other hand you are concerned about the amount of time he spends watching TV.

Reflecting back- Content

- **Content**
  - What is the parent telling you?
  - What are their specific concerns?
  - How might you want to guide the conversation?
  - Is there anything that suggests they needs more information?

Reflecting Back-Feeling

- **Feeling**
  - How does the parent feel?
  - How do you feel?
  - What feelings are driving behavior?
  - What feelings could enable change?
  - What feelings could impede change?

Reflecting Back-Meaning

- **Meaning**
  - What is the meaning of the behavior?
  - What does the parent value?
  - Does this say something about the family dynamics?

Core Values

Values For Your Child	Values for You	Values for Your Family
Be Healthy	Good Parent	Peaceful Meals
Be Strong	Responsible	Healthy
Have many friends	Disciplined	Getting along
Being fit	Good Spouse	Spending time together
Not feeling abnormal	Respected at Home	
Not being teased	On top of things	
Not feeling left out		
Fulfill her/his potential		
Have high self-esteem		
		Courtesy Bob Schwartz MD

Providing Information

- **Ask for permission**
- Provide nothing but the facts.
- Let patient interpret it.
- **Elicit-Provide-Elicit**

"Would it be okay if I shared information with you?"

Provide the information.

"What does this mean to you?"

PROS and CONS

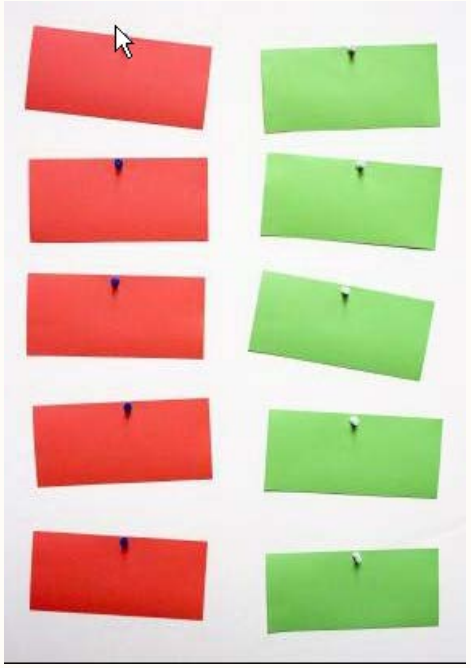
Could you tell me some things you like about _____?

What things are not so good about _____?

Could you tell me some of the reasons you might want to change_____?
What are reasons you might not want to change _____?

What benefits might there be if you change _____?

How would changing _____ affect your family?



Ingredients of Readiness to Change

- **Importance (**Why should I change?)
  (Interest)

- **Confidence** (How will I do it?)
  (self-efficacy)

- Rollnick S, Mason P, Butler C. Health Behavior Change: A Guide for Practitioners New York: Churchill Livingstone; 2001.

Importance and Confidence

- **IMPORTANCE**

  On a scale of 0 to 10, with 10 being the highest, how important is it for you to change (INSERT BEHAVIOR)?

  0 1 2 3 4 5 6 7 8 9 10

  Not at all Somewhat Very

- **CONFIDENCE**

  On a scale of 0 to 10 assuming you wanted to change (INSERT BEHAVIOR), how confident are you that you can do it?

  0 1 2 3 4 5 6 7 8 9 10

  Not at all Somewhat Very

- PROBE 1: Why did you not choose a lower number?
- PROBE 2: What would it take to get you to a higher number?

Importance and Confidence

- "It sounds like you are concerned about Alice's health and her grandmother's comments"
- "Yes, I am worried about Alice's self esteem" "I was heavy as a child and I don't want Alice going through that"
- "Where does this leave you?"
- "I think if Alice could get more active, that would help her weight".
- "How important do you think it is for you to have Alice increase her exercise?" "On a scale of 1-10, with 10 being the most important, where do you think you are?"
- "I think about an 8"
  - "What is it that makes you an 8 and not a 10?"
  - "What is it that makes you an 8 and not a 4?"
- "How confident are you that Alice will be able to increase her exercise?" "On a scale of 1-10, with 10 meaning you are the most confident , where do you think you are?"
- "I think about a 4"
  - "What is it that makes you a 4 and not a 7?"
  - "What is it that makes you a 4 and not a 2?"

Summarizing and Closing the Deal

" If it's ok, I would like to go over what we have discussed today."
- Summarize pros and cons of change.
- **Closure** – "What do you think might be a first step?"

If ambivalent: "Would it be okay if I shared some strategies that have worked for other families?"

If not ready to change: "It seems that you are not ready to make a change at this time. Perhaps, if it is ok with you, we can discuss this again at your next visit."

MI: How do you know when it's working

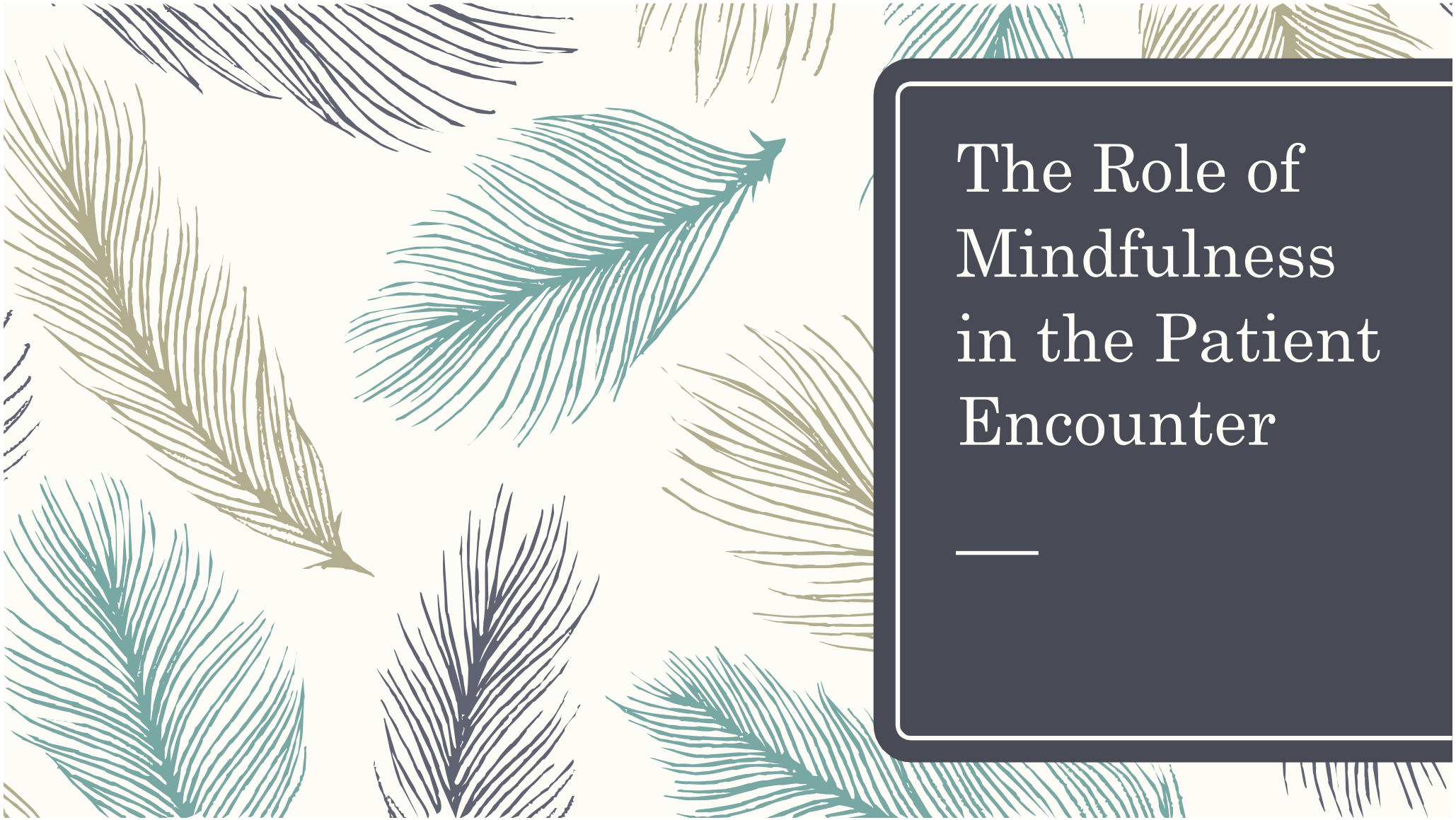
- Patient is doing most of talking
- Patient is talking about behavior change
- You are listening carefully and gently directing interview
- Patient is asking for information and advice

Basic Concepts of MI

- The patient, rather than the clinician, should make the arguments for change
- Providers can evoke the *patient's* own concerns and motivations
- Listen with empathy
- Minimize resistance
- Nurture hope and optimism

Credits and References

- Ken Resnicow, Ph.D.Professor. Health Behavior & Health Education. University of Michigan School of Public Health Ann Arbor, MI.
- Robert P. Schwartz, MD Department of Pediatrics. Wake Forest University School of Medicine. Winston-Salem, NC.
- Kerri Boutelle, PhD Associate Professor Pediatrics and Psychiatry UCSD HOPE curriculum
- Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to the addictive behaviors. American Psychologist, 47, 1102-1114. PMID: 1329589.
- Boston University School of Public Health;Wayne W. LaMorte, MD, PhD, MPH http://sphweb.bumc.bu.edu/otlt/MPH-Modules/SB/BehavioralChangeTheories/BehavioralChangeTheories6.html
- Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to the addictive behaviors. American Psychologist, 47, 1102-1114. PMID: 1329589.
- Johnson G et al Child Care Health Dev 2005;31;25-32
- Epstein LH Health Psychol 1994;13;373-383
- Cohen RY et al Health Educ Q 1989;16;245-253
- Miller WR, Rollnick S. Motivational Interviewing: Preparing People for Change. 2nd Ed. New York: Guilford Press; 2002
- Rollnick S et al BMJ 2005;331;961-963
- Rollnick S, Mason P, Butler C. Health Behavior Change: A Guide for Practitioners New York: Churchill Livingstone; 2001.


The Role of Mindfulness in the Patient Encounter

How can we make the patient encounter more meaningful?

- Stewart showed the link between effective physician–patient communication and patient health outcomes (that is, emotional health, symptom resolution, functional status, and pain control).
- He maintained that, for optimal communication to occur, physicians must be "mindful" of themselves, the patient, and the context
  - *Stewart MA. Effective physician–patient communication and health outcomes: a review. CMAJ. 1995;152:1423–33.*

Mindfulness Practice in the Clinical Encounter

- "Mindful practitioners attend in a nonjudgmental way to their own physical and mental processes during ordinary, everyday tasks."
- By taking this stance, the physician can be open to the whole person who presents as a patient and can skillfully treat that patient.
- "The goal of mindfulness is informed compassionate action incorporating relevant information, making correct decisions, and empathizing with the patient as a means of relieving suffering."
  - *Epstein RM. Mindful practice. JAMA. 1999;282:833–9*

Research

- Evidence suggests that mindfulness meditation practice is associated with neuroplastic changes in the anterior cingulate cortex, insula, temporo-parietal junction, fronto-limbic network,
  and default mode network structures.

  Mindfulness optimizes the information processing capacities of body and mind

  (Hotzel, et al, 2011)

Research

- Since 1978, over 30 empirical studies have been published on the use of mindfulness-based interventions with health care professionals
- Outcomes have shown improvements in:
  - Burnout symptoms & job engagement
  - Distress tolerance
  - Active listening and empathy
  - Nonjudgmental self-reflection and self-compassion

(Reference: Marks, Don PhD, "Mindfulness and the Therapeutic Encounter.)

Mechanisms of Mindfulness Meditation

Table 2. Components Proposed to Describe the Mechanisms Through Which Mindfulness Works

Mechanism	Exemplary instructions	Self-reported and experimental behavioral findings	Associated brain areas
1. Attention regulation	Sustaining attention on the chosen object; whenever distracted, returning attention to the object	Enhanced performance: executive attention (Attention Network Test and Stroop interference), orienting, alerting, diminished attentional blink effect	Anterior cingulate cortex
2. Body awareness	Focus is usually an object of internal experience: sensory experiences of breathing, emotions, or other body sensations	Increased scores on the Observe subscale of the Five Facet Mindfulness Questionnaire; narrative self-reports of enhanced body awareness	Insula, temporo-parietal junction
3.1 Emotion regulation: reappraisal	Approaching ongoing emotional reactions in a different way (nonjudgmentally, with acceptance)	Increases in positive reappraisal (Cognitive Emotion Regulation Questionnaire)	(Dorsal) prefrontal cortex (PFC)
3.2 Emotion regulation: exposure, extinction, and reconsolidation	Exposing oneself to whatever is present in the field of awareness; letting oneself be affected by it; refraining from internal reactivity	Increases in nonreactivity to inner experiences (Five Facet Mindfulness Questionnaire)	Ventro-medial PFC, hippocampus, amygdala
4. Change in perspective on the self	Detachment from identification with a static sense of self	Self-reported changes in self-concept (Tennessee Self-Concept Scale, Temperament and Character Inventory)	Medial PFC, posterior cingulate cortex, insula, temporo-parietal junction

Hotzel, et al. 2011

Mindlessness

- Mindlessness is more likely when people are distracted, hurried, or overloaded. To deal with production pressures people ignore discrepant clues and cut corners

- Mindlessness also occurs when people feel they can not act upon their concerns (how easy is it to question a practice in the unit?)

The Catch-22 Mindfulness Helps Resolve

- We must (and do) filter information:
  - Every observation is preceded by a choice of what to observe (and what not). We find what we are looking for and miss out on much more.
- And open to all that is present:
  - However, it takes a broad array of data and views and interpretations to make meaningful sense of things.

- https://www.psychologytoday.com/blog/the-athletes-way/201703/real-world-neuroscience-research-promotes-human-interactions

Mindfulness Practice

- Mindfulness is characterized by learned mental habits: attentive observation of self, patient, and context; critical curiosity; beginner's mind (that is, viewing the situation free of preconceptions); and presence.

- Epstein RM. Mindful practice in action. I: Technical competence, evidence-based medicine, and relationship-centered care. Fam Syst Health. 2003;21:1–9.

Mindfulness

- A process that enhances focus and clarity despite pressures of a busy day
- Helps physicians & staff to listen more carefully to patients, show more compassion, and approach problems more innovatively with an open mind
- Especially suited for primary care clinicians and staff, because it can counteract negative aspects of worrying, perfectionism and self-judgment common to physicians, neutralizes power of regrets from past and fear of the future
- Research shows enhanced well-being, sleep, concentration & memory/learning from practicing mindfulness.

(Reference: WellMD Stanford Medicine Websitehttp://wellmd.stanford.edu/healthy/mindfulness)

“We don’t see things as they are, we see things as we are.”

Anais Nin

– *Nin A. The Diary of Anais Nin, 1939-1944. New York, NY: Harcourt Brace & World; 1969.42*

Reported Benefits of Mindfulness Training

- I am able to be fully attentive to a conversation.
  - Pre-course: 26%, Post-course: 77%
- I am able to make time on most days to prioritize my work.
  - Pre-course: 17%, Post- course: 54%
- I am able to notice when my attention has been pulled away and redirect it to the present.
  - Pre-course: 23%, Post-course: 67%
- I am able to say no and set boundaries with ease and grace…less harsh, less guilt
  - Pre-course: 23%, Post-course: 80%

– *http://www.instituteformindfulleadership.org/Mindful_Marturano_spreads.pdf*

Reported Benefits of Mindfulness Training

- Percent reporting positive change:
  - 93% Taking time to reflect…space for discovery/innovation
  - 89% Enhanced listening…to self and others
  - 88% Exhibiting patience…with self and others
  - 80% Making better decisions…clarity

http://www.instituteformindfulleadership.org/Mindful_Marturano_spreads.pdf

Responses to Mindfulness Practice

- "Taking time 'out' allows me to be 'on' more often."
- "Experiencing that by slowing down I can accomplish more."
- "I'm already 'punching holes in the day'; I'm looking at my calendar and only attending those meetings that I need to attend. I focus on one task at a time, don't multi-task and am amazed by how much more I get done."

Courtesy Christina Bethell, PhD, MBA, MPH Professor of Pediatrics Johns Hopkins School of Medicine Director, The Child and Adolescent Health Measurement Initiative

- "Rediscovering the beauty of taste, sight, sounds, touch and how much I miss by not slowing down... I felt like a little kid."
- "Before this course I was so sure that I was great at multi-tasking, but now I realize that I was not giving the tasks at hand their true attention."
- "I'm definitely integrating mindfulness, when I am meeting with someone at work, I really focus on being attentive to the conversation and I really feel like I have connected more with people than I ever have."

A minute or two of Mindfulness meditation

- 1. Sit comfortably, with your eyes closed and your spine reasonably straight.
- 2. Direct you attention to your breathing
- 3. When thoughts, emotions, physical feelings or external sounds occur, simply accept them, giving them the space to come and go without judging or getting involved with them
- 4. When you notice that your attention has drifted off and become engaged in thoughts or feelings, simply bring it back to your breathing and continue
- Remember; it's ok and natural for thoughts to arise, and for your attention to follow them. No matter how many times this happens, just keep bringing your attention back to your breathing.

How much time is necessary for mindfulness:

- 10 minutes a day, everyday
- 10 minutes of doing nothing
- Sitting comfortable
- Being aware of your breathing
- Watching your thoughts come in
- And letting them go
- …. Just for 10 minutes

DJ Abatemarco 2011

A Few Tips for Mindful Living

- Take a few minutes in the morning to be quiet and still
  - Sit down, lie down and be with yourself
  - Gaze out of the window
  - Listen to the sounds of nature
  - Take a slow and quiet walk
- Mindful Eating
  - When you first taste your food, try to give it your full attention. Slow down, savor the taste and texture of your food, express gratitude for the food you are eating
    - *http://leftbrainbuddha.com/40-ways-bring-mindfulness-days/*

- We can practice bringing our mindful attention to daily activities that are often performed mindlessly.
- We can pay attention to the movement of the body, and the sights and sounds around us.
- Perhaps pick one of these activities to serve as your "call to mindfulness" during the day:
- Waking Up, Brushing teeth, Taking a shower, Drinking coffee, Waiting in line
- Sitting at a red light (instead of checking email, can you use that pause to connect to the breath and notice your surroundings?

Micro

Practices for Busy Physicians

- **Pager Practice:** whenever your pager or phone rings, pause, take 3 breaths, relax mind and body and then answer
- **Patient Practice:** whenever you enter an exam room or a patient's room, as you have your hand on the door handle, pause and take 1-3 breaths
- **Eating Practice:** when eating, pay attention to 3 bites.
- **Walking Practice:** find opportunities for walking meditation; just notice 3 things--name them without evaluation
- **Gratitude Practice:** balance critical views with appreciation
- **Silent Driving Practice:** pay attention driving home
- **Smile Practice:** Half smiling activates positive biochemistry

Mindfulness

- Mindfulness brings us into the present, enables us to experience what is happening now
- Mindfulness is the opposite of multitasking
  - Epstein RM. Mindful practice. JAMA. 1999;282:833–9
- Think of a patient encounter when you were preoccupied with calls you had to make, a line up of patients waiting to be seen, staff issues you had to deal with….
- Think of a patient encounter when you were able to focus on the patient and family at hand without distractions…….

The Chaos of Primary Care

- Demanding families
- Multi-tasking; EMR
- Staff needs
- Isolation
- Decision making
- Uncertainty
- Never enough time
- Rarely enough revenue

Steve Kairys, MD, MPH Professor and Chair of Pediatrics, Jersey Shore University Hospital, NJ

Mindfulness and Clinical Practice

- For too many healthcare providers, practice can become repetitive
- Being mindful allows one to become reflective and to step back from the day to day routines
- To ground oneself in order to care for yourself while providing the best care for your patients

Steve Kairys, MD, MPH Professor and Chair of Pediatrics,
Jersey Shore University Hospital, NJ

Mindfulness and Clinical Environment

- Take a moment and put yourself in the place of your patients
  - Walk to the front desk
  - Down the hall
  - Into the exam room
- What do you see and hear?
- How does it make you feel?

Mindfulness and the Clinical Environment

- Example:
  - When we first moved into our clinic space for Weight Management
    - *Scale etiquette*
    - *Tables and chairs*
    - *Picture on the walls*
    - *Noise in the halls*
    - *Food everywhere*

Bringing Mindfulness into the patient encounter

- **Before entering the room**
  - Take a breath, focus on your breath as you inhale and exhale being mindful of the present moment, the beginners mind, open to whatever comes, free of judgments and preconceptions
- **Entering the room**
  - Spend a moment to greet the patient and family honoring the time you will spend together
- **As you begin listening**
  - Focus on the patient, noticing distractions and returning to the patient as you would return to your breath during practice

Bringing Mindfulness in the patient encounter

- **As you examine the patient**
  - Be mindful of the power of gentleness
- **As you finish your encounter**
  - Breathe and pause, waiting a in a small moment of silence for whatever else may arise
- **As you leave your patient**
  - Take a breath, experiencing compassion, for you and for your patient, as you breath in and you breath out

Patient Experience

- Is there a way to practice mindfulness in the moment in the clinical encounter with the patient and family?

Mindfulness Vignettes

- A mom trying to breast feed her baby with PWS
  - History of difficult and painful breastfeeding –infant used to "bite" when feeding and mom always anxious
  - Taught three relaxing breaths to help her before baby latches on
  - Mom thought this was so helpful and began to nurse again.

Mindfulness Vignettes

- A teen with ADD, having a hard time in school, failing 2 subjects, anxious about end of year testing, weight going up,
  - "I'm not paying attention to what I am eating",
  - Discussed what it felt like to be anxious, how thoughts influence how our bodies feel (stress response), how our minds "need a rest" .
  - She was willing to try breathing. She and mom did it. She said, "it was a relief to let all those thoughts go" as she was breathing.
  - She wanted to try before she did her homework

Mindfulness Vignettes

- 14 yr old boy with Asperger Syndrome
- Mom and boy anxious in the visit, trouble focusing, arguing
- Willing to try breathing in the moment
- Both did
- Felt calmer, able to discuss issues and proceed with visit

The Patient Encounter: effects

- Health care professionals can influence the interaction and the character of the relationship with patients through their behavior in the encounter, where the patient can feel confirmed or excluded, or be given a sense of being empowered or discouraged

- *Drew N. (1986) Exclusion and confirmation: a phenomenology of patients' experiences with caregivers. Image 18, 39±43*
- *Takman C, Severinsson E,A description of health care professionals' experiences of encounters with patients in clinical settings Journal of Advanced Nursing, 1999, 30(6) 1368±1374*

State of the Practitioner: Mindfulness and Presence

- Mindfulness is characterized by learned mental habits: attentive observation of self, patient, and context; critical curiosity; beginner's mind (that is, viewing the situation free of preconceptions); and presence.
- Presence is defined as "connection between the knower and the known, undistracted attention on the task and the person, and compassion based on insight rather than sympathy"
  - Epstein RM. Mindful practice in action. I: Technical competence, evidence-based medicine, and relationship-centered care. Fam Syst Health. 2003;21:1–9.

Presence

- Presence is defined as “connection between the knower and the known, undistracted attention on the task and the person, and compassion based on insight rather than sympathy”

- Epstein RM. Mindful practice in action. I: Technical competence, evidence-based medicine, and relationship-centered care. Fam Syst Health. 2003;21:1–9.

Being Present

- Allows one to really listen; allows for more openness and less defensiveness or reactivity.
  - Examples: Someone is critical of you or someone else in a meeting.
- Listening allows for not becoming reactive, giving space to the person who is talking, perhaps seeing that person with newness or freshness.
- It provides the gap or space not to react to the words or the person but rather to respond from a place of calmness from within.
- Sets the conditions for a better chance of meaningful dialog.

Connection

- What is beyond the assessments and examinations, the words and actions that allows the experience of connection?
- Moment of consciousness and possibilities
- Genuine presence and connectedness between two human beings
- May generate inner strength and help the human being to acquire a sense of inner harmony
  - *Watson J. Postmodern Nursing and Beyond. 1999, Churchill Livingstone, London, 105–18*

Mutuality

- Both are affected in an encounter
- “To be present is to be close to the other, but also close to oneself … the presence of the other brings one closer to one’s own self”.
  - Na ˚den D, Eriksson K. Encounter: a fundamental category of nursing as an art. Int J Hum Caring 2002; 6: 34–9
- “To be available is to be so uncluttered by a sense of one’s own importance, so unthreatened by the strangeness of the other, that one may enter immediately into communion”
  - (15: 5) Keene S. Gabriel Marcel. 1967, John Knox Press, Richmond,

Experience

- “It is the quietness from me that makes others trust in me. I show that I have time to be with you now, without any explanations. To make myself available in the encounter, has to do with being quiet within oneself. I have to show that I can sit here, even though there is hurry in other places, because I have chosen to sit by you. I do not need to say this, because I show it in the way I am”.
  - *Na ˚den D, Eriksson K. Encounter: a fundamental category of nursing as an art. Int J Hum Caring 2002; 6: 34–9*

Additional Resources

- Kabat-Zinn, J. (1990) Full Catastrophe Living: Using the wisdom of your body and mind to face stress, pain and illness. New York: Dell Publishing.
- Santorelli, S. (1999) Health Thy Self: Lessons on Mindfulness in Medicine. New York: Random House.
- Stahl, Bob & Goldstein, Elisha. (2010.) A Mindfulness-Based-Based Stress Reduction Workbook. Oakland, CA: New Harbinger.
- Nin A. The Diary of Anais Nin, 1939-1944. New York, NY: Harcourt Brace & World; 1969.42
- Shapiro SL, Astin JA, Bishop SR, Cordova M. Mindfulness-based stress reduction for health care professionals: results from a randomized trial. Int J Stress Manag. 2005;12:164-176.
- Tait D, Shanafelt MD. Enhancing Meaning in Work-A Prescription for Preventing Physician Burnout and Promoting Patient-Centered Care, JAMA. 2009;302(12):1338
- Beckman HB, Wendland M, Mooney C, Krasner MS, Quill TE, Suchman AL, Epstein RM. The Impact of a Program in Mindful Communication on Primary Care Physicians. Acad Med. 2012 Jun;87(6):815-9. doi: 10.1097/ACM.0b013e318253d3b2
- Connelly JE. Narrative possibilities: Using mindfulness in clinical practice. Perspect Biol Med. 2005;48:84–94.
- Abatemarco DJ, Kairys S, Gubernick R, Kairys J. Expanding the pediatrician's black bag: A psychosocial care improvement model to address the "new morbidities". The Joint Com J on Quality and Patient Safety 2008; 34 (2):106-115.