Motivational interviewing

Mhari Coxon discusses trying a different approach to changing your patient's habits

My main role as a hygienist is education of patients to prevent dental disease. I used to use the advisory model of giving information out in large paragraphs to patients without finding out if they were ready for this change. I now use motivational interviewing to great success in my clinical day and in my home life too.

This form of interviewing is free and not scripted. Scripts have their place but it is my feeling that we all have amazing, genuine people skills that would be stunted if we try to conform to a set learned vocabulary. I personally believe that this is health care and ethical selling at its best as it is genuine. We are listening and then forming the best way forward for the individual at that point. Once the connection is there the initial sell (of health and elective treatment), reselling and future selling is very simple. It doesn’t even feel like selling.

Communication is key

By incorporating effective communication techniques into daily patient interactions, all the team can increase treatment uptake and decrease complaints. More importantly, as clinicians we can positively and effectively impact patient health outcomes without increasing the length of visit—a win-win situation for both parties, and indeed the goal of healthcare.

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Motivation is key to change, and can be influenced by social interactions and the clinician’s style and can be modified. When selling treatment, if the patient is not motivated to change or ‘buy’ then you will not close your sale and run the risk of appearing pushy. It is the team, and in particular the three nurses, who will develop motivation and interest from the patient.

Motivational interviewing (MI) is a cognitive–behavioural technique that aims to help clients identify and change behaviours and opinions. This form of influencing is subtle but very effective and will grow the trust required for patients to return and recommend. Essentially we are using the patient’s ownership and awareness of health developing as a tool to treatment uptake. We need to understand the patient’s journey to treatment acceptance to be able to guide them.

The Nuts and Bolts Questions – opening the conversation – permission to communicate

We have to decide whether the patient is interested in communicating before we launch into education about treatment and health. I have put some examples below that will help you to decide what we want to ask.

Do you mind if we spend a few minutes talking about your ___________?

What do you know about ________________?

Are you interested in learning more about ___________?

Miller and Rollnick conclude that MI has five basic principles:

• express empathy
• avoid argument
• support self-efficacy
• roll with resistance
• develop discrepancy

Empathy is sincere – and successful – when a patient acknowledges that he or she has been seen, heard, and accepted as a person.

Barriers to empathy include:

• Using medical terminology
• Confusing sympathy with empathy
• Feeling that it takes too much time
• Effective empathy can be exhibited by:
  • Greeting the client on neutral territory; ie the waiting room
  • Keep on an even eye level with maintained eye contact
  • Avoid physical barriers
  • Reflective speech - Repeat in-
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formation in patients own language
- Share experiences/anecdotes (where appropriate and never in a prolonged way)
- Accept patients thoughts and feelings
- Reserve judgement
- Use ‘hear’ ‘see’ ‘told’
- Open and closed questions
- Closed questions often lead to yes/no responses and the question/answer trap
- Open Questions usually allow the clients to tell their story and they permit a better understanding of the issues-open questions help build empathy

Avoid argument
Patients can be uncomfortable or nervous and this can result in
- Aggressive behaviour
- Derogatory comments
- Negative listening
- You feeling STRESSED!!!!!!

Only when it is the client, not the clinician, who voices arguments for change can progress be made. The goal is to “walk” with the clients (ie, accompany clients through treatment) not “drag” them along (ie, direct clients’ treatment).

This does not mean we should not provide advice and support, rather that we should not dictate our opinions to the patient.

**Roll with resistance**
Adjusting to resistance is similar to avoiding argument in that it offers another chance for the clinician to express empathy by remaining nonjudgmental and respectful, encouraging the client to talk and to stay involved.

The clinician should avoid evoking resistance whenever possible, and divert or deflect the energy the client is investing in resistance toward positive change.

The simplest approach to responding to resistance is with non-resistance by repeating the client’s statement in a neutral form. This acknowledges and validates what the client has said and can elicit an opposing response. This simple reflection is very effective.

You can also defuse resistance by helping the client shift focus away from obstacles and barriers. This method offers an opportunity to affirm your client’s personal choice regarding the conduct of his own life.

**Develop discrepancy**
Separate the behaviour from the person and help the client explore how important personal goals (eg, good health, fresh breath, straight teeth, and whiter smile) are being undermined by current patterns.

This requires the clinician to listen to the client carefully about values

The questions below are ways of evoking change in the patient. This is an important phase of discussion and can increase treatment uptake as well as improving health.

1. What would you like to see different about your current situation?
2. What makes you think you need to change?
3. Why are you concerned about your health situation/appearance?
4. What things will be different if you don’t change?

Try throwing these open questions into conversation with your patients then listen, without interruption to the answers. See if you can spot the internal discussion the patient has as they decide how they feel about things and decide if they are ready to change, have treatment, and alter their behaviour.

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**About the author**

Mhari Coxon is a dental hygienist practising in Central London. She is chairman of the London British Society of Dental Hygiene and Therapy (BSDHT) regional group and is on the publications committee of its journal, Dental Health. She is also clinical director of CPDRedGDP, which provides CPD courses for all DCPs. To contact her, email mhari.coxon@cpdredgdp.co.uk.