Behaviour Change

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The aim of the article is to provide a brief guide to **Behaviour Change utilising the clinical method of Motivational Interviewing when discussing interdental cleaning.**

Key Points:

1. When looking to gain patient compliance with interdental cleaning MI is a specific clinical method centred on developing intrinsic motivation in a person.
2. The need to change must come from within the patient, autonomous in their decision-making and understanding of the resulting consequences of decisions made.
3. MI requires the use of complex communication strategies, many hours of practice and the valuable feedback that a coach familiar with the method can provide.
4. Behavioural change and the resistance to change are substantially influenced by the communication style of the clinician

Behaviour Change

Introduction

Oral health interventions, such as the need for interdental cleaning, delivered by the dental team have been able to improve knowledge and attitudes; however, a long term behaviour change has always been a more complex goal (Tolvanen, Lahti, Poutanen, Seppa & Hausen, 2010). A behaviour change requires long term compliance with recommendations on a daily basis. The focus of this short article is about motivational interviewing (MI), providing a brief overview for those who are unfamiliar with it and an outline of how it can be applied when working with patients to implement interdental cleaning. It is an approach suitable for use in the dental practice when working with a patient towards compliance with tailored oral health interventions. It is often the case that following an appointment where oral health is discussed the patient will stay with, or after a period of time return to, old habits rather than move forward into life long changes that lead to positive health outcomes. Quite often the interdental cleaning advice has been offered repeatedly at many previous dental appointments and the reiteration of messages and demonstrations at each appointment may lead to a resistance to change on the part of the patient. Approaching change using the MI method can help the clinician to work with the patient to alter behaviour, however, it is the patient who will need to develop a self awareness of the need for change and will ultimately need to take personal responsibility to make the change.

The role of the dental nurse

The General Dental Council (GDC) requires that on qualification a Dental nurse (DN) is able to *describe the principles of preventive care and provide patients with accurate and effective preventive information in a manner, which encourages self-care and motivation* (General Dental Council 2013). Stated within the Scope of Practice document published in September 2013 by the GDC a DN may also choose to develop professionally furthering their skills in oral health education and oral health promotion. Additionally a DN may develop further skills carried out on prescription from, or under the direction of, another registrant, measuring and recording plaque indices. Prior to carrying out any of these additional duties a DN should ensure that they have undertaken the necessary education and training to ensure competence. A DN is advised to check that they are indemnified to carry out the additional skills that they have developed.

Motivational Interviewing Vs the Transtheoretical Model

It is important at this stage to draw a distinction between the Transtheoretical model (TTM) and MI. Both developed alongside each other in the 1980's and TTM was particularly successful with patients who had drug and alcohol addictions. The Transtheoretical model (TTM) by Prochaska and Diclemente is a conceptual model of change and advocates that a person will transit through a set number of stages on

their journey through the change process. The stages are pre-contemplation, contemplation, planning, action and then maintenance of change.

Centred on developing intrinsic motivation in a person, MI is a specific clinical method (Miller and Rollnick, 2009). Interdental cleaning is a skill that can be introduced as a child, a young adult or later in one's life and there can be inconsistencies in the messages and demonstrations delivered between clinicians leading to apathy or confusion in the patient. Patients are indecisive and can have mixed feelings about change, often seeing the advantages in the proposed change but maintaining a reluctance to change. Advocates of MI propose that change is not a linear path for the patient and relapse can occur at any of the stages resulting in the creation of a new plan and a change of direction to meet the goal.

Motivational Interviewing defined

MI was originally defined as *a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence* (Rollnick and Miller, 1995). Demonstrating an ongoing evolution, more recently MI has been defined *as a collaborative, person-centered form of guiding to elicit and strengthen motivation for change* (Miller and Rollnick, 2009). Motivation from the patient is central to enabling behaviour change, persuasion or intimidation by the clinician to change are not in the spirit of MI and may lead to resistance to change from the patient. The 'spirit' of MI is fundamental to success. It is based on the belief that people wish to feel better about their unhealthy behaviour and that people are ambivalent about changing finding reasons to both change and not to change. Resolution of ambivalence will require the clinician to consider the factors that contribute to the indecision of the patient and facilitate a discussion that will guide the patient to a point where they have the determination to make the required change. It is a collaborative process whereby the clinician works to quietly elicit discussions about change and the patient is empowered to make the modifications required. The discussions should respect the views of the patient and seek to clarify and resolve the indecision that surrounds the behaviour change. It is important that the clinician does not assume that the patient is ready to adopt the proposed change and if resistance on the part of the patient is detected this is a cue to the clinician that they need to adapt their approach to the discussions. The need to change must come from within the patient, autonomous in their decision-making and understanding of the resulting consequences of decisions made. This requires the clinician to listen and reflect on the patient's interpretation of the situation, to have empathy and assess the readiness of the patient to change. Empathy involves the clinician being able to see the world through the eyes of the patient, to understand and share their feelings.

Working with the patient – Interdental Cleaning

Behavioural change and the resistance to change are substantially influenced by the communication style of the clinician. The aim is to facilitate and support the patient

in their behaviour change in a way that is consistent with their own values as oppose to imposing change on them. Draw from the patient what they already know and do not assume the position of expert ready to tell them what you think they need. By drawing on the patient's thoughts and ideas their motivation for lifelong change and compliance will develop, as they will uncover their own reasons for change. To help the patient to consider in depth their inconsistent compliance with interdental cleaning a simple approach to communications through the acronym OARS can be employed; the use of Open questions, Active listening, Reflection and Summary.

Open questions cannot be answered with a 'yes' or a 'no', they explore and can offer a rich insight into how the patient feels. Have a selection of phrases or 'field of words' that a patient could identify with and associate with own personal goals regarding oral health, a few examples might be:

- "I don't want to lose any more teeth"
- "I would like to stop my gums from bleeding when I brush my teeth"
- "I want to maintain good oral health"

Active listening requires the clinician to engage completely with the conversation to help the patient to feel heard and understood through open body language, paraphrasing and summarising. For example; "As I understand it, it is very important to you to keep your teeth, but you are not that confident that you can achieve that goal. What would make you move your confidence level from 4 to 7 or 8?"

Reflection involves the clinician listening carefully to the patient to ensure that they reinforce the self motivating statements made that relate to change and commitment, whilst giving less attention to the negative statements. Summary comes from active listening and reflection, it enables a clinician to connect with the patient and emphasise the key points within the discussions and if needed, move to change the direction of the discussions.

Whilst MI is described here as being patient centred, the clinician will need to maintain a direction of travel with the patient towards the intended goals. In the case of interdental cleaning long term daily compliance and competent use of the recommended interdental aids is required. As a clinician understand the patient, refrain from arguing the reasons for change with them and rather roll with the resistance in a non-judgmental way. Rolling with resistance requires the clinician to avoid any negative interaction with the patient when resistance to change is encountered. Work with the patient to explore the consequences of their behaviour so they may understand the impact of the current behaviour. When a patient can start to relate their current behaviour to their values and their future goals, informed decisions can then be made about their choice of behaviour. The clinician can help the patient with direction of travel and help them move towards their goals. The patient/clinician relationship is important and a collaborative rapport will lead to trust between the two parties whereby discussions can be based on a mutual understanding.

For a clinician, MI may appear at first glance to be a straightforward approach however, it requires the use of complex communication strategies, many hours of practice and the valuable feedback that a coach familiar with the method can provide. With that in mind it is important to understand that clinicians (within the context of dentistry) are unlikely to be expert and already carrying out this method in practice, however, some may be able to recognise elements of MI that they do carry out naturally when working with patients.

Ethical Considerations

There are ethical considerations to be considered and one would not continue with the discussions; if it was evident that the patient were experiencing discomfort as a result of the interaction; where the clinician has a personal investment in achieving the goal in conflict with the patients own best interest; where intimidation is combined with a clinicians personal investment in achieving the goal in conflict with the patients own best interest. In the true sense of counselling MI is not appropriate for use with patients who have a medical history that would suggest psychotic, violent or suicidal tendencies. In such cases, within the dental field and the remit of changing oral health habits the clinician would need to make a judgment on how to approach the behaviour change in the best interests of the patient. Whilst discussions and demonstrations about interdental cleaning might seem innocuous and common sense to the clinician the patient's medical history and ability to engage with the change required must be assessed and considered.

Conclusion

Long term behaviour change has always been a complex goal. Compliance with recommended interdental cleaning regimes and the resistance to change are substantially influenced by the communication style of the clinician. MI is a complex method of communication that requires much practice over time and aims to develop intrinsic motivation within a patient and guide toward positive change. It is a clinical method to be used with those patients who display ambivalence about making the change to incorporate the recommended interdental regimes; it is not appropriate for those patients who already have the intrinsic motivation to make the change. At the heart of MI is 'spirit', the belief that people wish to feel better about their unhealthy behaviour and that people are ambivalent about positive change, instead finding reasons to both change and not to change. The clinician and patient should work collaboratively to explore patient ambivalence through the use of open questions and reflective listening. It is a patient centred, goal-orientated approach whereby the clinician works with the patient to develop in them a self-awareness of the need for change that will ultimately lead the patient to taking personal responsibility for making the change.

For those who wish to investigate motivational interviewing in more depth see Miller and Rollnick (2002).

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