

UNDERSTANDING PATIENT MOTIVATION II

INFLUENCING BEHAVIOURAL CHANGE: STRATEGIES FOR SUCCESS

Current thinking supports the view that empowering a patient to take ownership of their oral health, in partnership with their dental practitioner, is an effective means of motivating them to follow a different home care routine or treatment plan. This is the principle of 'concordance', where decisions are shared and negotiations take place between equals.

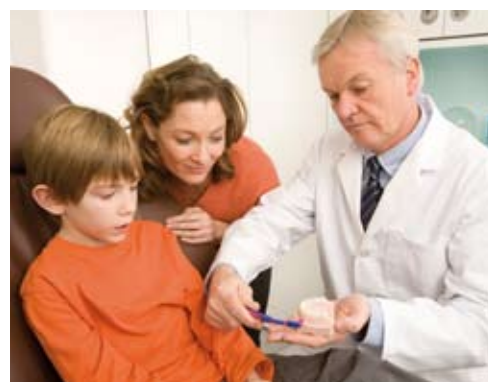
How easy is it to motivate your patient to modify their behaviour? Why do some people respond better to your approach than others? Understanding the psychology of behaviour is explored in this second article that reviews patient motivation and we discuss how certain strategies can be used in a dental setting to initiate and support behavioural change.

It is widely accepted that brushing for at least 2 minutes twice a day with fluoride toothpaste can contribute to good oral hygiene, yet such behaviour is frequently lacking (Eaton, 2008). It appears straightforward advice, yet most people don't follow it. So why is it that some patients apparently ignore simple instructions, despite the fact that your advice will benefit their oral health?

Belief structure

Attitudes and beliefs are thought to be major determinants of health behaviour and the logic of risk-benefit may not be very important in deciding behaviour. For example, a study of smokers who had already experienced a myocardial infarction showed that only about half managed to successfully quit (Taylor, 1990). Evidently, habits are hard to change even when the consequences are known.

One of the major challenges facing dental practitioners in this respect relates to the patient's ability to appreciate how ongoing repetitive effort now will give benefits



to their oral health in the longer term. Therefore, if you are trying to motivate your patients to modify their behaviour, for example, to follow a different oral hygiene regimen, you may have to alter the underlying beliefs and feelings associated with that behaviour.

Developed by social psychologists in the United States to understand why people do not take action to improve their health, the **Health Belief Model** (see next page) theorises that behavioural change is a balance of four beliefs: perceived susceptibility, perceived severity, perceived benefits and perceived barriers (Janz, 1984). People are more likely to be motivated to take a course of action that will promote their health if they believe a combination of factors: 1. they are at risk of a disease (susceptibility); 2. the disease has a negative impact on their health (severity); 3. a particular behaviour will improve their quality of life (benefits) and 4. there are only a few negative aspects of adopting that behaviour (barriers).



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The Health Belief Model

Applying the Health Belief Model to patients with periodontal disease, Chapple and Hill (2008) suggested the following:

- **perceived susceptibility** (subjective perception of the risk of getting the disease) = Am I personally susceptible to this disease?
- **perceived severity** (a person's subjective evaluation of the impact of the disease or consequences of the illness) = How bad is the disease and what are the consequences of me getting it?
- **perceived benefits** (subjective evaluation of the effectiveness of various actions available to reduce the threat) = If I brush my teeth, will I keep my teeth and will this improve my quality of life?
- **perceived barriers** (a person's anticipated negative aspects of a particular behaviour) = I don't have time to floss everyday; the cost of the products I've been recommended is really high.

Therefore, it is important not to simply assume that a diagnosis of a health problem is sufficiently motivating to bring about a shift in behaviour. Clearly, patients are likely to be highly motivated to seek and pay for treatment to avoid pain – if they have a toothache or a loose filling. Conversely, they may be less motivated to pay for a new crown if the old one is not causing trouble, even if you provide a detailed description of the problems that could potentially arise if the old crown is neglected. Instead a different approach, if they are not experiencing any pain, would be to focus on the anticipation of gain. Paying for a crown may not be exciting but treatment that results in a better smile, and stronger and whiter teeth might be.

Modelling change

The **'Stages of Change' Model** developed by DiClemente and Prochaska (1991) provides some useful insights into the behavioural change process (see figure 1 and next page). These two psychologists studied smokers and how they gave up their habit in the 1980s, finding that people work through six different stages at their own pace.

The model has been successfully applied to a whole range of behaviours including weight loss, injury prevention and overcoming alcohol and drug addiction. If you apply it to your patients, it will help you to understand that behaviour changes rarely take place immediately and as a single, discrete event.

For example, people with chronic dental problems cannot jump from Pre-contemplation to Maintenance. The stages are based upon measures of

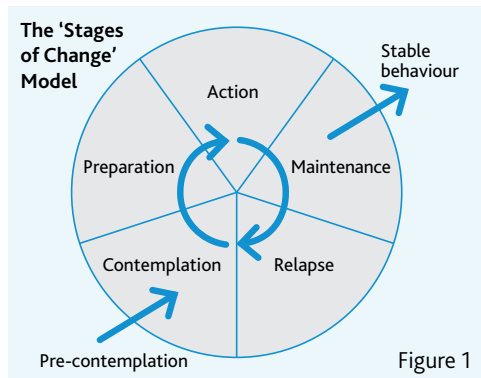


Figure 1

readiness to change, which include the degree of ambivalence, e.g. if your patient is in the Pre-contemplation stage, they won't have acknowledged they have a problem and may not be ready or willing to adopt the new behaviour.

For most individuals, a change in behaviour occurs gradually, with the patient moving from being uninterested, unaware or unwilling to make a change (Pre-contemplation), to considering a change (Contemplation), to deciding and preparing to make a change (Preparation). The decision to move to the next stage is an internal one – stable, long-term change cannot be externally imposed. Determined action is then taken and over time attempts to maintain the new behaviour occur. Relapses are almost inevitable and become part of the process of working towards life-long change.

Managing the process

Once you have developed an awareness of a patient's belief structure and attitudes to their health and well-being as well as an understanding of the process of behavioural change, the next step is to provide your patients with the appropriate help and support to motivate change.



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Stages of Change Model

This identifies six different stages of change (see figure 1).

Stage 1: Pre-contemplation – the individual who does not want to change his behaviour or is not aware or has not yet acknowledged that there is a reason why he needs to change his behaviour.

Stage 2: Contemplation – the individual acknowledges that there is a problem but is not yet ready or is uncertain whether he wants to change. He may be weighing up the pros and cons of changing.

Stage 3: Preparation – the individual is ready to change. The practitioner should be aware of this and help him to set realistic targets, without getting him to change too much too quickly.

Stage 4: Action/Willpower – the individual is in the process of trying to change.

Stage 5: Maintenance – the individual may have succeeded in changing his behaviour but still needs encouragement and support.

Stage 6: Relapse – on the way to permanent behaviour change, most people relapse *at least once*, returning to older behaviours and abandoning the new changes. When this occurs, the individual will have to start back at the Contemplation stage and continue the cycle on from there until he reaches the desired Maintenance stage once more.

Motivational interviewing (MI) is a cognitive behavioural technique which has been used as a tool for enhancing behaviour changes.

Based on the 'Stages of Change' Model, it focuses on uncovering the reason or reasons for engaging in a particular behaviour and when used correctly, this technique encourages patients to identify their oral health needs and the issues that may affect their attempt to change (Freeman, 1999). MI has five principles which can help to address ambivalence and facilitate the change process (Miller, 1991):

- express empathy – helps to engage with the patient
- develop discrepancy – identify where the patient is health-wise and where they want to be
- avoid argument – it is counterproductive
- roll with resistance – gently challenge thought processes that underlie the behaviour
- support self-efficacy – encourage the patient to believe that they can change their behaviour and that they will achieve their desired benefit.



can be helpful. A study of 157 university students showed that the only significant predictor of flossing change was 'planning' the implementation of the flossing regimen by using 'if-then' action plans. This involves planning that if one is unable to floss in the evening, then placing the floss by the toothbrush will ensure that flossing happens in the morning (Schüz, 2006). If patients are in the Action stage, then discussing with them what to do about their flossing regimen when their routine changes and they go on holiday, for example, can help ease changes in self-care behaviours.

The techniques described above, together with patients' readiness to change should enable patients to develop their own

Patients may not understand the need to make the investment now in order to achieve longer-term gain.

As readiness to change is also a vital part of the behaviour change process, planning what to do with regard to possible barriers

health priorities. If you have identified that your patient is not yet ready to change, the MI can be tailored to the individual

Good communication and education

Good communication is central to motivating change using a concordant approach. This is discussed in two further articles 'Why does communication sometimes fail?' and 'Top tips for successful communication'. In terms of patient education, this may require additional intervention than simply conveying a health message and imparting knowledge so that patients can understand the long-term benefits of your advice. For example, supporting your patients with leaflets or providing specific skills training, such as demonstrating tooth brushing technique, may be required to reinforce your message. Taking account of the different ways in which people learn and acquire information is also important (refer to the article 'What makes your patient tick?' for more information).

and when the time is right a personalised preventative regimen can be developed (Freeman, 1999).

Producing lasting and effective changes in health behaviours is however, not about being prescriptive but is about participation and empowerment for the patient to make any necessary changes in their own lives.

Practitioners need to develop techniques to assist patients who will benefit from behaviour change. The traditional method of imparting advice and education does not work with all



patients. Understanding the stages which are passed through in the process of successfully changing behaviour can enable you to tailor interventions individually.

Further information

For further information about concordance as an approach for understanding patient motivation, refer to 'Why don't patients always follow advice?'. Three further articles on effective communication to help get your message across and two slide decks on patient motivation and communication are also provided within the Patient focus section.

References

- Chapple ILC, Hill K. Getting the message across to periodontitis patients: the role of personalized biofeedback. *Int Dent J* 2009; **58**: 294–306.
- DiClemente CC, Prochaska JO, Fairhurst SK et al. The process of smoking cessation: an analysis of precontemplation, contemplation and preparation stages of change. *J Consulting Clin Psychol* 1991; **59**: 295–304.
- Eaton KA, Carlile MJ. Tooth brushing behaviour in Europe: opportunities for dental public health. *Int Dent J* 2008; **58**: 287–293.
- Freeman R. The psychology of dental patient care. 10. Strategies for motivating the non-compliant patient. *Brit Dent J* 1999; **187**: 307–312.
- Janz NK, Becker MH. The Health Belief Model: A decade later. *Health Education Quarterly* 1984; **11**: 1–47.
- Miller WR, Rollnick S (1991). *Motivational interviewing*. 1st edn. New York, London: Guilford Press, 51–63.
- Schüz B, Sniehotta FF, Wiederman A, Seemann R. Adherence to a daily flossing regimen in university students: effects of planning when, where, how and what to do in the face of barriers. *J Clin Periodontol* 2006; **33**: 612–619.
- Taylor CB, Houston-Miller N, Killen JD, DeBusk RF. Smoking cessation after acute myocardial infarction: effects of a nurse-managed intervention. *Ann Intern Med*. 1990; **113**(2): 118–123.

