

Professional Oral Care Needs Further Evidence on Health Behaviour Change Outcomes

Health education approaches provided by oral health professionals are often seen as being ineffective in changing patient behaviour. Especially in periodontal care, conventional oral hygiene instructions frequently have no long-term effect and must thus be repeated. Considerable behavioural research suggests that the root of this common problem can be traced back to a false assumption inherent in the health education approach itself: one assumes that behavioural change is simply a function of the patient having acquired the requisite knowledge or understanding from the given professional, in this case, the practitioner.

In contrast to educational approaches, however, more empathic behavioural support such as Motivational Interviewing (MI) is based on a different assumption of human behavioural change. It concludes that mere knowledge itself is insufficient to bring about behavioural change and that motivation to change is elicited from within the patient rather than externally imposed upon the patient by a practitioner. MI has been defined as 'a client-centred, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence'.¹ By eliciting and elaborating upon the patient's own reasons for change, the motivation for change is intrinsic or internal, rather than externally imposed.

Interestingly, soon after MI received attention in both general medical practice and clinical research, the founders, Miller and Rollnick, felt the need to additionally publish an article entitled 'What is Motivational Interviewing and what is it not?' In order to clarify their message to both researchers and clinicians, the authors stated that MI is not: 'i) the transtheoretical model of change (pre-contemplation, contemplation, preparation, action) as introduced by Prochaska and DiClemente³; ii) a way of tricking people into doing what you want them to do; iii) a specific technique; iv) a decisional balance; v) an assessment feedback; vi) a cognitive-behaviour therapy; vii) a client-centred therapy; viii) easy to learn; ix) practice as usual; and x) a panacea'.²

It is essential for both the clinician and the researcher to know the basic principles of health-behaviour change interventions in order to evaluate

the outcome of a certain counselling intervention used in clinical practice. Consequently, in order to clarify the behavioural interventions provided, future investigations in periodontal care should provide clear descriptions of the patients' health-behaviour change characteristics at baseline and any follow-up, such as awareness of the necessity for change, readiness to change (motivation, self-efficacy), resistance towards change, or ambivalence.

Additionally, specific information on how the consultation was structured should be recorded in future periodontal trials using behavioural interventions for patient counselling. In particular, a description on how the oral health professional was attempting to engage the patients should be reported in order to clearly describe what was done to: 1) establish rapport with the patient, 2) develop discrepancy, 3) roll with resistance, 4) resolve ambivalence, 5) elicit change talk, and 6) support self-efficacy (resources).

Researchers evaluating the impact of behavioural interventions in oral health care, reviewers of scientific articles and editors of dental journals should be aware of these matters. Thus, publications incorporating health-behaviour change interventions should be scrutinised by reviewers to ensure proper labelling of the methods used. Only clarity about what does (and does not) constitute behavioural counselling in both periodontal research and clinical practice can promote quality assurance in scientific research, practice, and training.

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