

Research

"A calmer way of working": an evaluation of motivational interviewing training in oral healthcare

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Statement of the problem

Oral healthcare practitioners often struggle to balance technical efficiency with person-centred communication in brief appointments. Motivational interviewing (MI) offers a structured, evidence-informed approach to supporting behaviour change and enhancing patient engagement in oral health.

Purpose of the study: This evaluation explored senior dental hygienists' experiences of a tiered MI training programme, examining perceived impacts on communication, clinical practice and practitioner well-being, and identifying barriers and enablers to implementation in Irish dental services.

Materials and methods

A mixed-methods evaluation was conducted following ethical approval from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (October 2023). Twenty senior dental hygienists participated in the MI training pathway; 14 who had completed at least introductory and intermediate levels completed an online post-training survey. Semi-structured interviews were conducted with three trainees and three members of the MI training team. Survey data was analysed descriptively (frequencies and percentages) in IBM SPSS Statistics 28.0, and interview data underwent reflexive thematic analysis.

Results

Participants reported increased confidence in using open questions, affirmations, reflective listening, and summaries (OARS), and a shift away from directive advice giving towards more collaborative, patient-centred discussions of behaviour change. They perceived that MI-consistent communication improved rapport, supported patient motivation, and made consultations feel calmer and less stressful. Time pressure, competing clinical demands and limited organisational understanding of MI were identified as major barriers to sustained use in routine practice.

Conclusions

Within the limits of a small, self-selected convenience sample, MI training appears to be a promising and valued approach for enhancing communication and supporting well-being among senior dental hygienists. Embedding MI within undergraduate and continuing professional development curricula, alongside managerial support, peer learning and access to skilled trainers, may help to normalise MI-consistent communication in oral healthcare.

CLINICAL RELEVANCE STATEMENT

Motivational interviewing equips oral healthcare practitioners with communication skills that support patient engagement in behaviour change and may reduce the emotional strain of repeatedly "lecturing" patients. This small evaluation suggests that MI-consistent conversations are valued by senior dental hygienists, but sustained imple-

mentation in Irish dental services requires time, organisational support, and ongoing supervision.

KEY LEARNING POINTS

1. MI promotes collaborative, patient-led communication in dentistry.

2. Training improves practitioners' self-reported confidence, empathy, compassion and satisfaction with consultations.

3. Sustainable implementation requires structural support, managerial buy-in, and ongoing mentoring or peer learning.

INTRODUCTION

Motivational interviewing (MI) is a collaborative, person-centred approach to communication aimed at strengthening an individual's own motivation and commitment towards change and growth.¹ Defined as a particular way of talking with people about change and growth, MI is grounded in partnership, acceptance, compassion, and empowerment. These four integrated elements capture its underlying spirit.¹ In contrast to directive or prescriptive styles common in dental consultations, MI fosters open dialogue that helps individuals to explore ambivalence, and draw on their own strengths and values, to promote patient activation in their own oral healthcare.² Through the four key processes of engaging, focusing, evoking, and planning, oral health practitioners can guide patients towards personally meaningful oral health behaviour change.¹ Emergent evidence highlights MI's contribution to oral healthcare, demonstrating improvements in self-care routines, caries prevention, and periodontal health.^{3,4} This study examines MI training for oral healthcare practitioners in Ireland, exploring its effectiveness, implementation challenges, and long-term sustainability in clinical settings.²

MATERIALS AND METHODS

A mixed-methods evaluation was conducted following ethical approval from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (October 2023). The training was delivered to senior dental hygienists selected by and funded through the National Oral Healthcare Office. In total, 20 hygienists participated in at least the introductory MI workshop, 12 progressed to intermediate training, and three completed the advanced level with coding, feedback and coaching. Fourteen trainees who had completed at least the introductory and intermediate levels completed an online post-training survey. Semi-structured interviews were conducted with three trainees and three members of the MI training team to capture different perspectives on training and implementation. Survey data were exported from Google Forms to IBM SPSS Statistics 28.0, cleaned, re-coded, and analysed using frequencies and descriptive statistics. Data were analysed using Braun and Clarke's reflexive thematic analysis, with iterative coding and theme development.^{5,6}

RESULTS

This research explores the experiences of senior dental hygienists and MI trainers who participated in a three-tier MI training pathway. The results from the survey and the

interviews are organised into five themes: motivations for participation; perceived benefits of communicating in an MI style; communication and empathy; barriers to integration; and, adoption of MI techniques. Survey findings are presented alongside illustrative quotes to capture participants' experiences and reflections.

MOTIVATIONS FOR PARTICIPATION

A recurring theme in participants' accounts was intrinsic motivation to develop more effective, person-centred communication. Over three-quarters of survey respondents (79%) reported attending primarily for continuing professional development, describing a desire to move beyond "lecturing" patients and to feel more effective with people who were ambivalent or overwhelmed. A smaller group (21%) attended because it was a work requirement.

"To get into dentistry very often? You're quite ready to be the expert ... unlearning those skills of telling – that was a difficult one to do." (Interview 6)

Several interviewees contrasted their usual "expert" role and information-heavy style of patient education with the more collaborative stance encouraged in MI. For these practitioners, MI felt more consistent with how they wanted to work, emphasising partnership rather than instruction.

BENEFITS OF COMMUNICATING IN AN MI STYLE

Participants unanimously agreed that MI improved their ability to provide person-centred care (100%). All respondents believed that using MI would support better clinical outcomes for their patients, although the evaluation did not measure patient outcomes directly. Practitioners also reported that MI helped them feel more confident and less pressured during challenging consultations, shifting the focus from persuading patients to partnering with them in autonomous decision-making. One participant summarised this insight:

"What struck me was that we were to do less than 50% of the talking. Before motivational interviewing, I did nearly all the talking. It's a game changer in ways – you're bringing them on a journey". (Interview 2)

Another participant described the emotional and energetic difference in this new way of working:

"Before MI, it felt like you were a rat on a treadmill ... With motivational interviewing, I'm not on the treadmill anymore. It feels nice and means I'm preserving my energy". (Interview 1)

Across interviews, participants described feeling calmer, less frustrated, and more in control when using MI, particularly in consultations that had previously felt repetitive or confrontational. Self-reporting accounts suggest a perceived positive impact on job satisfaction and well-being, although no formal burnout or stress measures were used in this evaluation.

COMMUNICATION AND EMPATHY

Participants highlighted MI's ability to help them tailor their advice empathetically to each patient's social and personal context:²

"We would see patients from so many different backgrounds ... it's about taking off the one-size-fits-all hat and putting ourselves in the patient's position". (Interview 1)

This narrative aligns strongly with MI's 'spirit' of collaboration and compassion, particularly in contexts where patients are managing housing instability, financial hardship, or chronic illness.

Many participants found that simple, open questions such as "How do you feel about your teeth?" opened space for new kinds of conversations, ones rooted in empathy rather than judgement²:

"I would have never talked about feelings to patients before. That's a powerful question". (Interview 2)

BARRIERS TO INTEGRATION

Lack of time was cited as the most significant barrier, with all survey respondents identifying time pressure as a key constraint. Participants described the challenge of integrating MI into short appointments alongside high clinical demand. One participant, for example, felt that working without consistent nursing support and with a rapid turnover of patients made it difficult to slow down and use MI more fully:

"I work on my own a lot. I don't even have a nurse with me ... I'm writing notes, cleaning down between patients – you're time limited". (Interview 3)

Others noted that brief encounters in public clinics limit opportunities for follow-up or relationship building,² but also make the case for structured brief interventions using MI to support patient activation in their own oral healthcare:

"In the HSE, you might only see them once or twice ... but in private practice, seeing someone every few months, you can really see how MI makes a difference". (Interview 1)

Language barriers and working with children were also raised as implementation challenges⁷:

"With kids ... it's more rule-governed behaviour. You don't really get into the change talk". (Interview 1)

ADOPTION OF MI TECHNIQUES

Despite practical barriers, participants reported integrating core MI techniques into their daily work. Nearly all respondents indicated frequent use of open-ended questions (93%), reflective listening (93%), affirmations (93%), and use of summaries (86%). Around three-quarters reported that they understood the core MI 'spirit', while 58% felt confident exploring ambivalence. These figures are based

on practitioners' self-ratings in the post-training survey rather than external assessment of MI competence. Practitioners noted that they routinely used reflective statements such as "It sounds like you're doing your best in a difficult situation" to validate patients' experiences and evoke change talk. Many also spoke about adopting a more strengths-based mindset, shifting from identifying problems to celebrating small progress²:

"After doing the training, I was thinking right, let's just keep it positive. Praising small change – I even used it today with a patient with diet". (Interview 2)

These examples show that MI principles can be embedded even within short dental appointments when practitioners adopt an intentional MI-consistent form of communication in brief interventions.

TRAINING EXPERIENCE AND DESIGN

Feedback on the training design was overwhelmingly positive. Trainees valued the spaced delivery over several months and the combination of theory, role-play and reflection.² Having a dental co-trainer who could contextualise examples for practice settings was also considered crucial²:

"As [NAME] was able to come in from the dental aspect and talk about the dental side of things, it was a nice mix for me". (Interview 2)

Some participants noted practical difficulties with recording role-plays for advanced assessment because of data protection and confidentiality concerns – for example, uncertainty about storing audio on HSE devices, and complying with the General Data Protection Regulation (GDPR) and local governance policies. Nevertheless, most felt that the reflective exercises and opportunities for practice and feedback were 'game changers' for learning.

Minor suggestions included ensuring that training materials were distributed in advance and incorporating more Irish case studies. Participants felt that scenarios reflecting Irish dental service structures, medical card provision, local patterns of oral health inequality, and culturally familiar ways of talking about diet, smoking, and dental attendance would make it easier to apply MI skills in everyday practice.

ORGANISATIONAL SUPPORT AND SUSTAINABILITY

Perceived managerial support for MI implementation was moderate. Several participants noted that while managers were positive about staff attending the training, they did not fully understand what MI involved or how it might change day-to-day practice. This limited understanding was experienced as a barrier to implementation, because no additional time, supervision or opportunities for peer learning were built into services to support sustained use of MI.

"They're sending people off to do these courses, but they're not fully sure what exactly is happening on [them]". (Interview 4)

Sustainability emerged as a central theme. Trainers and trainees alike emphasised the need for a "train-the-trainer model" and ongoing peer support. These reflections align with implementation science frameworks, which highlight the importance of organisational structures and long-term support to embed behaviour change interventions.⁷

DISCUSSION

The findings show a clear demand among dental professionals for patient-centred approaches that move beyond instruction. Participants viewed MI as a practical framework that helped them to listen more deeply, build more empathy and compassionate communication skills, and support patients' activation in their oral health. This perceived shift in conversations is consistent with the wider MI literature, which emphasises collaborative, autonomy-supportive consultations.

Although participants demonstrated strong knowledge and enthusiasm, structural realities such as time pressure and staffing limitations constrained implementation. This mirrors previous research findings that, while healthcare professionals value MI, consistent application requires system-level support, attention to workload and service design.

These points indicate how brief, 'micro-MI' interactions – such as asking permission, using open questions, and offering reflections – can be woven into routine preventive appointments without extending appointment time excessively, provided that practitioners adopt an intentional, patient-centred stance.

This resonates with wider work on adapting evidence-based practices for local service contexts, where training is most durable when it is reinforced over time and supported in the workplace. Integrating MI modules into undergraduate and postgraduate dental curricula could normalise MI as part of core clinical communication, with staged teaching, supervised practice, and assessment across training years rather than reliance on a single course. The potential benefits include earlier skill acquisition, greater confidence managing ambivalence in brief consultations, and a shared language across the team that supports sustainability. Limitations include the resource demands of skills-based teaching and feedback. Without trained educators and meaningful assessment, curricular inclusion risks becoming theoretical and may not translate into routine practice. Integrating MI modules into undergraduate and postgraduate dental curricula could normalise MI as part of the profession's core skill set.

An important perceived benefit in this evaluation was the impact on practitioner well-being. Several participants reported feeling less drained and more satisfied in their work when using MI,⁸ particularly in consultations that previously felt repetitive or confrontational. Future research should examine whether MI training has measurable

effects on burnout and job satisfaction, using validated instruments.

RECOMMENDATIONS FOR MI IN ORAL HEALTHCARE

For MI to thrive within dental settings, organisations need to create conditions for its application.² The following practical enablers emerged from the data:

- protected time within appointments to allow for meaningful dialogue;
- managerial understanding of MI principles to support its integration; and,
- recognition in reporting systems, e.g., 'MI delivered' tick-boxes in reports to managers.

For MI to be sustained and effective in oral healthcare, it needs to be embedded within organisational structures and everyday practice rather than relying solely on individual enthusiasm. This includes aligning appointment systems, supervision, quality frameworks, and service priorities with person-centred, preventive care.

RECOMMENDATIONS FOR MI TRAINERS

Participants praised the tiered structure (introduction-intermediate-advanced) and valued having a dental co-trainer alongside an experienced MI trainer. They suggested that building a community or network of dental MI trainers with access to expert supervision could help to maintain standards, support ongoing skills development, and make the training more empowering, not just for practitioners but ultimately also for patients.⁹

IMPLICATIONS FOR PRACTICE

1. For oral healthcare practitioners: MI offers a structured yet flexible communication approach that can make difficult conversations about behaviour change feel more collaborative and less confrontational. In this evaluation, practitioners reported greater confidence and sense of calm when using MI-consistent communication, but these are self-reported perceptions rather than measured well-being.

2. For educators: integrating MI into undergraduate and postgraduate dental curricula, and providing opportunities for supervised practice, can help to establish MI as a core professional skill rather than an optional add-on.

3. For managers: supporting staff with protected time, resources, and acknowledgement of MI-related activity, e.g., through supervision, peer learning, and service planning, may enhance job satisfaction and help staff to sustain MI-consistent practice.

4. For policymakers: investing in national or regional MI trainer networks and aligning funding models with preventive, relationship-based care can support sustainability and equitable access to training.

LIMITATIONS

This research reflects the experiences of a small convenience sample of senior dental hygienists who self-selected into both the MI training and the evaluation. The sample is not representative of all oral healthcare practitioners and findings are not generalisable to other programmes or populations. Data are based on self-reporting, including practitioners' perceptions of changes in their communication, well-being and patient outcomes, rather than objective clinical or behavioural measures. Nevertheless, the depth of qualitative data provides rich, context-specific insight into MI implementation within dentistry, and can inform the design of future training and research.

CONCLUSIONS

Within the limits of this small, self-selected cohort, MI training appears to be a promising and valued approach for enhancing person-centred communication and supporting practitioner well-being among senior dental hygienists.

Participants reported feeling more effective and calmer in consultations when using MI-consistent skills. To move beyond individual enthusiasm, however, MI needs to be embedded structurally through undergraduate and continuing professional development curricula, access to skilled trainers and coaching, protected time for practice and reflection, and organisational commitment to patient-centred preventive care.

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