Training Material for the CHATTERBOX intervention

- Training session one: Communication skills workshop 1 & 2
- Training session two: PowerPoint presentation on use of CHATTERBOX

COMMUNICATION SKILLS

Workshop [1]
QUESTIONING, EXPLAINING AND LISTENING

INTRODUCTION

Six key elements of communication have been identified:

- understanding non-verbal communication
- listening
- helping people to talk
- asking questions and obtaining feedback
- accepting other people's feelings
- giving feedback.

The skills involved in questioning, explaining and listening are fundamental to interviewing techniques. Communication is usually thought of as a two way process in which the dental professional initially appears to be passive, listening and the patient active, talking. This is initially a difficult situation for both dental professional and patient, since the dental professional is usually active and the patient passive - an apparent reversal of roles. Further difficulties arise as the patient may feel that the dental professional is being critical or judgmental while the dental professional may feel that [s]he is being supportive and tactful in her approach.

Other problems arise, in communication, as a result of time in consultation and the confines of the dental surgery. Both of these can cause distortion of the communication process which can further be exacerbated by:-
The dental professional must listen actively, listening with the third ear.

Therefore whether questioning, explaining or listening to the patient the dental professional must actively use and perfect these skills.

**QUESTIONING**

Questions are used for finding out more about patients' needs, wants, feelings etc. Different types of question exist and lie along a continuum, with respect to category. Each of these question categories are used for different purposes (Figure 1).
OPEN QUESTIONS

[1] Open questions allow the patient to talk. The patient is in control and can bring as much or as little information they feel is necessary, or wish to impart, to the interview.

[2] Open questions allow the patient to set the agenda.

[3] Open questions allow the patient to ventilate their anxieties and concerns.

[4] Open questions are usually used at the beginning of an interview/conversation.


Examples: How have you been since we met last?

How are you doing?

How can I help you?

FOCUSED QUESTIONS
Focused questions help to guide the interview/conversation.

Focused questions help the patient to tell the health professional more about a topic they have difficulty in speaking about.

Focused questions often say "I appreciate that it is hard to tell me [an open intention] about subject x [guidance or direction] but you must try [support].

Examples: Tell me more about the pain, what is it like?

CLOSED QUESTIONS

Closed questions are important. They help to clarify important points brought to the interview/conversation by the patient.

Closed questions are sometimes described as YES/NO questions. Usually there is only a yes or no answer.

Closed questions are usually used late in the interview to clarify. If used too early in the conversation the patient will be unable to volunteer information and will just answer your questions in order to be helpful.

Examples: Its the tooth at the back that has been keeping you awake at night?

GENERAL GUIDELINES FOR QUESTIONING
[1] Take time to think before you speak.

[2] Move between open, focused, and closed questions during the conversation.

[3] Avoid jargon, however if used it is important to be sure that the patient understands you.


[5] LEADING QUESTIONS are to be avoided. The patient can feel so intimidated that even if they do not understand what you are saying they will say yes.

Example: The plaque around the teeth is causing the infection, you can see that can't you? [YES!].

**EXPLAINING**

Explaining or giving advice to patients, is fundamental to the work of the health professional. Explaining is also an integral part of negotiating health goals with clients, using such frameworks as SMARTIS or ARMPITS. Explanations must be clear, concise and to the point. Advice must be specific and precise.

Perhaps the most important thing about explaining is clarity: to be quite clear about your objectives. Some questions you might ask yourself before you talk to your client are:

[1] What changes do you want them to make?
[2] What you want your client to know, feel, be able to do?

GENERAL GUIDELINES FOR EXPLAINING AND GIVING ADVICE

[1] Be realistic in the objectives you set - give only 3 or 4 key points. 

[2] Advice and instructions should be given early in the session - most important information should be given first. 

[3] Emphasise those items you think are the most important - repeat key points. 


[5] Avoid jargon - make sure that technical words are understood. 

[6] Information is best given in a structured way. 

[7] Use visual aids [health education posters, mouth/tooth models] where possible, support what you are saying with a leaflet. 

[8] Put client/patient at ease by checking if they are dentally anxious or have any worries - be friendly - not officious. 

[9] Establish rapport, understanding and feedback. 

[TACADE "One to One"]
LISTENING AND NON-VERBAL COMMUNICATION

The third and most important of the communication skills is active listening. This is not simply hearing words being spoken but involves a concerted effort:-

• to listen to the way the words are said.

• to be conscious of the feelings underlying the words spoken.

• to recognise hidden feelings.

• to be aware of what is left unsaid.

Often the main task of the listener is to help the person to talk. Again specific skills are involved in this. These are:-

• encouraging the patient to talk.

• giving attention to what is being said - being interested in the patient.

• reflecting feelings - for instance you seem pleased, upset.

• paraphrasing - the patient’s words to clarify what they have been telling you.

• summing up - a brief re-statement of the main content and feelings the patient has alluded to during the interview.

Listening involves being aware of non-verbal communications. This is important since 65% of all social interactions are made up of non-verbal
communications. Non-verbal cues are more readily believed than verbal statements of intent - "actions speak louder than words" [Argyle 1973].

Some of the non-verbal aspects of communication which dental health professionals need to be aware of, since these can affect the clients' ability to cope with the dental experiences and communicate their feelings to the dental team, are:

- **LEVEL/POSITION**

  Refers to differences in height between people, whether people are sitting, standing or lying. If one person is standing and the other lying [as can occur in dentistry] the person who is lying can feel uncomfortable, vulnerable and at a disadvantage.
• **Proximity**

Refers to how close people are to one another. In certain social situations the invasion of a person's personal space is disconcerting and unacceptable; at other times it is acceptable and welcomed. In dentistry the patient has given the dental professional permission to invade their social space for the delivery of treatment and is given in trust.

• **Posture**

Refers to how people stand, sit, lie or "hold themselves". Posture can indicate whether the patient is relaxed, uneasy or anxious. For instance a young child lying in the dental chair with her knees drawn up to her chest tells the dental professional how anxious she feels.

• **Eye Contact**

This is important as a first step in establishing rapport with patients. This can convey to patients that the dental health professional is interested, willing to understand their needs and feels empathy for them. Patients who avoid making eye contact with the dental professional are often frightened of dental treatment or the dental professional's response to their behaviour or to what they have to say.
• **NON-VERBAL REINFORCERS OF SPEECH**

These include tone, pitch, speed of talking and can indicate feelings such as anger, fear doubt etc. Another indicator of anxiety is referred to as 'ahs, ars and uhms'. These filled pauses indicate that the patient is trying to find words to convey their feelings, doubts etc to the dental professional.
Role-Play

This exercise allows you to practice your communication skills.

A series of vignettes between dental health support workers and their clients will be role-played by all members of the group. During each interaction two people will act as dental health support workers and patient [following given scenarios] and two as observers. Each person will have the opportunity to role play and to act as observer.

Feed-back will be sought at the end of each scenario. Feed-back should be positive and constructive.
Observer Schedule

Your job is to sit back and observe the encounter. Consider:

What behaviours is the patient exhibiting? [both verbal and non-verbal]

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How is the DHSW dealing with patient's behaviour?

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What behaviours is the DHSW exhibiting? [both verbal and non-verbal].

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How would you describe the encounter?

constructive..........................................destructive

cooperative...........................................uncooperative

negative.............................................positive

hostile...............................................friendly

purposeful.........................................confused
COMMUNICATION SKILLS

Workshop [2]
HELPING PATIENTS TO CHANGE THEIR HEALTH BEHAVIOURS

INTRODUCTION

Patients' adherence with advice on oral health care is dependent on a range of factors such as perceived susceptibility, the potential severity of the condition, the costs to the individual of making the changes etc. [Health Belief Model]. Bringing about lasting and effective changes in health behaviours is not about manipulating patients and getting them to do what we, the health professionals want them to do. Rather it is about exploring the patients' attitudes and values in relation to their own oral health and encouraging them to identify and express their own dental health needs, as well as empowering them to make any necessary changes in their own lives.

Behaviour change is a very complex process, and in most cases is dependent on whether or not the patient is ready to change. The role of the health professional is to identify the patient's state of readiness to change, and to provide the appropriate help and support to enable them to make the necessary changes.
Prochaska and DiClemente [1986] proposed a model of behaviour change in which change is seen as a process, having five basic stages:

1. **PRE-CONTEMPLATION**
2. **CONTEMPLATION**
3. **ACTION**
4. **MAINTENANCE**
5. **RELAPSE**

The first two stages **PRE-CONTEMPLATION & CONTEMPLATION** include the period during which the patient is becoming aware of the problem and the potential benefits of changing their behaviour, but they are not yet ready to change. They are also becoming aware of the alternatives available to them to help them make the necessary changes. It is wrong to assume that people already know about the alternatives which are open to them, they may be obvious to us as health professionals, but not so clear to our patients. This part of the process can take a long time, as it involves information gathering, and working through feelings about making changes before making any decisions.
When the patient reaches the ACTION AND MAINTENANCE stages they have come to realise that the benefits of changing outweighs the 'costs' to them which the change in behaviour may incur. These are not necessarily financial costs, but the fact that they have to give up, what are for them, enjoyable and pleasurable practices or experiences. During this part of the process the health professional is usually involved in working with the patient in helping them to identify realistic goals which will help them to make the necessary behaviour changes.

The RELAPSE stage occurs when [or if] maintenance strategies breakdown, and the undesirable behaviour is resumed. This stage is quite common, particularly where the behaviours are complex and difficult to sustain e.g. smoking. This reinforces the need for agreeing realistic goals which the patient is more likely to be able to achieve.
One of the strengths of the Prochaska and DiClemente stages of change model is that it recognises and allows for relapsing behaviour and the redirection of action. It also requires us to think beyond the K-A-B model of health education, which assumes that the provision of information leads directly to behaviour change, and accept that change is an evolving 'process' in which our role [as health professionals] is that of 'facilitator'.

**MOTIVATIONAL INTERVIEWING**

Rollnick et al [1993] have developed a method of negotiating behaviour change based on Motivational Interviewing Techniques.

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**NEGOTIATING BEHAVIOUR CHANGE**

1. **CHOICE OF ACTIVITIES**
   - let client select
2. **ASSESS READINESS TO CHANGE**
   - NOT READY
   - UNSURE
   - READY
3. **UNDERSTAND AMBIVALENCE**
   - NEGOTIATE, HELP, PLAN, ACTION

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Much of their work has resulted from research on drug addiction where they found that the success of failure of negotiating behaviour change is dependent on certain concepts.
Choosing the activity card

Ambivalence

Many people feel ambivalent about the idea of changing their behaviour as it often means having to give up things which provide them with a lot of pleasure and enjoyment. We need to try to understand the underlying reasons for the patient's conflict. This can be done by exploring their attitudes to both the costs and the benefits of changing their behaviour. However if they perceive that the costs greatly outweigh the benefits they are unlikely to make the necessary changes.
Readiness to change

The patient's state of readiness is a critical factor in the process of change. At one end of the scale it may be that the simply require information to enable them to start to consider the possibility of change, while at the other end they may need assistance to help them identify the range of options open to them and to start to think about the benefits which change will bring them. The approach used by the health professional should be determined by the patient's state of readiness.

Resistance

This inertia to change can be influenced by the behaviour of the health professional. If the health professional tries to move too fast, or a confrontation situation occurs it is likely that the patient's resistance will go up. It usually indicates a need to change the approach or strategy used.
Two agendas

Where two totally different agenda exist [i.e. that of the patient and that of the dental health professional] it is unlikely that lasting behaviour change will take place. It is important to ensure that the patient is directly involved in identifying the behaviours to be modified and in setting their own health goals. Negotiating behaviour change falls somewhere between advice giving and counselling, recognising both the patient's agenda and your own.

Rollnick et al [1993] propose that health professionals can make mistaken assumptions about their clients, which can adversely affect the outcome of their interaction. They suggest that patients are more likely to openly consider change if we avoid imposing these assumptions on them.

Some dangerous assumptions include:

- this person ought to change
- this person is ready to change
- this person's dental health is a prime motivating factor for him/her
- if [s]he does not decide to change behaviour the consultation has failed
- patients are either motivated to change or not
- now is the right time to consider change
- a tough/frightening approach is always best
- I'm the expert - [s]he must follow my advice.

Principles of good practice in negotiating behaviour change include:
• respect for the autonomy of the patients and that their choices are important
• readiness to change must be taken into account
• ambivalence is common and reasons for it need to be explored and understood
• target/goals should be identified by the patients
• the expert [you] provides information and support
• the patient is the active decision maker
CHATTERBOX TRAINING
(DAPER project- Phase III)

Inverness 7th March 2013
Sucharita Nanjappa

Development of CHATTERBOX

• Objective: to develop an evidence-based intervention to identify parental dental concerns and facilitate engagement with a health care worker to enable parents to access dental care for their children, as part of the Childsmile programme.

• Design informed by findings from Phase I and II of the DPAER project.
Main parental concerns:

- Going to the dentist:
  - found travelling difficult
  - expensive
  - perceived the dentist as not being a family friendly place
- Parental exclusion:
  - feeling down
  - not feeling like usual self
  - not wanting to do anything and feeling miserable
- Related to where they lived:
  - not feeling settled in their homes
  - having difficult neighbours
  - not being happy with where they were living
- Higher concerns were predicted for:
  - parents who were not working
  - who did not own their home
  - who had a greater number of children.

CHATTERBOX Kit

- A timeline base: Relevant activity cards selected and placed on the timeline base to construct a visual picture of an average day for each family
- 81 reusable activity cards: 72 cards, separated into categories and colour coded to simplify selection, 9 cards are blank, allowing for parents to create their own variations
- Appointment postcards: made unique by having the child’s foot/hand imprinted onto the front of the postcard