ALL IN THE MIND

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Most, if not all, readers will have experienced the situation in which, when divulging in non-dental surroundings that he or she is dentist, people look slightly aghast and in mock anxiety clamp their hands across their mouths and say that we mustn't take too much notice of their teeth.

I confess that I have a metaphorically similar reaction when someone tells me they are a psychologist. Instead of being anxious about what they might be able to glean purely from my physical characteristics my concern is also what they can tell about me by my manner and demeanour; either something that I am trying to keep hidden or something which I don't even know or recognise about myself. Insecure? Is my therapy hour up yet?

As we gradually move away from dental surgery toward a greater role as oral physicians there comes the need for us to add further sets of skills, those of psychology and an understanding and appreciation of the values of behavioural sciences. Why? Well, because the changes that we are increasingly going to have to advocate to our patients, especially in relation to prevention, involve motivation. Behavioural change is key to the successful conduct of a preventive regimen but understanding the process is also essential if we are to effectively engage those for whom we care and to whom we offer advice.

There has been to date, however, something of a clash of scientific cultures. The evidence-base on which dentistry, or more specifically dental surgery (operative intervention), is based is seen to have its roots in a logical,

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practical progression of actions to eliminate disease and provide repair either mechanical (hard tissue) or biological (soft tissue). Social science by contrast tends to be viewed as 'soft' science, incapable of providing hard evidence, giving concrete ways forward or issuing logical steps for treatment planning. A bit woolly, a bit rinky-dink.

Yet it is the value of understanding this science that enables us to explain, for example, the stage of change model as described by Prospancha and DiClemente as long ago as 1982 and which can be applied to many processes which involve a change in behaviour such as the establishment of a new health-care habit.¹ The stages of the model include: precontemplation, contemplation, determination, action and maintenance, and readers are recommended to research more on this for self-application in understanding and managing their personal routes to changing behaviour as well as for their patients.

But if there are lingering doubts about the value of these approaches, similar suspicions surround the execution and publication of qualitative research. The verbatim comments of a small number of people are not seen as valid evidence from which to reach proper conclusions compared to, say, a large survey or a clinical trial. This, despite the fact that much of the information which we intuitively glean from our patients is not collected quantitatively from tick-boxes but from the way they dress, speak, walk from the surgery door to the dental chair (we make our

initial assessment with credible accuracy in all of about six seconds). We then convert this into appropriate treatment planning. Do you always treat a Class I cavity exactly the same on every patient? If no, then the variations are likely to be due as much to qualitative judgment as scientific rigour; a co-operative adult or an anxious child.

It is salient to remember that we talk about the art and science of dentistry, in that order, and I do not think that this is for reasons of alphabetic purity. It is possible to apply a blend of both and tools exist to help with this. Oral health related quality of life is an example. By asking a series of questions on quality of life and mapping oral comfort onto them it is possible to reach a quantified, subjective view of the impact of oral health, or oral disease on an individual. Again, our tendency may be to dwell on the word 'subjective' but as before it is the psychological profile of the individual patient which dictates the appropriate course of treatment to which they wish to consent rather than the technical method of providing it or the desire of the clinician to provide it. Such considerations also enable us to take a more creative, artistic and possibly, more holistic approach to care which is often expressed as putting the mouth back into the body but which might also now include the mind in addition.

However, a final thought. If you are thinking of inviting me to a social event I would really appreciate a warning if there are psychologists on the guest list. Nothing personal.

1. Prochaska J O, DiClemente C C. Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy Res Pract* 1982; **19**: 276–288.

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