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Editorial.

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Tobacco cessation counselling: Motivating clients to quit

Joan M. Davis, RDH, MS, CTTS

Though much has been done to discourage tobacco use through education, programs, policy, and law, people continue to use this toxic substance with known carcinogens—often leading to disease or even death.¹ According to the *Canadian Tobacco Use Monitoring Survey (CTUMS) 2009 half-year results*,² 17% of Canadians 15 years or older (approximately 4.8 million) reported currently smoking. In the US, an estimated 20.2% (or 46 million) of Americans 18 years or older smoked.³ Overall, smoking prevalence has not changed from the previous year in either country. One could ask—why not? Tobacco use often leads to a chemical dependence and the establishment of behavioural patterns leading to an addiction or habit that can be very difficult to stop.⁴

What we know about tobacco related oral health issues

Over the past sixty years, research has clearly demonstrated that the use of both smoked and, to a lesser degree, smokeless tobacco can lead to disabling disease or even death.¹ Even those smoking 1–4 cigarettes a day, light smokers or “chippers” have been shown to have a significantly higher risk of dying from heart disease than non smokers.⁵ In addition, profound oral health risks are associated with smoked tobacco including oral cancer, precancerous lesions⁶, periodontal disease^{7,8} increase in tooth loss, and implant failure^{6,9}. Smokeless tobacco use, though not containing many of the 4,000 harmful chemicals found in tobacco smoke, can lead to precancerous lesions, dental caries and gingival recession.⁶

In recent years researchers have explored the harmful oral effects of being exposed to passive smoking also called second hand or environmental smoke (ETS) on children. Erdemire et al.¹⁰ reported children exposed to ETS were found to have an elevated level of cotinine, a major metabolite of nicotine. Periodontally, these children had a lower clinical attachment level than children not exposed to tobacco smoke.¹⁰ Another study¹¹ showed an increase in the incidence of dental caries to be significant in 5 year olds. Interestingly, “even after adjustment for parental educational level, dietary and oral hygiene habits, a more than threefold elevated risk for caries associated with parental smoking was revealed in 5-year olds.”^{11p.255} Evidence is mounting that children are profoundly affected by exposure to ETS resulting in both general and oral health problems.

Tobacco cessation counselling in dental hygiene

As oral health professionals committed to health promotion and disease prevention, it may be time to take a step back and explore the concept of tobacco cessation counselling (TCC) and what it means. The often repeated US Public Health Service (PHS) *Treating Tobacco Use and Dependence 2008 Update*'s¹² five As (Ask, Advise, Assess, Assist, Arrange) or brief intervention counselling¹³ (BIC—Ask, Advise, Assist, Arrange) are considered a brief

intervention taking 3–5 minutes. A similar model is the *Ask, Advise and Refer* from the American Dental Hygiene Association where the tobacco using client is encouraged to quit then given “quit information”.¹⁴ At the heart of these models is to identify tobacco use then educate the client on the benefits of quitting. The PHS *Guideline*¹² reports those who receive even a brief tobacco intervention have a significant increase in reaching and maintaining long term abstinence. The *Guideline*¹² goes on to stress the likelihood of long term abstinence is even greater with counselling and medications. In 2004, Canadian Dental Hygienists Association published *The Tobacco Use Cessation Services and the Role of the Dental Hygienist – CDHA position paper*^{15p.1} where, among several recommendations, stated: “Dental hygienists can change clinical culture and clinical practice patterns so that every client who uses tobacco is identified and offered at least brief counselling”.

The spirit of motivational interviewing

While there may be many opinions as to what exactly entails effective tobacco cessation counselling, the intervention often involves more than imparting knowledge or education alone. Health education can be effective in motivating some to make a change in their health behaviour, but in others, it may cause *resistance* resulting in the classic response “Yes, but...”. When asked, healthcare providers often report client resistance as a barrier to offering tobacco use counselling. Could it be that at least some of the problem lies with the clinician rather than the client? Of PHS's five As, the first three¹²—*Asking, Advising* and *Assessing*—could be offered in two ways. To illustrate the direct educational way:

I see that you smoke. Your oral health is at risk and you really need to quit smoking in order to save your teeth.

The second way would be supportive, empathetic:

I see that you smoke, would it be OK if we talked a little more about it?

Advice would follow after a collaborative dialogue has been started. Which method would elicit defensiveness, and which would make a client feel at ease?

The theory of Motivational Interviewing (MI) has been extensively utilized in both clinical settings and research protocol. Psychologists first used this counselling technique to treat alcoholism.¹⁶ MI has been advocated as an effective client centred tool for healthcare providers when

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Dental
hygienist

Client

SAMPLE MOTIVATIONAL INTERVIEW

The simulation explores a conversation where tobacco smoke has compromised the health of the client, and oral pathology is present. The intent is to share how the “spirit” of MI may sound between a dental hygienist and a new dental client...

As the intervention evolves, both the clinician and client are engaged. They build trust through acceptance, empathy, and support, leading the client to more disclosure. This conversation could encourage the client to agree to a quit plan, or it could end in the client expressing interest in quitting but not quite ready to do so. Either way, a rapport is established which opens the way to further discussions at a later appointment.

Background: 41 year old female, smoker for 25 years, not interested in quitting

Oral Pathology/Condition: Abnormal leukoplakia

Oral Sign: White thickening of the mucosa discovered during an oral cancer screening

CESSATION INTERVENTION

Dental hygienist:	<i>Did you realize you had this change of tissue in your mouth?</i>	(Show with a mirror) Pause...Listen... (Creating awareness, inviting client's involvement)
Client:	<i>No! What causes that?</i>	Client becomes involved and seeks more information
Dental hygienist:	<i>Well, this change in the cells is related to your smoking. I know you said you were not interested in quitting right now, but would you mind talking a little bit about it now?</i>	(Asking permission) Pause...Listen...
Client:	<i>Yeah! I don't want to get cancer or anything. Is that what that is?</i>	Continued client involvement, information seeking questions—client leads
Dental hygienist:	<i>The toxins in the tobacco smoke have altered the cells in your mouth and the white area, or leukoplakia, is considered precancerous.</i>	Pause...Listen... (Providing targeted education without lecturing, righting)
Client:	<i>I had no idea! My uncle died of cancer and he suffered a lot. If I quit smoking, would that area go away?</i>	Silence – give the client time to think, reflect Client generated reflection moving closer to considering a behaviour change
Dental hygienist:	<i>This type of leukoplakia can disappear over time if you stop smoking. Have you tried to quit in the past?</i>	Exploring past quit attempts to understand better the struggles unique to the client
Client:	<i>Well, I quit for 6 months a few years ago...</i>	Client continues to be involved, not resistant or defensive – the clinician is listening, non judgmental, resisting the urge to educate
Dental hygienist:	<i>Tell me more about that. How were you able to succeed?</i>	Supporting past quit attempts, learning from the experience, building on what the client says—empowering
Client:	<i>Well, I used the patch, and it worked for a while but I went back to smoking. I suppose I could try that again...</i>	This is an example of Change Talk — use what the client has said to move the individual forward. The client needs to hear this rather than being told he or she needs to do it
Dental hygienist:	<i>It is great to hear that you had success with the patch! That is certainly an option you could choose to quit. Can you tell me a little about what started you to smoke again?</i>	Giving the client control over the quit plan, using the change talk Support, empathy, reflection, exploring specific triggers for the client

Table 1. The Spirit of Motivational Interviewing.

Collaborative	Partnership between patient and clinician, dancing rather than wrestling
Evocative	Elicit or bring out the patient's own motivation and resources for change
Honoring patient autonomy	Recognize it is the patient who makes their own decisions – the power is in their hands, the clinician cannot change anyone

Adapted from Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Healthcare: Helping Patients Change Behavior*. 2008;6–7.

treating behaviourally based chronic diseases,^{17–19} and encouraging good oral care.²⁰

Over thirty years of articles, books, and reports available on MI indicate significant improvement in patients' smoking behaviour.^{12,21–23} According to Miller and Rose,²¹ MI emphasizes two main components:

1) a *relational* component where empathy and interpersonal elements are used, and

2) a *technical* component where patients are encouraged to share their thoughts, preferences and ambivalence, allowing the clinician to move the conversation in a positive, health changing direction.

Emmons and Miller^{19p.70} state, "*Readiness to change is not a client trait but a fluctuating product of interpersonal interactions*", contending that clients do not stay in a static stage as described in the stages of change (precontemplation, contemplation, preparation, action maintenance).²⁴ The active interaction of eliciting, reflection, examining discrepancies then resolving them may move a client from precontemplation to preparation stage in just a few minutes. At the heart of MI is establishing a rapport and building a relationship of trust between clinician and client where the client is in control of his or her own health. This is especially important between oral health providers and their clients who seek dental care on an annual or semi annual basis over many years. If a client perceives a clinician as judgmental, policing bad behaviour, or another tobacco lecture, the client may immediately disregard the advice, or even change providers.

MI is considered a brief psychotherapy, and has numerous aspects and skill sets to learn. Though some of the basic concepts are not difficult, MI takes time, self awareness, and practice to gain mastery. In response to the time

Table 3. Motivational Interviewing resources.

Motivational Interviewing Org. www.motivationalinterview.org
<i>Motivational Interviewing in Healthcare: Helping Patients Change Behavior</i> (2008) by S. Rollnick, W. Miller and C. Butler. New York: Guilford Press. www.gilford.com
<i>Motivational Interviewing: Preparing People for Change</i> (1991) by W. Miller and S. Rollnick. New York: Guilford Press. www.gilford.com
<i>Building Motivational Interviewing Skills: A Practitioner Workbook</i> (2009) by D. Rosengren. New York: Guilford Press. www.gilford.com

constraints involved in client care, brief adaptations of MI requiring from 5 to 30 minute interventions have been introduced.¹⁹ Rollnick et al.²⁵ provide a practical approach to helping people change unhealthy behaviours without alienating them—within the time allotted for client care.²⁵ The authors offer a rich array of concepts, frameworks, and vignettes that clinicians can learn and practise on their own.²⁵ The "spirit" of MI is described as *collaborative, evocative* and *honoring* of client autonomy (Table 1). The client is viewed as an equal partner in the individual's health care, working out issues and making positive changes with the clinician acting as facilitator in the process. The guiding principles of MI are: *resist, understand, listen, and empower* (Table 2). Again, the clinician must relinquish the role of "authority and educator" and resist the urge to correct, or fix the "unmotivated or unknowledgeable" person.²⁵ Rather, by taking the stance of listening and understanding the client's motivation or reasons for change or not changing, the clinician can empower or give control back

Table 2. The Four Guiding Principles of Motivational Interviewing: RULE.

R: Resist the Righting Reflex	Resist the inner need to make things right, correct, often by education
U: Understand Your Patient's Motivation	It is the patient's own motivations (not ours) that are likely to trigger behaviour change
L: Listen to Your Patient	Listen at least as much as informing – often the answer lies within the patient
E: Empower Your Patient	Help patients explore how they can make difference in their own health

Adapted from Rollnick S, Miller WR, Butler CC. *Motivational Interviewing in Healthcare: Helping Patients Change Behavior*. 2008;8–10.

of the client.²⁵ For example: *You have five caries. You need to cut down on your sugar intake and brush your teeth more effectively.* Or,

I'm concerned that you have five caries this visit. Can you tell me about what you think may be happening here? (Pause, listen)

The first is accurate but authoritative, in one direction and almost certain to evoke defensiveness or rebuttal. The second educates, shows empathy, and provides an opportunity for self reflection, assessment, and client empowerment to direct the discussion. For resources on health behaviour change, see Table 3.

CONCLUSION

How can we be effective in helping our tobacco using clients quit? Addressing this behaviourally based chronic, relapsing disease from a client centred approach, clinicians can establish rapport and trust. This will empower and support clients as they make positive health choices in both the short and long term. As clinicians, we have the ability and opportunity to learn these proven techniques and skills that will help not only our tobacco cessation efforts, but all of our client interventions, breaking the cycle of chronic relapsing disease.

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