



Invigorating Oral Health Care

using Motivational Interviewing in Clinical Practice

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On the most recent webpage of Spectrum Dialogue, the center notation reads, “SPECTRUM dialogue is distributed to dental technicians and dentists throughout Canada as well as dental technicians and key opinion leaders throughout the US. The journal is committed to fostering better communication between doctors and laboratories in order to optimize patient care” (italicized emphasis ours). We could not be more emphatic in extending this ‘dialogue’ to the importance of better communication among dentists, dental technicians, and all dental team members to the people we serve, all in service of optimizing patient oral health care.

It seems like we are being inundated with the need to communicate differently and more effectively. Clearly, Palmeri Publishing plays a leadership role in managing and distributing no less than twelve dental-related journals. Knowledge translation and concomitant best clinical practices, in turn, stem from information dissemination from these and a myriad of other dental journals, conferences, research, and other professional experiences. At issue for us in this article, is the whole concept of effective communication from dental teams to patients. Most of us know about and utilize information dissemination from such things as self-assessment mechanisms for initial patient contact, the dental exam, discussing dental treatment options, discussing costs and insurance, and concluding the visit. At the same time, we posit that our communications with patients could be far more effective and have much greater impact than would seem to be the case currently.

A day in the life of a dentist or dental staff member likely would include at least one time where we ask a patient to change his or her oral health behaviour. We spend endless hours trying to convince our patients about the need to improve their oral health, their sanative procedures, and yet we end up doing this every time they come to us for care appointments – whatever was said previously is either forgotten or just not heeded. In essence, we make a huge assumption that somehow patient can take the information we provide and transform that knowledge into new or different, sometimes radically different oral health behaviours. We would ask rhetorically, how is that working for you and your patients? What if the communication issue is not about patient non-compliance and instead it is about our inability to optimize and maximize our communication with them? Somewhat ironically then, we ask it of our patients on a daily basis; perhaps it’s time we changed and improved our own communicative behaviour. When dental team members are asked to change their own behaviour, how many of us are willing to do so? We can no longer assume or take responsibility for our patients’ oral health just as we cannot expect our physician to take ownership for our own overall health. A person’s well-being or state of health is theirs to own and theirs to fulfill. Our job as health care providers is to offer the information – with permission – to our patients along with any necessary intervention that will help them accomplish their preferred state of well-being. Motivational Interviewing (MI) is one powerful behaviour change technique that allows the communication and information

aspect of what we do to be relatively stress-free. Further, it empowers patients to make the decisions needed for what they want to achieve with respect to their oral health in partnership with their dental staff. This article will provide an introduction to MI; render illustrative examples and discuss cases regarding why MI works; and offer an applied introduction to the use of MI specifically within professional health practices such as dentistry. What we suggest herein is that using some easily-learned MI skills, can change and/or re-invigorate the way dental teams communicate more effectively with (instead of to) their patients. Our overall intention is to raise the awareness among dental professionals of the potential utility to short- and long-term oral health care in integrating MI methods within clinical practices.

Definitions of MI vary and might be encapsulated in this one: a client-centered, yet goal-directed counselling method for helping people to resolve ambivalence about health behaviour change by building intrinsic motivation and strengthening commitment. The architects of MI, William R. Miller and Stephen Rollnick¹ were heavily involved in finding an adjunct method for working with people suffering from addictive behaviours, primarily those who were alcohol dependent. While the word ‘counselling’ in the foregoing definition might, at face value, suggest that MI is only for professional counselors, it most definitely is not a technique or method confined to that professional category. Instead, the spirit and intent of MI can be learned and utilized by any health professional who seeks to have a better, more mutually satisfying, working relationship with his or her patients/clients. We would draw your attention to the italicized portion of the definition, building motivation and strengthening commitment (in this case, toward the patient’s oral health goal/s). MI is a communication style, a way to be with patients in service of health behaviour changes that work and persist for the patient and for dental staff members.

What does success look like for a dentist in the 21st century? What does success feel like for a dental patient in the 21st century?

Clearly, the mouth is the primary gateway to anyone’s health. By extension then, exemplary oral health care means much more than merely treating the teeth and gums of our patients and dispensing information unsolicited. Similarly, the attainment of optimal health is much more than dental treatment techniques. That said, how many dentists and dental staff members would give emphatic yes-answers to these questions:

- ...those who are frustrated that the (oral) health instructions given at every check-up never seem to get anywhere - you feel like you are saying the same things over and over ?

- ...those who feel that you work harder at attaining good oral health for your patient than the patient does ?
- ...those who feel that when you speak to some patients or patient care-givers, it seems as if they just shut down or look at you as if you are from another planet ?

There exists some kind of gap then, in connecting with our patients. We have a wealth of health information and expertise but it seems that patients are reluctant to take our advice, don’t perceive its relevance, and/or don’t heed that advice – there is some disconnect happening. What can you do to close that gap or make the connection happen? What if, instead of feeling like you are wrestling with your patients, you could move toward a sense of dancing or being in partnership with your patients? We suggest that a way to do this is to learn and adopt some basic MI methods and ways of being in connection and communication with your patients.

I have some information about treatment _____.
Would you like me to share it with you?

Consider the question in the box above. As dental professionals, we have expert knowledge and advice and the tendency or habit might be to dispense that advice as though it were prescriptive and wanted by our patients. We are trained to fix teeth, gums, the mouth etc., in short, to right what’s wrong. However, in the area of human behaviour change and in the words of MI practitioners, it is important to ‘resist the righting reflex,’ the tendency to give prescriptive, unsolicited behaviour change information or advice. Instead, what if you asked each patient for permission to share that information? This might, at first glance, seem counterintuitive – of course they want my advice, that’s why they are here. However, unless you have asked and/or established this pattern of seeking permission to give your expert information, how do you know your patients want it? A great deal of research has been done on what happens to information pamphlets given to patients by health care professionals; most of those pamphlets are tossed in the first trash can after leaving professional offices. Knowledge or information is not power, only potentially so; getting permission to impart knowledge is power-ful. Thus, in the permission question above, a patient might say, no thanks. So be it; that is his or her choice. However, if the patient says ‘yes,’ you have her or his attention and you have closed or greatly decreased the communication gap; for motivation and behaviour change, getting permission is like bringing the right substrate in contact with the correct enzyme – the biological comparison is apt and the behaviour change platform is established for real, two-way communication to happen. People are more motivated to make change when the change is based on their own decision – in this case, their ‘yes’ – than when an authority figure tries to impose change². Of equal value is the

fact that questions like this permission-one take the responsibility for our patients' oral health care process away from us and onto our patients; we cannot make them follow our advice, but we can communicate with them far more effectively if we know what they need and what they are willing to hear and/or do about their oral health care in partnership with our dental staff.

Health promotion is the process of enabling people to increase control over and improve their health (World Health Organization)

This brings us to a key feature of optimal oral health care and it is this. Oral health care is as much about aural care as it is oral care. We cannot expect to be impact-ful with our clients, to work in partnership with them unless we actually listen to them and show them we are listening. Listening, truly listening is a huge and integral component of enabling patients to increase control over and improve their health. People need to be seen for who they are and what they are experiencing and for the most part, seeing someone means using your ears before your mouth reacts. Consider a couple of examples concerning the impact of not listening versus listening. A parent comes with her child and says to a dental team member, "we're really scared about being hurt; I told my son you wouldn't hurt him with a big needle." One common, very reactive, not-listening response by a dental team member might be, "that won't happen here, we're very careful" (a prime example of the 'righting reflex'). While the intent might be to reassure, the impact is that the patient/parent is not seen, certainly not heard. A more reflective, 'seeing' response might be, "I see that you're scared. What's that like for you? What would help?" The latter response acknowledges the patient's fear, asks what it's like to be him-in-fear (and listens to the patient's response) and then asks what might be done to help. The effect on the patient is profoundly different. Instead of feeling dismissed or kind of stepped-over in the reactive response, the more reflective, truly aural response engages the patient and dental team member as a partnership – substrate to enzyme – and, very likely, goes a long way toward establishing a bond of trust.

What's important to you about your oral health care?

What if oral health care is about much more than oral health care? Consider a second, real clinical example of listening attentively to a patient. A 37-year-old man with moderate hemophilia came to dental university hospital clinic in another country. He was married, had a tremendous anxiety disorder centered on hospitals, and was perceived to be argumentative, generally difficult in demeanor, and 'smelly' by clinical staff members. A severe hemorrhaging issue

following an appendectomy in his late teens coupled with massive bleeding following wisdom teeth – removal at 20 years of age, meant that he had not been back to a dentist in 17 years. His wife persuaded him to come to the clinic and he was in abject terror, could not allow anyone to look in his mouth, and was visibly shaking and distressed. When he spoke, he covered his mouth with his hand and the dental team said they could smell his halitosis two meters away; his wife reported she could not bear to kiss him. He said he had become scared to put a toothbrush in his mouth in case he broke anything and because he was afraid of bleeding. When they finally were able to talk with him, the dental staff asked him some standard dental-clinic entry information inquiries and one very powerful question, "what's important to you about your oral health?" Two of the staff members had undergone some basic MI-training and were trying out their newly-acquired interviewing skills. The patient perked up immediately at the question, stated that he had never been asked that before, and he said he had 3 priorities: to get rid of his halitosis; to have his decayed teeth removed; but most importantly, above all else, to have better relations with his wife. It turned out that he and his wife had not been intimate for more than a year. He deeply loved her and his entire motivation in even coming to the clinic was tied to his feelings for her. There was a long process of getting him into surgery and lots and lots of reflective listening and encouragement, all tied to his primary motivation, followed with complete technical success in treating his oral health issues (inclusive of smoking cessation later in the process); however, the key question, the turning point was this fundamental, what's-important-to-you question together with really listening to his response. In this case, and very likely in most cases, oral health care was and is about so much more than just oral health care. If we can find out what is important about each patient's oral health care, by using similar questions as the one above and by listening to the responses (that is, using MI methods), practicing dentistry might be more fulfilling and patient adherence and satisfaction might be increased concomitantly.

What are your goals for your oral health care?

Listening implies something has been elicited in conversation. MI is predicated on the use of open-ended or powerful questions. We suggest that effective, guiding communication – an MI conversation – is an implied nuance of oral health care, in this case, a dental staff member communicating orally. The intent of MI questions is not to interrogate the patient but rather to guide them toward the oral health care changes they want to make when they are ready to make them. Ideally, we want to move them from status talk to change talk, that is, from using the language of old habits, the way it has always been,

to the language of possibility, from ‘I can’t’ or ‘it doesn’t work’ to ‘I want to’ or ‘I really need to’ or ‘I can.’ For the most part, powerful, open-ended questions pry the lid off of resistance to change and most often those questions start with ‘what’ not ‘why.’ Notice the boxed question above; it invites a patient to reflect on his or her goals, perhaps resulting in a list of those objectives, as in the patient with hemophilia example provided earlier. If we ask the question, ‘why do you think oral health care is important?’ or ‘why aren’t you able to take better care of your oral health?’, we will get either a list of what the patient thinks we want to hear, the “right” answer, and/or we will get justifications, from a place of defensiveness, for her behaviour. What-style of questions invite; why-style of questions tend to build barriers, put up defenses even though they might be well-intentioned. In addition, what-style questions demonstrate that we are interested in our patient’s perspective (goals, in this case) and they give us information, answers about oral health care from which we can build treatment plans and understand our patients’ needs and desires. Listening to the answers to open-ended questions means reflecting back or mirroring the answers your patients give, perhaps charting those answers. If we asked,

What are the important components of your oral health?

and the response was something like: feeling good about me, avoiding cavities, and my smile, then we might say something like, “So, if I’m hearing you correctly, it sounds like you want to feel good about yourself, have a nice smile, and prevent cavities as much as possible, is that accurate?” By reflecting back, using the words used by your patient, you

show you have heard them and that you are affirming or acknowledging them in your response. MI has a good acronym for its core strategies to move a person from status talk to change talk, OARS:

- Open-ended, powerful questions
- Affirming or Acknowledging responses
- Reflective Listening
- Summarizing

Summarizing, for example, involves confirming what the patient says is her first step in meeting or achieving one of her stated goals for her oral health care. Asking the patient to summarize what you have discussed can often cement the patient’s movement toward his or her proposed oral health care change/s.

What would a revised, MI-based intake and exit set of questions look like?

One place to start the process of shifting to the use of MI within a clinical practice is in shifting the way we ask patients’ appointment and/or extended care intake and exit questions. For example, instead of asking, ‘Why did you attend your dental appointment today?’, consider the impact-potential of these intake questions:

- What is important to you about attending your dental appointment today?
- What are your concerns, if any, about your dental appointment today?
- What does oral health care mean to you?
- What are your goals or priorities for your teeth and gums or your oral health care? 1, 2, 3 – have them itemize goals/priorities



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- What is your current level of satisfaction re reaching each of these goals (on a scale of 1-10 for each one)?
- By when would you like to achieve each of these goals?
- What do you need to say ‘yes’ to in order to achieve these goals?
- What do you need to say ‘no’ to in order to achieve these goals? [the say yes/no to questions might have more resonance for some than the what-changes version]
- What can we do to partner with you to help you achieve these goals?
- If our staff members have information/suggestions for your oral health care, would you like us to share that information with you [the all-important permission question that Miller and Rollnick recently added to their core strategies acronym, OARS] ?

Notice that these questions are open-ended and individually patient-centered rather than more standard yes/no type of intake questions; the latter questions are not ‘bad’ questions, they provide important clinical information. What if you charted patient responses to these behaviour-oriented questions and used that information on an ongoing basis to monitor oral health care objectives, goal-seeking, and achievements? The same holds true for dental visit exit questions:

- What was the best thing about your dental appointment today?
- What would have made today’s appointment better for you?
- In what ways are you better prepared to reach your teeth/gum goals as a result of today’s dental appointment?
- When you leave here today, what will you do differently to reach your gum/teeth goals? When will you start? What help can we provide in supporting you in reaching these goals?
- To what extent do you feel the dental team understood your needs today?
- In a sentence or two, please describe the way you were treated today by the dental team/staff? Or, how did dental staff/team treat you today? Please give examples.
- What can we do to serve you better or more effectively?

These exit questions provide staff with important feedback, reinforce the team or collaborative approach to ongoing health care, and they summarize patient intent, satisfaction with, and intended behaviour change, goal-oriented actions. Perhaps these, and other intake and exit questions and their answers could be charted to encourage greater attention to patient motivation via more potent two-way communication among the dental team and your patients.

What is the future of patient-centered oral health care?

A recent article by Eric Curtis in the American journal, the Academy of General Dentistry Impact, talks about, ‘The Business of Oral Health Care: A Look into the Corporatization of American Dentistry.’³ The article discusses the benefits of, trends toward, and criticisms of large dental group practices – the big-boxification of dentistry – compared to the smaller, often solo practices in the profession. Management companies provide alluring advantages such as staff recruitment, equipment funding, marketing, patient scheduling and so forth. At the same time, the author notes some of the disconcerting issues that have arisen, ones like allegations of overtreatment, low-quality care, assembly-line-services, and questionable business practices such as cutting fees that impact smaller practices. What Curtis astutely points out is that regardless of practice-size, “the best basis for creating good oral health is a solid patient-doctor relationship.” If only the bottom-line, perceived corporate mentality drives dental practices, then patients will not be seen or heard or motivated. Whether one favours a corporate dental model or not, oral health care is fundamentally and irrevocably related to the best patient-centered care possible.

Of parallel, state-of-the-profession interests are a series of review and advocacy articles that have appeared in Dental Clinics of North America (DCNA). For example, Akabas et al discuss the potential role for dental professionals regarding nutrition and physical activity in health promotion and disease prevention.⁴ The article very poignantly notes the potential role that dental staff can play in collaborating with patients to make their desired lifestyle changes real (re nutritional and physical activity practices) via becoming proficient in the use of “active listening and motivational interviewing.” In the same issue, the authors of “Tobacco Cessation in the Dental Office”⁵ discuss one of most prominent oral health issues, smoking behaviours, and recommend a variant of MI by using the ‘5 A’s for Brief Intervention’ clinical practice guidelines – Ask about tobacco use, Advise to quit (we might revise to Advise to quit, with permission), Assess willingness to quit, Assist in quit attempt, Arrange follow-up – established by the US Department of Health and Human Services. Dental-practice initiated interventions for the reduction of obesity, overeating, and diabetes are emphasized in another⁶ of the articles in this DCNA issue. The point is that dentists and dental team professionals are in a unique and important position to play a leading, collaborative role in the oral/systemic health care of their patients. Dental staff personnel are stewards of the gateway to oral and aural health care. Learning to use more effective communication skills via MI does not mean dental staff must become experts in the areas of information

dispensing about nutrition, physical activity, obesity, overweightness, diabetes, smoking cessation or any other health care issue, in fact, just the opposite. The use of MI involves igniting patient motivation to change, collaborating and facilitating that change, if asked, and perhaps pointing to patient-identified and needed resources or support in achieving their oral health (and by implication, systemic) care. Our intent in this article was to offer an applied introduction to MI and its tremendous potential for improving and invigorating the overall process of oral health care. We would recommend MI training for all dental staff members in any clinical setting; like any new skill MI takes learning and practice. Clearly, MI is an evidence-based,⁷ patient-centered communication method that can be readily inserted into the repertoire of dental practices and skills, fully in service of enabling people to increase control over and improve their oral, and possibly their overall health. The important question is, What are you willing to change to promote more effectively your patients' oral health? ■

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- 7 For a set of research articles pertaining to the use of MI in dentistry, see the following resource list: <http://www.specialtybehavioralhealth.com/wp-content/MI-Dentistry-References.pdf>



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Dr Friedman has published and lectured extensively both nationally and internationally with specific interest in Risk Management, Early Childhood Caries, Motivational interviewing, Special Needs and Behavior. He completed an extensive co-active leadership training program with "Co-Active® Leadership Institute" and has been involved in numerous workshops related to oral health, risk management and motivational interviewing.