1. Explain how the PAPM model was used to address planning and intervention characteristics in the Costanza et al. (2009) article.

According to the Costanza et al. (2009) article, the modified Precaution Adoption Process Model (PAPM) used a nonrandomized small pilot study to measure the effectiveness of a maximally intensive intervention for motivating long overdue middle class, insured and white American women to receive a mammogram.

Of the three hundred and twenty-five eligible Health Maintenance Organization patients of eighty-four UMass Memorial Health Care primary care practices, forty-five patients completed counseling and data collection. These women were staged pre- and post-counseling calls using the 7 stages of the PAPM to address planning and intervention characteristics in this article. The stages were; (1) unaware (never heard of the risk/screening test), (2) unengaged (aware of and acknowledges others' risks), (3) undecided/deciding (acknowledges personal risk and is deciding), (4) decided no, (5) decided yes/planning, (6) acting (adopts the behavior), and (7) maintenance (repeats the behavior). Pre-counseling call staged thirteen women into stages 2 to 4 (not planning) amongst which, 7 were in stage 3 (undecided/deciding), and 5 in stage 4 (decided no). Thirty-two were staged into stage 5 (decided yes/planning); with 7 in stage 5a (>3 months), thirteen in stage 5b (planning within 3 months), and 2 in stage 5c (already scheduled for a mammogram) (Costanza et al, 2009).

Findings from a focus group conducted with women overdue for mammograms, was used to sub classify women in stages 4 and 5. Women in PAPM stage 4 (decided no) were sub classified as either stage 4a (definite
no: would never get a mammogram) or stage 4b (qualified no: would consider getting a mammogram if their perceived risk increased). Women in stage 5 (decided yes/planning) were sub classified into 3 subgroups. (a) stage 5a (decided yes: plan to get mammograms at >2-year intervals and/or no plans to get one in the next 3 months), (b) stage 5b (decided yes: plan to get a mammogram in next 3 months but unwilling to commit to a specific date), (c) stage 5c (decided yes: ready to schedule a mammogram) (Costanza et al, 2009).

The transitions from stages 2 to 6 followed the dictates of the PAPM and were facilitated by the use of a computer-assisted telephone interviewing (CATI), print materials, motivational interviewing (MI), and facilitated scheduling. The use of CATI maximized fidelity to the counseling protocol by use of an algorithm, prompting the interviewer with text of statements and queries on a computer screen, and entry of the subject's responses into the computer by the interviewer (Costanza et al, 2009).

The MI component addressed resistance to screening. It’s principles was used to develop counseling modules that explored the importance a subject attaches to screening, assessed confidence in a subject’s ability to assess a mammogram and concerns of subjects who had either decided against screening or were undecided (Costanza et al, 2009). A booklet (print material) with sections on the nature of cancer of the breast, risk of breast cancer, guidelines for screening, mammograms, and several graphics (some illustrated and compared the size of cancers detectable by mammography to the size (much larger) usually identifiable by clinical breast examination) was given to subjects before the call and it was referenced during the calls. Mammograms were scheduled during counseling calls to increase the likelihood of completion. Facilitated scheduling was aimed at reducing wait time and influencing completion rates (Costanza et al, 2009).

Post-counseling call, thirty-eight of the forty-three women were transited to stage 5 (decided yes/ planning). A year post-counseling call, the subjects were followed up to ensure transition to stage 6 (acting). Of the thirty-three women in stage 5, 60.5% were transited to stage 6 by receiving a mammogram (Costanza et al, 2009).
2. Determine and explain if the use of the model made sense based on the description of the model in the appropriate textbook chapter and supplemental materials.

Based on the description of the PAPM in the textbook chapter and supplemental materials the use of the model in the article authored by Costanza et al. made sense. Costanza et al. sub classified stages 4 and 5 for the benefit of the study though, the textbook and supplemental materials did not sub classify stages 4 and 5. With findings from a focus group conducted with women overdue for mammograms; women in stage 4 (decided no) were sub classified into stage 4a (definite no: would never get a mammogram) or stage 4b (qualified no: would consider getting a mammogram if their perceived risk increased). While, women in stage 5 (decided yes/planning) were sub classified into 3 subgroups; (a) stage 5a (decided yes: plan to get mammograms at >2-year intervals and/or no plans to get one in the next 3 months), (b) stage 5b (decided yes: plan to get a mammogram in next 3 months but unwilling to commit to a specific date), (c) stage 5c (decided yes: ready to schedule a mammogram) (Costanza et al, 2009). To suit the objective of this article, Costanza et al. did not follow up the participants up for longer than a year. Stage 7 (maintenance – repeats the behavior) of the PAPM was not assessed by following the subjects up for many than a year to see how many of the 60.5% of the thirty-eight women who acted (received mammograms) repeat mammograms in the future (the behavior).

In review of your chosen secondary articles, how did the application of the model differ between the interventions? In your opinion, is one application a better use of the model than the other? Explain.

The Weinstein & Sandman (1992) article; followed the dictates of the PPM and used 6 of its 7 stages to examine a series of empirical studies of home radon testing in order to see what support they provide for a stage perspective in general and for their model in particular.

These 6 stages are; (1) stage 1 (never heard of radon), (2) stage 2 (never thought of radon), (3) stage 3 (undecided about testing), (4) stage 4 (decided not to test), (5) stage 5 (plan to test), and (6) stage 6 (testing).
The authors did not apply stage 7 (the maintenance stage) of the PAPM because radon testing need not be continued over time (Weinstein & Sandman, 1992).

The Elliot, Seals, & Jacobson (2007) article followed the dictates of the PAPM and used all its 7 stages to provide a guide on how to influence persons and transit them from unaware/unengaged stages to the stages of adoption and maintenance for osteo-protective behaviors (dietary calcium, calcium supplements, exercise and bone density screening by dual energy X-ray absorptiometry) by adapting a questionnaire from previous studies. I am of the opinion that the authors used stage 7 of the PAPM model because it was necessary to achieve their study aim. The maintenance stage is necessary to study “adoption and maintenance” of osteo-protection behaviors.

In my opinion none of the 3 applications is a better use of the model. The authors of the different articles adapted the application to suit their study objectives. Costanza et al. will probably follow up the subjects that were successfully transited into stage 6 (received mammogram) into the future to see if they transited into stage 7 (repeated mammograms) because breast cancer screening needs to be continued over time.
References

