

# The Dental Hygienist's Role in Patient Home-Care Motivation



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"Motivation is not a force that can be used on others; motivation must come from the self."\* Or to quote Maureen Forcier, RDH, who has been in clinical practice for almost 40 years, much of it in periodontal practices, "the patient's got to want to do it!"

Prior to any meaningful behavioral changes taking place, the patient must perceive a reason for them to occur. And prior to that, the dental hygienist must be motivated to help the patient identify such reasons.

The purpose of this supplement is to equip the dental hygienist with some of the theoretical and practical keys to motivation, so that he or she can unlock for patients the doors leading to learning and change.

\*Huntley DE: Five principles of patient education. *Dental Hygiene* 1979;53:420-423.

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# Communication: The Key to Motivation

All communication occurs as a chain of events. There is a *sender*, a *message* that travels through a *channel* to a *receiver*. Communication can break down at any point in this chain. One factor that affects the success of communication is how the sender speaks—volume, tone, vocabulary, and proximity to the receiver. A second factor is how threatening, ill-timed, or garbled the message is. The clarity of the channel affects communication because if the channel is blocked by the receiver—whether due to a hearing deficit or anxious feelings—it could prevent the message from being received. Finally, whether the receiver perceives the message as negative, positive, or critical contributes to the message's successful or unsuccessful delivery.

For communication to be successful everything in the chain has to work, and there are many opportunities for a link to

break. For example, if a patient who is very nervous comes into the office, the basic need for security has not been met. Prior to any home-care instructions being given, the patient must be made to feel comfortable. Otherwise the communication channel is blocked by anxiety. When a patient comes into the office looking tired or harried, it could be because of a fight with a spouse or stress at work.

We need to take that extra time to find out if there is a problem. Doing that will ultimately save both the dental hygienist and the patient time and discomfort. The first link in the communication chain that we need to be aware of is the patient's state of mind at the time of the appointment. Not an easy task!

Communication is a two-way street. Our first impressions of others are based upon certain constructs that we have developed over time. Constructs are hypotheses or concepts by which each of us judges other people. In addition to comprising the sum of our current and past experiences, impressions are based on verbal and nonverbal cues. In fact, nonverbal cues make up 80% of most of our interpersonal messages.<sup>1</sup> Sometimes our concepts lead us toward accurate perceptions of others, and sometimes to stereotypes. For example, one may perceive all older adults as

frail, forgetful, and unable to learn new techniques. Our concepts both influence and are influenced by our perceptions of others. All perception is selective, based on our past experience, values, and our current physical and psychological condition.

Therefore, our behaviors differ from one interactive context to another.<sup>2</sup>

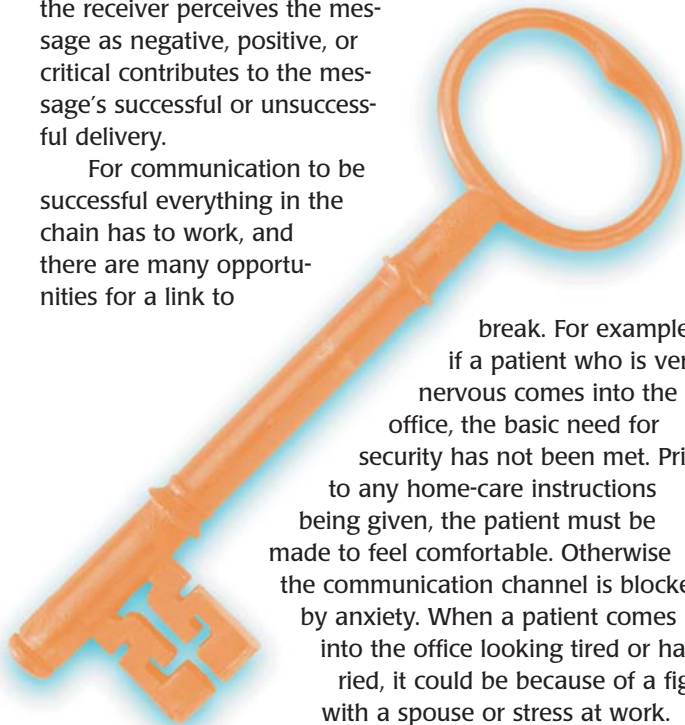
## Internal and External Factors

The channel for our message can be blocked in many ways. The internal factors (what is going on inside the patient's mind) that prevent our message from getting through are the most important, and the most difficult to change. We are all carrying internal baggage—messages—that we have been given or picked up throughout life. Our communication with and opinion of others start before a word is said. The first few minutes of an encounter with a patient are the most important, as it is difficult to alter a first impression.<sup>3</sup> Was there a smile? Were you put off by how the patient looked or was dressed? Did the patient feel that you looked angry? Did you decide that the patient wasn't going to be receptive to your message? Did we stereotype each other? Without realizing it, before a word has been exchanged, both the patient and the dental hygienist have formed opinions about each other that will either facilitate communication or prevent our message from getting through as we wish.

You and your patient have been sending nonverbal messages since you first saw each other. Then you begin sending verbal messages. Is our greeting friendly and relaxed, and does this patient perceive it that way? Do you speak and act as rushed as you may often feel? How carefully have you phrased your message? Is it an authoritative command, or a collaborative suggestion? Is it threatening or friendly?

What we do, as dental hygienists, is definitely threatening to many of our patients! As hygienists, we are constantly invading someone else's "personal space." Our profession requires us to work within that distance reserved for the most intimate of contacts. To be effective, we must enter the individual's "safety zone." It is important to remember this fact and the discomfort that this might cause for many people. Physical proximity, in and of itself, is enough to block our communication. In order to feel safe, some individuals will block out everything we do or say. This does not mean the patient will never hear our message, but that getting the message through might take longer than if the patient felt safe and receptive. In this case, the message can be given in a different manner, and in a different space. When giving instructions, we may need to sit further away from the patient in order to keep a "safe distance," to respect the patient's personal boundaries.

In addition to personal constructs and conceptions, and the role of perception on the part of the sender and the



receiver of a message, are external factors. What external factors might affect our message and the ability to motivate the patient? Is the patient physically comfortable in the chair, distracted by noise or movement, or bothered by the type or loudness of the music?

## The Importance of Feedback

Any or all of these factors may be interfering with the channel of communication or the ability of the dental hygienist to successfully motivate the patient. How will we know if anything “got through”? In order to be effective, communication must be interactional. This means that the sender not only sends messages but listens for and receives feedback. Otherwise there is no way to know if the message that we have intended to send has been “received” and understood as we intended. Feedback is a response by the receiver to the sender’s message.<sup>2</sup> Feedback allows us to know if and how the message (input) that was sent was received or whether it was blocked. Feedback could be con-

sidered a return message to the sender which conveys information about the effectiveness of a previous message. The feedback provides us with information to modify and regulate our subsequent messages (output), leading to the development or change in the communication.<sup>2</sup>

Countless internal and external limitations may exist at every patient appointment. The dental hygienist must determine which ones are within his or her control to remedy, and which ones are not, realizing that any factors interfering with the channel of communication may affect the dental hygienist’s ability to motivate the patient successfully. Listening carefully to the patient’s feedback will help indicate whether the message we intended to send was received by the patient.

### Notes

1. Leib-Brilhart B: *Communication 301*, Fairfax, VA, George Mason University, 1988.
2. Hargie ODW (Ed.): *The Handbook of Communication Skills*, 2nd edition. New York, Routledge Publishing, 1997.
3. Broome B (Ed.): *Understanding Relationships: Selected Readings in Interpersonal Communication*. Dubuque, IA, Kendall Hunt, 1986.

## Applying Maslow’s Hierarchy of Needs to Effective Communication

An understanding of Maslow’s five-level model for a hierarchy of needs is important for developing motivational skills. According to Maslow, human needs have different priorities. As each is met, a person is motivated to fulfill the next need in the hierarchy, until achieving the highest level of being: self-actualization.<sup>1</sup> At the base of the hierarchy are the physiological needs that must be met for the individual’s basic survival—food, water, and shelter. The next level represents an individual’s “security needs”—safety, health, freedom from fear, freedom from pain. Patients who are frightened or in pain must have their security and physical comfort needs met first; only then can psychological needs be addressed.

The psychological needs of the dental hygiene patient are most often utilized to motivate the patient’s compliance with home care. “Belongingness” and love needs—to affiliate with others, to be accepted, and to feel a part of a group—are the most basic of these “socialization” needs.

As one moves toward self-actualization, the next level includes self-esteem, a need to be competent and gain approval and recognition. At the highest level on the hierarchy are self-actualization needs: to find self-fulfillment and realize one’s potential.<sup>1,2</sup> Adults are most often motivated by self-esteem and self-actualization needs; whereas, children, especially teenagers, are driven to meet social and self-esteem needs.<sup>3</sup>

Oral health care personnel, including dental hygienists, are most often taught to observe and fulfill the physical needs, but the psychological needs are of equal or of even more importance when it comes to patient motivation, and may be more difficult to discover and understand. For most patients, their own perceived needs will assume a much more important position (thereby, being more likely to be acted upon), than those needs that the hygienist points out to them. In patient motivation, it is up to the dental hygienist to find out what is most meaningful to the patient, working not only to help the patient fulfill those needs, but to help the patient attach similar meaning to the needs that the dental hygienist feels are most important.

Motivation and understanding are the keys to initiating and maintaining any lasting behavioral change, and it is up to the dental hygienist to provide them to each patient. The most successful motivation is based on two principles: an understanding of the psychological needs of the patient, and developing the patient’s understanding of the problem and of the benefits of any ensuing behavioral changes. The patient must perceive the changes to be necessary. Motivation is self-induced and must come from within.

### Notes

1. Maslow AH: *Motivation and Personality*. New York, Harper and Row, 1970.
2. Papalia DE, Olds SW: *Psychology*, 2nd edition. New York, McGraw-Hill Book Company, 1988.
3. Huntley DE: Five principles of patient education. *Dental Hygiene* 1979;53:420-423.

# Know Your Patient's Personality Type

In order to achieve effective patient motivation we need to know what drives our patient, what “key” will unlock a particular individual. There are five basic factors that are internal, or personality-based, which motivate a person. These motivational areas can be classified as 1) money, 2) self-preservation, 3) power/recognition, 4) romance/social, 5) popularity/pleasing others.\*

We have all seen patients whose underlying concern is money. For example, someone who has lived during the depression but is now easily able to afford a procedure, may insist that they can't, that everything “costs too much.” Others place value only on something that “shows”—they would easily spend money on a pair of shoes, or on jewelry, but not on their oral health, which nobody's going to see. Patients motivated by money are most easily swayed by effectiveness of oral health care—the idea that the procedure will save money later. In order to be motivated, these patients must be convinced of the importance of the product or service which you are selling.

Self-preservation is a key motivator for people who are interested in whatever will keep them healthy. Sometimes fear of disease or disability drives them. They are often “naturals” for home-care instruction compliance, once they understand the function and importance of our instructions for keeping the teeth and periodontal structures healthy. Already very health conscious, many will be aware of the latest health information, and expect us to be well-informed and current on the latest techniques in oral health maintenance and disease prevention. They appreciate being shown new products, and informed about what you have learned from the continuing education seminars that you have attended or current literature you have read. Sharing such information with these patients is often quite helpful in motivating them to comply with or try new home-care procedures. These patients may be among the most easily and successfully motivated.

Then, there are patients who demand recognition of their own power. Frequently, these people work in positions of power, and want you to know that they are “in control.” They are often referred to as “Type A personalities” and their time is very important. These are the patients who arrive late and immediately ask “how long is this going to take,” the implication being that however long it takes, it is too long. Each of their appointments “must” be completed on time. These patients do not want to be “bothered” with home-care instructions since they “already know how to do that” and they've “heard it before.” These can be the most frustrating patients. When they need to be informed about the poor condition of their mouths, it has to be done very

carefully, as they generally will be offended if told they are doing less than adequate home care. However, since they truly don't want their time wasted, information presented concisely, with cause-and-effect shown efficiently, is effective, especially if put in terms of how much time a procedure can save them. These patients must feel in control, and will not comply with home-care instructions if they don't believe that they have initiated the action and are making the decisions about what they will or will not do.

Patients motivated by “romance” or feelings related to social—self-esteem and self-actualization—needs often are interested in looking good, staying young-looking, and doing what makes them feel good about themselves. Many “baby boomers” are a natural market for “look good, feel good” services. A sense of social identification, of doing what's “in” sometimes works to motivate these patients. Often, these are the patients most concerned about their breath or their looks; initially, they might be more interested in aesthetic procedures than preventive maintenance. Their home-care instructions can best be phrased in terms of not only what they need to do for their health but also how it will make them look younger and feel better. We must stress the home-care benefits that appeal to those self-esteem and self-actualization needs. It's important to notice and comment on their efforts at home care. Praise them by telling them how their attention to your home-care instructions has improved the look of their teeth.

Lastly, there are those patients who are “people pleasers”; they want to be liked by you and by everyone else. They, also, are interested in cosmetic improvements that will make them more “popular.” Their self-esteem and self-actualization needs include your approval, and sometimes they tell you they have been doing everything you have told

them to do, even though it is obvious they have not. Praise for the effort or any improvement on the part of these patients works won-

ders for continued home-care compliance. Point out how they can improve—in terms of how they can become “even more effective”—but always include positive commentary regarding what they have already accomplished.

*To achieve effective patient motivation we need to know what drives our patient, what “key” will unlock a particular individual.*

\*Personal communication with Beverly Dunn, DDS, August 1998.

# Developing Patient Ownership and Solutions

In order to be successfully motivated, all patients must feel a sense of ownership. The dental problem is in *their* mouth, and *they* must own the solution. As dental hygienists, we cannot “fix” the problem for them, but patients can neither manage nor develop opportunities to solve their problems unless they are able to identify and understand them. The first step is exploring and clarifying the patient’s problem. Patients need to “buy into” the problem as theirs and buy into any options that might be available to solve their problems. It is our responsibility to help them understand the options which are open to them, so that they have the knowledge they need to make informed decisions.

As patient educators in developing motivational programs for patient home care, dental hygienists need to know how adults learn. Knowles, in *The Adult Learner*, has formulated four basic axioms.<sup>1</sup>

- Adults need to know *why* they must know something before they are willing to invest the time and energy in learning it.<sup>1</sup>
- Adults are task-oriented in their learning, learning best those things learned in the context of using them to do what we *want* to do.<sup>1</sup> (As Maureen Forcier, RDH, puts it: “The patient’s got to want to do it!”)
- Adults come into any educational situation with a wide variety of backgrounds, experiences, prejudices, and abilities. *Start with what interests the patient.*<sup>1</sup>
- Adults have a deep psychological *need to be self-directing*. “We resent being talked down to, having decisions imposed on us, being controlled, directed and otherwise treated like children.”<sup>1</sup>

Help patients work things out for themselves with professional, caring concern. Develop the patient’s interest in the problem and the solutions. Patients’ interest in solving problems starts when they understand the ramifications of doing nothing—when they understand the outcomes of continuing on the course upon which they are headed, or of changing their oral health care behavior. The cost to themselves in terms of health, discomfort, time, and money must be clarified. Each patient must be helped to understand the benefits of taking action. Patients will generally seek to improve their situation if 1) they view the problem as serious or disturbing enough, 2) if they are committed to their personal health, and 3) they believe that the solutions offered are worth the time and effort spent, and will actually improve their condition.

Patient self-responsibility (ownership) is central to successful home-care motivation. Base goals and treatment



options on the patient’s understanding of the problem. Help the patient to look at the present situation and then look at preferred situations. Find out what action the patient is willing to take, and what “yes, buts” and blockages must be overcome. Find out the patient’s agenda.

The patient must “own” as much of the process as possible. In an interview which appeared in the *Journal of Practical Hygiene*, Irene Woodall made the same point by stating, “To encourage the partner-in-care relationship, the hygienist should educate patients and allow them to help plan their treatment. This is vital to motivate patients to accept responsibility for their own treatment and to develop enduring habits that will guarantee a healthier future.”<sup>2</sup> The goal is for the dental hygienist and the patient to become “cotherapists.”

## Notes

1. Knowles M: *The Adult Learner: A Neglected Species*, 3rd edition. Houston, TX, Gulf Publishing Company, 1984.
2. Rethman J: In the spotlight: Interview with Nancy Andrews, managing director of Woodall and Associates. *Journal of Practical Hygiene* 1998;7(3):14.

# Strategies for Achieving Goals— Treatment Planning

In treatment planning, the first step is listening to the patient. One needs to hear what the patient is saying and thinking without interrupting or prejudging. Without listening, we can't begin to understand the patient's point of view or frame of reference. We must understand the patient's viewpoint before we can try to change it. Changing habit patterns requires collaborative care planning. It is important to utilize feedback from patients to know how well what you have been saying has been received and understood. Patients can be helped to change their attitudes, assisting in the development of new perspectives on problems and solutions.

After looking at the present situation, the second step is enabling the patient to envision an improved situation. What does the patient want to happen? What do you, as the cotherapist, want to see change? How can you work together to create a treatment plan? In order to motivate patients to change habit patterns, not only do attitudes need to be changed but it is necessary to devise a variety of solutions to allow for flexibility. Once goals have been created, help patients critique them. To be successfully met, goals must be 1) clear, 2) specific, 3) realistic for the patient to attain, 4) directly capable of demonstrating some improvement in the patient's problem, and 5) able to be accomplished in a specific time frame.<sup>1</sup> The treatment plan will succeed only to the degree that the goals of the plan are realistic and obtainable.

The next step is to assist the patient in choosing goals, based on the priorities you have established together as cotherapists. Once the patient has done this, assist him or her in making a commitment to that choice. Having made a commitment, the patient is responsible for accomplishing the goals he or she has chosen. As cotherapists, we can help the patient identify incentives for keeping the commitment. If these steps are well negotiated and truly reflect the priorities of the patient, the scene is set for successful implementation of our goals. Now it is up to the dental hygienist to help the patient develop strategies to achieve the goals.

Patients may have a clearer idea of what they would like to accomplish without necessarily knowing how to reach their objective. Working with the patient, devise as many strategies as possible to achieve success. This increases the likelihood that one or a combination

of several methods will work for that patient. One of the reasons people fail to achieve goals is that they do not understand the various strategies for attaining the goals. It is up to the dental hygienist, as cotherapist, to help the patient choose the strategies that best fit the patient's needs, preferences, and resources (from both therapeutic and psychological standpoints). The dental hygienist and the patient, as a team, also need to consider what factors are likely to block the successful completion of the home-care procedures selected. Finally, these strategies need to be translated into a step-by-step plan that includes a time frame for implementation.<sup>1</sup>

Only after these steps have been completed can we begin teaching and demonstrating specific home-care procedures to the patient. In an article in *Dental Hygiene*, Diane Huntley presents five basic principles for patient education. The underlying principle of instruction is to present only as much information as the patient can understand and process at one time. If the person you are instructing is given too much information, or if something is blocking the ability to process the information that has been given, he or she is not going to remember it, let alone comply with the instruction. First check for internal and external barriers to communication, as well as any psychological and physical impediments. Information is best presented in small, concise chunks, in multiple forms (e.g., spoken, written, and demonstration).

Most of us tend to speak too quickly for the patient to assimilate the information we have presented. The second principle—going at the patient's pace, not yours—addresses this. Ask for feedback from the patient so you can verify his or her understanding of what you just explained. It is better to give less information that is clearly understood than to try to transmit a large amount of information that may go "in one ear and out the other." This is true also of teaching and demonstrating the actual physical skills, such as flossing, using a new appliance (e.g., an electric brush), or changing brushing techniques. By assessing the patient's ability and, if necessary, slowly teaching one skill at a time, the dental hygienist increases the patient's chances of success.

Supervising the patient's progress is the third teaching principle. The patient must demonstrate what you have taught. There is no other way for you to

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know how your instructions have been interpreted, and whether the patient has developed the skill correctly. Often patients believe or act as if they understand when they really haven't developed the skill. If the patient doesn't demonstrate a skill to your satisfaction, don't move on to a new skill until the old one is mastered.

The fourth principle has to do with feedback. Providing immediate feedback to patients helps prevent them from learning a technique or information incorrectly. Behavioral theory stresses the importance of feedback occurring as soon as possible after an action takes place.<sup>2</sup> If we wait until the patient's next appointment to evaluate what they are doing, they have had sufficient time to develop incorrect, possibly harmful techniques. Also, patients will often modify what they have been taught. The longer a habit is perpetuated, the more difficult it becomes to change. By supervising and giving immediate feedback, the dental hygienist may prevent incorrect performance from becoming a habit. For the patient to participate fully as a cotherapist, he or she must learn self-evaluation skills, such as checking the anterior teeth for remaining plaque after they have brushed, flossed, and rinsed.

Feedback must be provided in a nonjudgmental, supportive manner. Providing positive, rather than negative, reinforcement is the fifth principle. "Positive reinforcement is anything that increases the probability that a behavior will be repeated."<sup>3</sup>

Rosenberg, in Broome's *Understanding Relationships*, noted three axioms applicable to patient motivation and feedback.

1. We value those things at which we consider ourselves good—devaluing those at which we are poor.
2. We are more likely to listen to messages with which we agree.
3. We are more willing to expose ourselves to experiences at which we excel as opposed to those at which we feel we are a failure.<sup>4</sup>

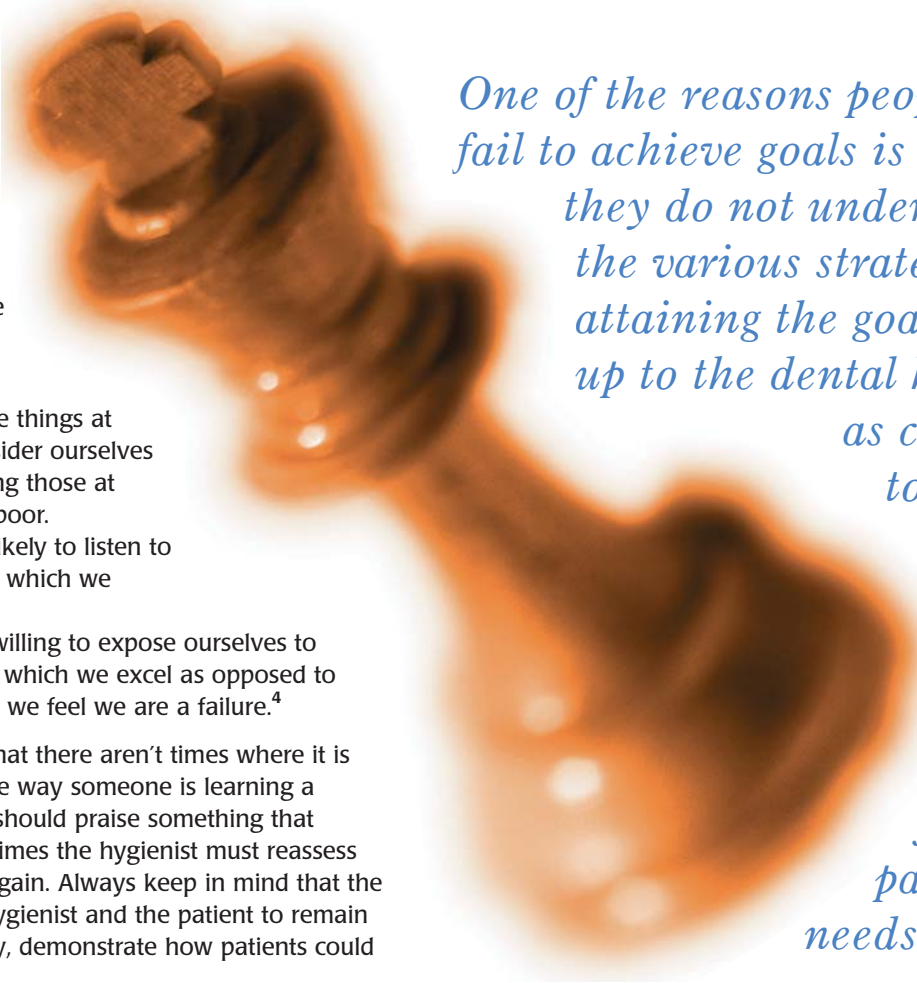
This is not to say that there aren't times where it is necessary to change the way someone is learning a technique, or that you should praise something that needs changing. Sometimes the hygienist must reassess a situation and begin again. Always keep in mind that the goal is for the dental hygienist and the patient to remain teammates. If necessary, demonstrate how patients could

"do something more effectively to accomplish the results they have worked so hard to achieve," rather than how they could do something better, which implies that they are not doing it correctly. The relationship as cotherapists needs to remain intact. One never wants to make the patient feel incompetent. Plan for success!

With the cotherapeutic relationship established and goals set, it is the professional's responsibility to teach the patient the skills. To be successful, we must educate patients as to what their needs are, the tools available to meet the needs, and how to use the tools. It is up to the dental hygienist not only to demonstrate for patients, but to make sure they understand what we have said, and to help them become proficient in the use of tools *to the best of their ability*.

## Notes

1. Egan G: *The Skilled Helper*, 3rd edition. Pacific Groove, CA, Brooks/Cole Publishing Company, 1986.
2. Papalia DE, Olds SW: *Psychology*, 2nd edition. New York, McGraw-Hill Book Company, 1988.
3. Huntley DE: Five principles of patient education. *Dental Hygiene* 1979;53:420-423.
4. Broome B (Ed.): *Understanding Relationships: Selected Readings in Interpersonal Communication*. Dubuque, IA, Kendall Hunt, 1986.



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# Products for Home Care: “Different Strokes for Different Folks”

There is an unbelievable plethora of oral health care products available today. Go into any grocery store or pharmacy and the array is overwhelming—there is literally something for everyone. A dental hygienist can and should use this abundance to tailor each and every home-care regimen specifically to the needs of the individual patients (see sidebar). Following is a discussion of different home-care product areas.

Toothbrushes and toothpastes seem to elicit the most requests for information from patients. Some of the factors to consider when selecting a manual brush are type of bristles, bristle arrangement, grip, and shape of brush head. Bristles come in natural and nylon; and hard, medium, and soft. Many years ago, hard, natural bristles were recommended. Today, we have come to understand that a soft-bristled, multitufted brush causes less damage to the gingiva

and is as effective for cleaning. Some brush heads are triangular, some rectangular, and there are differences in size. When it comes to brush heads, bigger is not necessarily better. It is up to us to suggest the brush that best fits the needs of the patient, considering the patient’s mouth size, ability to open, muscular configuration, and dexterity. Both manual and electric brushes now come with indicator bristles that alert the user that it is time to change brushes.

Electrically powered brushes are no longer considered a luxury. Beyond a shadow of a doubt, experience and research clearly demonstrate that powered brushes have a positive effect on the patient’s periodontal health.<sup>2-4</sup> Exhaustive laboratory and clinical testing demonstrate that powered toothbrushes are as effective as or more effective than manual toothbrushes, removing plaque more easily, faster, and more efficiently.<sup>2</sup> Powered brushes appear to solve many of the problems patients have complying effectively with home care when using manual toothbrushes. In addition, they have a proven motivational effect on patients’ home-care compliance.<sup>2-4</sup> When recommending a powered toothbrush, pay attention to the speed of vibration, and the direction of oscillation. Based on information from manufacturers and your own experience, you will learn which oscillation best addresses each patient’s dental needs. The cost of the unit, cost and availability of the replacement brushes, and the reputation for service and warranty on the part of the manufacturer are additional considerations.

Given the variety of toothpastes available and the claims their manufacturers make, no wonder patients are at a loss when choosing one. A recent article in *Consumer Reports* states, “Crest and Colgate alone account for more than 110 pastes and gels in various formulas, flavors, packages, and sizes.”<sup>5</sup> There are gels and pastes and powders: in some people gels tend to sensitize the teeth, especially if their teeth have just been bleached. Some people don’t like the consistency of paste, and for others, powder is too much effort. The choice of matrix can be based strictly on personal preference.

For those who form large quantities of calculus, “tartar control” toothpastes might reduce, soften, or slow the process. Tartar control toothpastes are available as gels and pastes; they contain pyrophosphates or other chemicals which slow tartar formation in some patients. Again, some individuals are sensitive to the tartar control gels. Several toothpastes reduce tooth sensitivity; these contain potassium nitrate or fluoride combinations.<sup>5</sup>

There are toothpastes designed specifically to fight gingivitis. Crest Gum Care uses a stannous fluoride compound as an antimicrobial. Colgate’s Total uses an antimicrobial formula containing triclosan which has been proven effective in product research.<sup>5,6</sup> However, in the August 1998 issue of



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*Nature International Weekly Journal of Science*, an article entitled “Triclosan Targets Lipid Synthesis,” expressed concern about the capability of triclosan to generate resistant strains of bacteria.<sup>6</sup>

There are toothpastes to whiten the teeth using a variety of ingredients, and there are toothpastes with baking soda. Chesebrough-Pond’s Mentadent is a fluoride toothpaste combining baking soda and peroxide in a specially patented container. There also are toothpastes containing only “natural” ingredients. If a patient tells you that something about a toothpaste bothers him or her, there are plenty of alternatives on the market with which to experiment. Don’t insist that the patient is imagining an unwanted effect, or that “no one’s ever had that happen.” *Consumer Reports* found that “used regularly—brushing for at least two minutes, twice a day—most...toothpastes will get rid of plaque and surface stains and deliver fluoride to fight cavities.”<sup>5</sup>

Fluoride is the single greatest decay preventative ever discovered. Fluorides offer not only the benefits of remineralization but antibacterial action as well. In addition to a variety of “in-office procedures,” toothpastes are a reliable source of fluoride for the patient. Most oral health care professionals agree that fluoride is the one ingredient that should be present in all toothpastes in the amount approved by the American Dental Association (ADA).<sup>5</sup> Since a young child could conceivably ingest more than the approved amount of fluoride, the amount of toothpaste that a young child is using should be carefully monitored; home fluoride rinses generally are not recommended for very young children. There are three different types of fluorides available in toothpastes—sodium fluoride (the most common), sodium monofluorophosphate, and stannous fluoride—and there are different types of fluoride therapies available for home use, depending upon the needs of the

## Multiple Methods of Teaching and Motivating the Patient

Developing patient motivation and compliance is a process. For patients to become interested in complying with their home care and able to do so effectively, they must feel confident and relaxed in the office and with the office personnel. The friendliness and continuity of the staff help the patient arrive at a certain comfort level with the office. If the patient believes in the quality of the professional care that he or she receives in the office, and that the staff is knowledgeable about current techniques and advances, the patient is much more likely to hear what you are saying, believe in it, and become compliant.

The first step toward patients’ understanding their own oral health needs is to see the manifestations of their oral condition in a mirror or with the use of an intraoral camera. Such devices are probably among the most effective teaching aids any dental office could have. One almost always hears the patient gasp when they see their own mouth “in living color.” It really gets the patient’s attention! Send the patient home with a printout of the image—in addition to giving him or her something to think about, it offers a visual reminder of what needs to be done. It is well documented that intraoral cameras often prompt increased acceptance of treatment recommendations.<sup>1</sup> Visualization of his or her treatment needs helps the patient to make an informed decision which increases not only compliance, but also feelings of ownership of the problem—and the solution as well.

There are video tapes available that describe many of the solutions to various patient needs, such as crowns

and bridges, veneers, bleaching, bonding, implants, and orthodontics to name a few. Intraoral cameras, videos, and computer graphics are just a few of the new technologies we can utilize to inform patients and help erase the mystique and fear of dental procedures. Viewing a treatment option is a first step that allows patients to become informed consumers, ask intelligent questions, and begin to understand the procedure. It is more effective when a patient views a procedure than it is when he or she is just given the information about a procedure.

If you wish the patient to use a specific product or technique, it is most effective to demonstrate it by using it on the patient. Then have the patient demonstrate it back to you. Have patients watch themselves in the mirror. Give and receive feedback. If possible, use an intraoral camera to take a photo of the technique being demonstrated so that the patient can refer to it while performing home care. A video demonstrating the technique also is helpful. The most requested videos seem to be those on correct brushing and flossing.

If you are suggesting a product, send a sample home with the patient. Include clearly printed information such as the name of the product, where to obtain it, and how and when to use it. Think about making products available in the office. Although some patients will resent it, feeling that you have become a “salesperson,” many find this helpful. As with all other decisions, it is important for patients to maintain control over the decision concerning which products they want to use.

### Note

1. Palmer PR: New technology in oral health care. *Access* 1998;12(6):24-32.

patient. For a patient at low risk for decay, living in an area with fluoridated water, a fluoride paste may be adequate. For those at moderate risk, the daily use of a 0.05% NaF fluoride rinse might be enough protection, and are available in alcohol-free formulations.

As the population has aged, there are many more patients who would benefit from in-home fluoride therapy. Changes associated with aging, such as thickened saliva, gingival recession, medications and related xerostomia, and disease processes and treatments associated with cancer are a few of the factors that change the flow, and thereby the natural cleansing action, of saliva.<sup>7</sup> Also, the older patient's diet sometimes contains fewer crunchy or cleansing foods—as opposed to foods that break down into starches, which stick to the teeth and are more likely to produce plaque. In addition, since most people over the age of 50 did not grow up with fluoride in the water supply, they are at greater risk



*Given the variety of toothpastes available and the claims their manufacturers make, no wonder patients are at a loss when choosing one.*

of decay. For patients with moderate-to-high risk, a 0.4% SnF<sub>2</sub> fluoride application is often recommended. Studies have associated remineralization and prevention of root caries with the regular use of a SnF<sub>2</sub> fluoride product. It has also been shown to change bacterial growth and plaque indices. In addition, dentinal hypersensitivity has been proven to decrease with the use of 0.4% SnF<sub>2</sub>.<sup>8</sup> For patients at the highest risk for caries, e.g. those with radiation- or chemotherapy-induced xerostomia, the highest concentration of self-applied fluoride is provided in a 1.1% NaF fluoride gel delivered by a custom made tray. "Studies utilizing the custom-tray technique show dramatic results in rampant caries control."<sup>8</sup>

Ease of delivery, preference as to taste and delivery system, and ability and willingness of the patient to comply to a particular home-care routine must be considered. It is suggested that patients in nursing homes for whom tray delivery of fluorides is not possible have their teeth brushed with a 0.4% SnF<sub>2</sub> strength fluoride toothpaste and/or utilize a fluoride rinse to brush the teeth and lavage the mouth (if they

no longer have the ability to rinse the paste from the mouth).

There is a large variety of mouthrinses—all carrying different claims as to what the product is supposed to accomplish. They were originally designed as "mouth deodorizers" to improve "bad breath." We now understand that the underlying cause of malodorous breath must be discovered and treated in order for improvement to occur. There are mouthrinses that have antimicrobial properties. Listerine, used as directed, has ADA approval as an antimicrobial. It is the only over-the-counter product to have this rating. Stannous fluoride products and products containing chlorhexidine are the most effective antimicrobials. These usually are available only by prescription. Antiplaque rinses were thought to be promising when first discovered, but did not really seem to do what everyone thought they would.

Oral lubricants can help improve the quality of life for people with diminished salivary flow. Salivart is sold over the counter, but there are numerous products with varying degrees of efficacy about which each dental hygienist should be aware. If one brand doesn't work for a particular patient, try another. Hopefully you will have been able to obtain information about and a sample of each one so that you can solicit feedback from the patient as to how well the product worked for him or her. These products tend to be somewhat expensive, but can be very effective. Anyone who has poor salivary flow due to medication, chemotherapy, radiation, Sjögren's syndrome, or for any other reason should be encouraged to try one.

Flossing appears to be the area of greatest patient non-compliance. "A study by Wilson, et al. revealed that only 16% of 961 periodontal patients followed over an eight-year period, complied with the recommended maintenance schedules."<sup>9</sup> The results of this study are an excellent example of how different our perceived ideal can be from clinical reality.<sup>9</sup> Any product or technique that can demonstrably make flossing easier will be more likely to make it actually happen! There are many different types of floss (besides waxed or unwaxed) with different thicknesses, filaments, and coatings. They are available at the trade shows; try them in your own mouth. If a patient is resistant to flossing, find out why. Explore probable causes of the problem, and suggest several products which might help. If the problem is that the floss tends to shred and fray because it is difficult to insert between teeth, Oral-B has developed two new products to address these concerns, without being slippery and therefore difficult to hold. SATINfloss and SATINtape both have a unique ingredient to make them resistant to shredding: a soft, pliable polymer called Pebax.

Other products available to assist patients in being more successful with their interproximal cleaning include floss threaders, proxibrushes, rubber tip interdental stimulators, sulcus brushes, and a power-assisted device, InterClean by Braun Oral-B—all available at pharmacies and all types of stores. "Initial studies indicate that patients find this power-assisted product easier to use than manual flossing preferring it 2:1 over floss."<sup>9</sup> It has been deemed as effective as floss for removing plaque and reducing gingivitis.<sup>9</sup>

Among the other home-care products available for interproximal and subgingival cleansing are mechanical irrigating devices which can deliver antimicrobials when needed. These devices can be used to deliver a variety of solutions directly to the source of a problem, irrigate certain areas of the mouth, or lavage the whole mouth depending on the patient's specific needs. This is especially helpful when a patient has crown-and-bridge work or implants, or is unable for any reason to perform the necessary care effectively. For patients with dentures, several types of adhesive products are available in a variety of forms to help anchor dentures more securely in the mouth. Denture cleaners and brushes can help the patient clean removable partials and dentures.

While it is suggested that patients who wish to have their teeth whitened undergo this procedure under professional guidance in the dental office, there are products on the market to "whiten the teeth." None of these over-the-counter products have ADA approval, as they have not been tested by the Food and Drug Administration, and are considered to be "cosmetic" only. But patients do frequently ask about these products, and we should be prepared with answers.

Attending meetings where you can watch and listen to representatives of the various dental products companies demonstrate products and how to use them is most helpful. These representatives are a good resource for information if you have patients with specialized needs, or if you are hav-

ing any problems selecting or finding a product. Dental hygienists are advised to spend some time in the supermarket dental products aisle on a regular basis so that we are familiar with what is available for patients. The real challenge is to match the best products to the patient's specific needs.

## Notes

1. Palmer PR: New technology in oral health care. *Access* 1998;12(6):24-32.
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# Keeping Up the Momentum at Recall Appointments

Each time a patient returns for an appointment is time for a nonjudgmental evaluation. Motivational models are dependent upon feedback; patients must know that their efforts will be evaluated. Patients must know whether they are meeting the goals they have—with your help—established. Feedback must be phrased in positive terms (see sidebar). This is the single most important factor to remember when motivating or giving feedback. The patient's efforts as well as improvements should be praised. Don't wait until a patient perfects a skill to give a compliment. If patients' efforts are not recognized, most likely discouragement will occur and they will stop trying, especially if it is a skill they find difficult. Pointing out the patients' failures, while not mentioning their achievements, may cause the patient to feel that learning the desired skill isn't worth the effort. Behavior rewarded is more likely to recur.<sup>1</sup> Simply repeating instructions, without rewarding the patient's efforts, lowers self-esteem and will rarely lead to success.

There are at least eight characteristics of helpful non-threatening feedback.<sup>2</sup>

1. Feedback that is focused on the goal rather than the person. Demonstrate what needs to be done and how it can be most effectively achieved.
2. Feedback based on facts, observations rather than inferences.
3. Feedback focused on description rather than judgment; report to the patient what you see, not what you think about it.
4. Feedback focused on description of how nearly the goal has been met rather than on "good" or "bad."
5. Feedback focused on the sharing of information rather than on lecturing.
6. Feedback focused on the exploration of alternative solutions rather than having only one correct way of doing something.
7. Feedback focused on the amount of information the person receiving it can use, not on the amount of information you have or that you want the patient to receive.
8. Feedback focused on the value it may have to the patient, not necessarily for yourself.<sup>2</sup>



Show the patient areas needing improvement. If a patient is having a problem mastering a particular skill, show empathy and comment on the part of the process at which he or she is successful, even if it is only praise for the effort the patient has made. Commenting only on what is wrong, while not mentioning what the patient is doing correctly or improving upon, can only lead to feelings of defeat and low self-esteem for the patient. Threat and punishment (negative comments, in this case) can lead to avoidance of the behavior we are trying to encourage. “Whatever is to be learned will remain unlearnable if we believe that we cannot learn it or ...the learning situation is perceived as threatening.”<sup>1</sup>

Continue the patient’s education as cotherapist. Demonstrate new techniques which may improve the patient’s effectiveness; sometimes another way of doing a home-care routine must be worked out. Share new products, especially those designed to make home care easier, faster, and more successful. When planning and reevaluating the patient’s progress in home care, physical and cognitive abilities must be taken into account.

After reevaluating the goals originally established, it’s time to set new goals—perhaps redirecting the patient’s efforts in another area or continuing on the same path toward the original goals. Orient patients toward a home-care program at which they can be successful. The patient’s feelings of self-esteem must always be validated. In any program, success can be defined as progress, not perfection.

Today people are living longer, and they have a strong interest in living healthier, better lives. In 1996, over 13% of the population was over 65 years of age, according to data from the American Association of Retired Persons. With the aging of the “baby boomers,” this figure is expected to increase to over 20% by the year 2010, with the fastest

growing segments of the population being those between 74 and 85.<sup>3</sup> A greater number of these individuals are keeping their teeth, and will need our assistance in setting and achieving goals that address their changing needs.

As more studies are made public linking oral health to quality of life and to such medical conditions as heart

disease, diabetes, premature babies, and other serious health problems, people are becoming more aware of the link between their oral and general health. The more educated patients are concerning their role in maintaining their own oral health, the more interested they become in their own home care, and the better patients they become. Patients want to know what we as health professionals can do for them and what they can do to improve their own oral health. It is our responsibility to help motivate patients to be cotherapists in the successful maintenance of optimal oral health.

### “Don’ts and Caveats”

1. Don’t lecture.
2. Don’t insult the patient.
3. Don’t forget the “golden rule”: treat others with as much sensitivity and compassion as you would want to be treated.
4. Don’t hurt.

### Notes

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3. Meltzer L: How to help your elderly patients have a successful office visit. *Access* 1994;8(5):55-59.