

**SESSIONE
DI PSICOLOGIA ODONTOIATRICA**

**BEHAVIOR ANALYSIS
IN DENTISTRY TRACK**

CONGRESSO DI PSICOLOGIA ODONTOIATRICA – 9 MAGGIO

Applied Behavior Analysis: l'ultima risorsa per l'odontoiatria privata in Italia

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PRESENTAZIONE DEL CONGRESSO

Da quest'anno la conferenza internazionale sulla *Behavior Analysis*, arrivata alla sua nona edizione, si arricchisce di una sezione esclusivamente dedicata all'Odontoiatria. L'esigenza di applicare i principi e le tecniche dell'analisi del comportamento è dettata dalla necessità di fornire ai professionisti – soprattutto quelli che operano privatamente – gli strumenti indispensabili per poter affrontare e superare i nuovi scenari competitivi che il settore sta presentando.

Infatti in odontoiatria, più che in qualunque altra branca della medicina, gli scenari aperti dalle nuove offerte di cura impongono di affrontare in modo scientifico 3 temi:

1. LA COMPLIANCE DEI PAZIENTI ALLE TERAPIE

E' nella comunicazione che il medico ottiene *in primis* l'accettazione del piano di cura, ma per ottenere la successiva adesione ai comportamenti di prevenzione e terapia, la comunicazione in studio non è sufficiente: nel congresso saranno presentate tecniche di auto-monitoraggio, *feedback*, *token economy* per motivare i pazienti a quei comportamenti. Quest'anno il congresso è arricchito dalla presenza di Daniel J. Moran, tra i massimi esperti di *Acceptance and Commitment Therapy*.

2. LA GESTIONE DEL PERSONALE PER AUMENTARE LA QUALITÀ E PRODUTTIVITÀ, E QUINDI LA COMPETITIVITÀ DELLO STUDIO

Il *Performance Management* (PM) è un protocollo d'intervento che permette di capire quali sono i comportamenti dell'odontoiatra, dell'assistente, dell'igienista, degli addetti alla segreteria... più importanti per il successo dello studio. Il PM dà poi gli strumenti per misurare e rinforzare (e anche premiare) chi mette in atto quei comportamenti. In altre parole, il PM è la risposta sicura e documentata per tutti coloro che vogliono trovare una via operativa (e non solo a parole) per l'ottenimento

dei risultati, per il bene dei propri pazienti e per il successo della propria attività clinica. In questo congresso, Aubrey Daniels – il maggior esperto al mondo in materia – parlerà di *leadership*, un ingrediente fondamentale per il *Performance Management*.

3. LA FORMAZIONE DEL PERSONALE

La formazione professionale del personale di studio deve rispettare i criteri di efficacia: il concetto “*faccio il corso per imparare conoscenze e abilità nuove che prima non sapevo dire o fare*” è tanto banale quanto inatteso dalla maggior parte dei corsi, che non sottopongono a pre-post test i propri studenti. La *Behavior Analysis*, che si basa esclusivamente su evidenze sperimentali, ha escogitato e messo a punto metodi, come per esempio il *Precision Teaching*, che consentono rapidi incrementi di prestazione. I risultati ottenuti verranno presentati durante il congresso.

In altre parole, l'*Organizational Behavior Management* (OBM) verrà presentato e discusso come risposta sicura e documentata per tutti coloro che vogliono trovare una via operativa (e non solo a parole) per l'ottenimento dei risultati, per il bene dei propri pazienti e per il successo della propria attività clinica.

CHAIR DELL'EVENTO



Carlo Guastamacchia Laureato in medicina e specializzato in clinica odontoiatrica, ha introdotto e diffuso in Italia l'ergonomia odontoiatrica. Attualmente è professore a c. di “Ergonomia e Comunicazione” al CLID dell'Istituto S. Raffaele di Milano (Dir. Prof. E. Gherlone) e al CLODP dell'Università degli studi di Genova (Dir. Prof. G. Blasi). Ha scritto oltre 250 pubblicazioni in ambito odontoiatrico, in particolare numerosi testi relativi alla “Pratica Professionale” (Ergonomia, Marketing, Psicologia della comunicazione). È stato Direttore Scientifico di Dental Cadmos e di Prevenzione e Assistenza Dentale (di cui fu fondatore). È fondatore e direttore (2013) della rivista e-reader ECO (Ergonomia & Comunicazione in Odontoiatria).

BEHAVIOR ANALYSIS IN DENTISTRY – 9TH MAY

Promoting Psychological Flexibility in Clinical Settings

Daniel J. Moran

Quality Safety Edge

ABSTRACT

A primary clinical aim of Acceptance and Commitment Therapy is to improve the psychological flexibility of each individual client. Psychological flexibility is a characteristic of human behavior where the person is mindful of the present moment, and willing to experience private events while behaving effectively. In clinical settings, therapists can utilize the six components of ACT for case conceptualization and treatment application in order to improve psychological flexibility: acceptance, defusion, self-as-context, committed action, values clarification, and mindfulness. Change in psychological flexibility is measured with the Acceptance and Action Questionnaire, an instrument shown to correlate in clinically worthwhile directions with changes in psychopathology and quality of living measures.

Keywords: Psychological Flexibility, Acceptance & Commitment Therapy, Values Clarification, Commitment, Mindfulness, Defusion, Self-as-Context

WHAT IS PSYCHOLOGICAL FLEXIBILITY?

Psychological flexibility is a construct referring to the process of contacting the present moment without avoiding or defending against private events (thoughts, emotions, sensations), as a conscious, historical human being, and depending upon what the situations affords, changing or persisting in behavior in the service of chosen values (Hayes, Luoma, Bond, Masuda, & Lillis, 2006; Hayes, Strosahl, & Wilson, 1999). According to Bach & Moran (2008), psychological flexibility is evidenced when a person is able to “change his or her behavior in the service of attaining valued goals and outcomes” (p. 6). Research suggests that psychological flexibility functions as a mediator of psychotherapy treatment change, so that increases in psychological flexibility influence change in depression measures (Zettle & Hayes, 1986), pain (McCracken, Vowles, & Eccleston, 2004), psychosis (Bach & Hayes, 2002), and anxiety (Forman, Herbert, Moitra, Yeomans, & Geller, 2007); therefore promoting change in psychological flexibility is an important clinical aim.

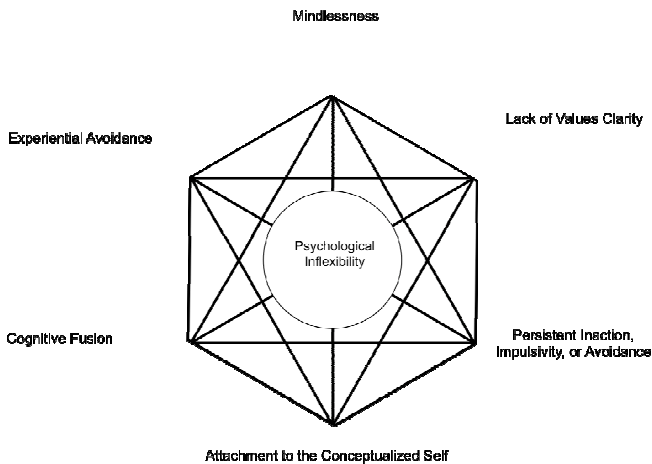
Clinicians using Acceptance and Commitment Therapy interventions target change in psychological flexibility. Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) is an approach to psychotherapy based on modern behavior analysis. ACT therapists utilize classical and operant conditioning, as well as Relational Frame Theory, in order to case conceptualize clinically-relevant concerns. In ACT, behavioral problems are viewed as influenced by the client’s psychological inflexibility.

WHAT IS PSYCHOLOGICAL INFLEXIBILITY?

People can demonstrate psychological inflexibility when they engage in any of the

following:

- 1) Experiential avoidance – the unwillingness to come in contact with private events, such as emotions, sensations, urges, etc.
- 2) Cognitive fusion – when “verbally related antecedents and consequences such as thoughts, feelings, and judgments, have relatively greater influence over responding than directly contacted nonarbitrary contingencies” (Bach & Moran, 2008).
- 3) Attachment to the conceptualized self – being rigidly governed by verbal descriptions and judgments about one’s self.
- 4) Persistent inaction, impulsivity, or avoidance – when dimensions of overt behavior do not meet one’s own expectations or lead to diminished quality of life.
- 5) Lack of values clarity – not having clear verbal understanding of personal goals and behavioral processes related to long term reinforcers.
- 6) Mindlessness – having verbal behavior about the past and future dominate behavior in a manner deleterious to chosen valued goals.



HOW IS PSYCHOLOGICAL FLEXIBILITY MEASURED?

The Acceptance and Action Questionnaire (AAQ; Hayes et al., 2004) was the initial instrument for measuring psychological flexibility, and has since been revised for a seven-item second edition (AAQ-II; Bond et al., 2011). The AAQ-II is a general measure of ACT processes that influence psychological flexibility, and has been tailored to address certain clinical concerns (ex. the Chronic Pain Acceptance Questionnaire, CPAQ, McCracken, 1998). A meta-analysis utilizing 32 studies (combined n=6628) investigated the relationship between the AAQ measures and various measures of psychopathology and quality of life measures. Overall, the

measures of psychological flexibility have a moderate relationship with general psychological outcomes (weighted effect size = .42) thereby suggesting that attempts to alter psychological flexibility can be a worthy clinical endeavor. The six components to the ACT model address the aforementioned six clinical issues related to inflexibility.

THE SIX COMPONENTS OF THE ACT MODEL

In the ACT Treatment Model, there are six corresponding components that promote psychological flexibility:

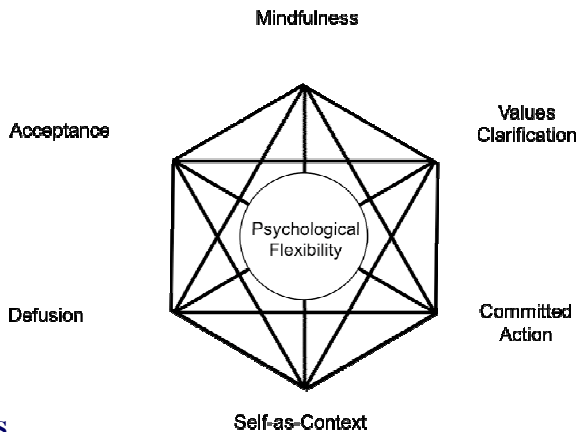
- 1) *Acceptance* means actively contacting psychological experiences fully, directly without needless defense while behaving effectively (Hayes et al. 1996). As a clinical endeavor, clients are invited to simply notice that they are having an emotional experience, sensation, or other private event without trying to get rid of that experience. According to ACT, the actions people take to avoid or remove the experience of a private event can become clinically relevant. A pithy example is when someone feels anxious before giving a career-oriented public presentation, so in order to reduce anxiety, the person chooses to avoid giving the presentation. This avoidance may remove the anxiety sensations and could lead to negatively reinforcing the avoidance behavior of a social anxiety repertoire. But at the same time, the person is not accessing the reinforcers related to making the presentation, and therefore is not behaving effectively if they value their career. When the person learns to accept the private events that are typically labeled “anxiety” and does not try to avoid those private events, the person is in a better position to engage in effective action.
- 2) *Defusion* occurs when a person learns that they do not have to take their thoughts literally. Private verbal behavior (cognitions) can have an influence on people’s behavior. For instance, a client who is fused with the thought “No one likes me” does not see it as merely a thought, and instead takes it as a literal truth thereby approaching people he meets through the lens of “No one likes me.” This may lead to avoiding social interaction even when social interaction is available from people who might actually like him. Fusion is a byproduct of language and it is easy to fall into self-defeating behavior when thoughts are taken literally (Hayes, Strosahl, & Wilson, 1999, pp. 72-74). Consider the person who experiences obsessions about germs for whom simple actions, such as going out of doors, leads to fear of sickness and death. Defusion allows the individual to see thoughts as thoughts, and rather than regarding thoughts as literal truths about the world. The thoughts of germs and the danger of the outside world are seen as ‘chatter’ and cognitive byproducts of one’s history. Defusion frees the client to act on the basis of values and the current environmental contingencies rather than on the basis of fused verbal content.
- 3) *Self-As-Context* is a sense of self that comes from a consistent point of

view from which the person is able to notice and observe all changing stimulus events. “Self is a valid and useful behavior-analytic concept” (Lattal, 2012) and behavior analysts have recently published a modern natural science treatise on self and perspective taking (see McHugh & Stewart, 2012). From an applied point of view, ACT attempts to help the client become less influenced by verbalizations about his or her own personal descriptions. Interventions aim to show that statements such as “I am a bad person,” are simply verbal behavior, and in the vast amount of other personal verbalizations one could make about oneself, that statement is not helpful towards value directed committed actions. Self-as-context exercises help the client distinguish between having a core perspective that remains unchanged in the midst of on-going changes in the environment. ACT can capitalize on a person’s ability to simply notice unhelpful self-concept statements because once those verbalizations have less influence, then the person’s repertoire is likely more flexible for doing a broader number of actions.

- 4) *Committed Action* is well within the realm of clinical behavior analysis. This is the component of the ACT model that focuses on measurable, overt behavior change. In order to demonstrate successful behavior therapy, there should be a concomitant change in the dimensions of behavior (rate, duration, latency, intensity, etc.). When fostering psychological flexibility in clinical settings, evidence of achieving that goal comes from being able to see changes in clinically relevant behaviors. Developing a treatment plan including evidence-based practices is at the foundation of committed action. The client is encouraged to engage in the treatment plan even when there are obstacles and relapses, in order to demonstrate commitment. Clinical change is often difficult and ACT suggests using direct contingency management (applied behavior analysis) and indirect verbal interventions (such as values clarification) to support clinically relevant behavior change.
- 5) *Values* are verbally construed global desired life consequences. By “verbally construed,” ACT suggests that people learn values from social interaction and can verbally articulate the appetitive aim of behavior. More colloquially, values are what people describe as important and vital in life. Values give direction to the person’s actions. For instance, an ACT therapist discusses what is meaningful to the client, such as “honesty,” “making the world more beautiful,” and/ or “raising healthy children.” These verbalizations can give direction to the person’s actions. Once clarified the client can set up achievable goals that are aligned and motivated by the person’s values.
- 6) Mindfulness is also called “contacting the present moment” in ACT. The basic premise is that a person can only perceive what is happening in their environment if they are able to notice the events occurring in the “here and now” rather than getting caught up in thoughts about the past or the

future. Killingsworth & Gilbert's (2010) research suggests that people are distracted from their overt environment about 47% of the day. This is called mindlessness, and is related to missing important cues for action. If a client is inflexibly influenced by their private events about the past and the future, they are more likely to miss antecedents for valued committed action. ACT attempts to help clients be more present focused through mindfulness exercises in order to expand the duration of their attention span.

The six components of ACT are used for case conceptualization and also in order to guide the therapist in developing treatment plans and reactions to client issues in session.



CONCLUSIONS

The hexagon model helps clinicians promote psychological flexibility with exercises and interventions related to each one of the components. Acceptance and Commitment Therapy utilizes the combination of these concepts in conjunction with other evidence-based therapies in order to improve quality of living and reduce suffering. Because of psychological flexibility's relationship to other clinical measures, ACT is well-positioned to supplement behavioral health initiatives to address clinically relevant behaviors.

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L'efficacia del feedback nel posizionamento degli attacchi ortodontici

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ABSTRACT

La procedura di feedback rappresenta, nella gestione dell'attività ortodontica, uno dei metodi più efficaci nella ricerca di un incremento della performance lavorativa. E' una modalità di controllo di prestazione che risale agli anni '70: ancor oggi è utilizzata perchè molto efficace e di facile applicazione. Si tratta di un metodo basato sugli schemi di rinforzo che agiscono sulle conseguenze dei comportamenti, incentivati da "informazioni di ritorno", i feedback: dal flipper anni '60 alla tecnologica console di un moderno videogioco, il display, indicante una performance raggiunta, è un potentissimo incentivo a migliorare il proprio impegno nel raggiungimento di un migliore risultato (performance). La procedura è stata applicata ad una giovane odontoiatra, frequentatrice di uno studio ortodontico. Dopo un anno di apprendimento la sua prestazione nel posizionare attacchi ortodontici non era ritenuta ottimale e, valutato il suo corretto livello di conoscenza delle procedure, si è deciso di agire sull'elemento "motivazione".

La procedura di feedback si è rivelata efficace nell'aumentare la performance in termini di motivazione al compito, che migliora fino a sfiorare il 100% di successo, da considerarsi elevatissimo, anche nelle circostanze in esame.



Raffaello Cortesi è Laureato in Medicina e Chirurgia, con Specialità in Ortognatodonzia. Ha in seguito ottenuto il Diploma Universitario di Ortodonzia, il Diploma Italian Board of Orthodontists, il Diploma European Board of Orthodontics. E' Professore a.c. Scuola di Specializzazione in Ortognatodonzia - Università degli Studi di Cagliari. E' Libero Professionista che esercita in Cremona e Verolanuova (BS)

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Applicazione della Behavior Analysis in ambito sanitario: Il percorso formativo delle ASO

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ABSTRACT

Contrariamente a quanto molti ritengono, il percorso formativo degli ASO non può essere strutturato in base alla preparazione, ai ricordi universitari, all'umore del docente, alla capacità di comunicazione del professionista (datore di lavoro) e al suo interesse nella valorizzazione delle risorse umane come oggi di fatto si attua delegando la formazione del personale ai singoli titolari di studio.

Deve seguire un processo formativo unitario calibrato su:

- Specificità dei compiti operativi degli ASO,
- importanza della comprensione della comunicazione verbale e non verbale nel rapporto con collaboratori, dirigenti e pazienti,
- modulazione del metodo di comportamento degli ASO sulla base delle forme espressive e comportamentali più adatte a raggiungere il risultato prefissato.

Tutto ciò nella consapevolezza che in ambito sanitario qualunque ruolo ritrova la sua piena dignità e potenzialità di sviluppo all'interno di una visione di lavoro di equipe che vede la collaborazione e il rapporto con gli altri come elemento centrale del processo formativo.



Fulvia Magenga Lavora come Assistente di Studio Odontoiatrico dal 1987. Dal 1999 collabora con il dott. Giulio C. Leghissa – Milano. Ha frequentato il corso di formazione ed aggiornamento per ASO all'Università Vita Salute S. Raffaele di Milano nel 2004. Nel 2009 ha conseguito il titolo di ASO Certificata dalla Regione Lombardia. E' il segretario generale di SIASO, Sindacato Italiano Assistente di Studio Odontoiatrico e segue l'iter burocratico per il raggiungimento del profilo professionale, alla riqualificazione del personale occupato e al percorso di studi, con la Camera dei Deputati, con il Ministero della Salute e con le Regioni del Coordinamento Interregionale di Sanità.