DENTAL SECRETS

Second Edition

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DEDICATION

To my father, H. Richard Sonis, D.D.S.,
with admiration and gratitude.

CONTENTS

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PREFACE TO THE FIRST EDITION

This book was written by people who like to teach for people who like to learn. Its format of questions and short answers lends itself to the dissemination of information as the kinds of "pearls" that teachers are always trying to provide and for which students yearn. The format also permits a lack of formality not available in a standard text. Consequently, the reader will note smatterings of humor throughout the book. Our goal has been to provide a work that readers will enjoy and find useful and stimulating.

This book is not a substitute for the many excellent textbooks available in dentistry. It is our hope that readers will pursue additional readings in areas which they find stimulating. While short answers provide the passage of succinct information, they do not allow for much discussion in the way of background or rationale. We have tried to provide sufficient breadth in the sophistication of questions in each chapter to meet the needs of dental students, residents, and practitioners.

It has been a pleasure working with my colleagues who have contributed to this book. I would like to thank Mike Bokulich for initiating this project. Finally, I am grateful to Linda Belfus, our publisher and editor, for her assistance, attention to detail, and patience.

PREFACE TO THE SECOND EDITION

The practice of dentistry has undergone a number of changes since the first edition of Dental Secrets was published only a few years ago. New materials, techniques, instrumentation, regulatory issues, and advances in understanding the biologic basis for treatment are all reflected in the new edition. The successful question-and-answer format of the first edition is the same, although every chapter has undergone some revision. Where appropriate, the authors have added figures or tables. New questions were added and obsolete questions were deleted. A new chapter on the use of computers in dentistry reflects the impact of this technology on the profession. One thing has not changed: the authors still love to teach those who love to learn.

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1. PATIENT MANAGEMENT: THE DENTIST-PATIENT RELATIONSHIP

Elliot V. Feldbau, D.MD.

After you seat the patient, a 42-year-old woman, she turns to you and says glibly, "Doctor, I don't like dentists." How should you respond?

Tip: The patient presents with a gross generalization. Distortions and deletions of information need to be explored. Not liking you, the dentist, whom she has never met before, is not a clear representation of what she is trying to say. Start the interview with questioning surprise in your voice as you cause her to reflect by repeating her phrasing, "You don't like dentists?," with the expectation that she will elaborate. Probably she has had a bad experience, and by proceeding from the generalization to the specific, communication will advance. It is important to do active listening and to allow the patient who is somewhat belligerent to ventilate her thoughts and feelings. You thereby show that you are different perhaps from a previous dentist who may not have developed listening skills and left the patient with a negative view of all dentists. The goals are to enhance communication, to develop trust and rap port, and to start a new chapter in the patient's dental experience.

As you prepare to do a root canal on tooth number 9, a 58-year-old man responds, "The last time I had that dam on, I couldn't catch my breath. It was horrible." How should you respond? What may be the significance of his statement?

Tip: The comment, "I couldn't catch my breath," requires clarification. Did the patient have an impaired airway with past rubber dam experience, or has some long ago experience been generalized to the present? Does the patient have a gagging problem? A therapeutic interview clarifies, reassures, and allows the patient to be more compliant.

A 36-year-old woman who has not been to the dentist for almost 10 years tells you, "My last dentist said I was allergic to a local anesthetic. I passed out in the dental chair after the injection." A 55-year-old man is referred for periodontal surgery. During the medical history, he states that he had his tonsils out at age 10 years and since then any work on his mouth frightens him. He feels like gagging. How do you respond?

Tip: In both cases, a remembered traumatic event is generalized to the present situation. Although the feelings of helplessness and fear of the unknown are still experienced, a reassured patient, who knows what is going to happen,

can be taught a new set of appropriate coping skills to enable the required dental treatments. The interview fully explores all phases of the events surrounding the past trauma when the fears were first imprinted.

After performing a thorough examination for the chief complaint of recurrent swelling and pain of a lower right first molar, you conclude that, given the 80% bone loss and advanced subosseous furcation decay, the tooth is hopeless. You recommend extraction to prevent further infection and potential involvement of adjacent teeth. Your patient replies, "I don't want to lose any teeth. Save it!" How do you respond?

Tip: The command to save a hopeless tooth at all costs requires an understanding of the denial process, or the clinician may be doomed to perform treatments with no hope of success and face the likely consequences of a disgruntled patient. The interview should clarify the patient's feelings, fears, or interpretations regarding tooth loss. It may be a fear of not knowing that a tooth may be replaced, a fear of pain associated with extractions, a fear of confronting disease and its consequences, or even a fear of guilt due to neglect of dental care. The interview should clarify and inform while creating a sense of concern and compassion.

With each of the above patients, the dentist should be alerted that something is not routine. Each expresses a degree of concern and anxiety. This is clearly the time for the dentist to remove the gloves, lower the mask, and begin a comprehensive interview. Although responses to such situations may vary according to individual style, each clinician should proceed methodically and carefully to gather specific information based on the cues that the patient presents. By understanding each patient's comments and the feelings related to earlier experiences, the dentist can help the patient to see that change is possible and that coping with dental treatment is easily learned. The following questions and answers provide a framework for conducting a therapeutic interview that increases patient compliance and reduces levels of anxiety.

1. What is the basic goal of the initial patient interview?

To establish a therapeutic dentist-patient relationship in which accurate data are collected, presenting problems are assessed, and effective treatment is suggested.

2. What are the major sources of clinical data derived during the interview?

The clinician should be attentive to what the patient verbalizes (i.e., the chief complaint), the manner of speaking (how things are expressed) and the nonverbal cues that may be related through body language (e.g., posture, gait, facial expression, or movements). While listening carefully to the patient, the

dentist observes associated gestures, fidgeting movements, excessive perspiration, or patterns of irregular breathing that ma hint of underlying anxiety or emotional problems.

3. What are the common determinants of a patient's presenting behavior?

1. The patient's perception and interpretation of the present situation (the reality or view of the present illness)
2. The patient's past experiences or personal history
3. The patient's personality and overall view of life

Patients generally present to the dentist for help and are relieved to share personal information with a knowledgeable professional who can assist them. However, some patients also may feel insecure or emotionally vulnerable because of such disclosures.

4. Discuss the insecurities that patients may encounter while relating their personal histories.

Patients may feel the fear of rejection, criticism, or even humiliation from the dentist because of their neglect of dental care. Confidential disclosures may threaten the patient's self-esteem. Thus patients may react to the dentist with both rational and irrat1 comments, their behavior may be inappropriate and even puzzling to the dentist. In a severely psychologically limited patient (e.g., psychosis, personality disorders), behaviors may approach extremes. Furthermore, patients who perceive the dentist as judgmental or too evaluative are likely to become defensive, uncommunicative, or even hostile. Anxious patients are more observant of any signs of displeasure or negative reactions by the dentist. The role of effective communication is extremely important with such patients.

5. How can one effectively deal with the patient's insecurities?

Probably acknowledgment of the basic concepts of empathy and respect gives the most support to patients. Understanding their point of view (empathy) and recognition of their right to their own opinions and feelings (respect), even if different from the dentist's personal views, help to deal with potential conflicts.

6. Why is it important for dentists to be aware of their own feelings when dealing with patients?

While the dentist tries to maintain an attitude that is attentive, friendly, and even sympathetic toward a patient, he or she needs an appropriate degree of objectivity in relation to patients and their problems. Dentists who find that they are not listening with some degree of emotional neutrality to the patient's information should be aware of personal feelings of anxiety, sadness, indifference, resentment, or even hostility that may be aroused by the patient. Recognition of any aspects of the patient's behavior that arouse such emotions helps dentists to

understand their own behavior and to prevent possible conflicts in clinical judgment and treatment plan suggestions.

7. List two strategies for the initial patient interview.

1. During the verbal exchange with the patient all of the elements of the medical and dental history relevant to treating the patient's dental needs are elicited.

2. In the nonverbal exchange between the patient and the dentist, the dentist gathers cues from the patient's mannerisms while conveying an empathic attitude.

8. What are the major elements of the empathic attitude that a dentist tries to relate to the patient during the interview?

- Attentiveness and concern for the patient
- Acceptance of the patient and his or her problems
- Support for the patient
- Involvement with the intent to help

9. How are empathic feelings conveyed to the patient?

Giving full attention while listening demonstrates to the a patient that you are physically present and comprehend what the patient relates. Appropriate physical attending skills enhance this process. Careful analysis of what a patient tells you allows you to respond to each statement with clarification and interpretation of the issues presented. The patient hopefully gains some insight into his or her problem, and rapport is further enhanced.

10. What useful physical attending skills comprise the nonverbal component of communication?

The adept use of face, voice, and body facilitates the classic bedside manner, including the following:

Eye contact. Looking at the patient without overt staring establishes rapport.

Facial expression. A smile or nod of the head to affirm shows warmth, concern, and interest.

Vocal characteristics. The voice is modulated to express meaning and to help the patient to understand important issues.

Body orientation. Facing patients as you stand or sit signals attentiveness. Turning away may seem like rejection.

Forward lean and proximity. Leaning forward tells a patient that you are interested and want to hear more, thus facilitating the patient's comments. Proximity infers intimacy, whereas distance signals less attentiveness. In general, 4—6 feet is considered a social, consultative zone.

A verbal message of low empathic value may be altered favorably by maintaining eye contact, forward trunk lean, and appropriate distance and body

orientation. However, even a verbal message of high empathic content may be reduced to a lower value when the speaker does not have eye contact, turns away with backward lean, or maintains too far a distance. For example, do not tell the patient that you are concerned while washing your hands with your back to the dental chair.

11. During the interview, what cues alert the dentist to search for more information about a statement made by the patient?

Most people express information that they do not fully understand by using generalizations, deletions, and distortions in their phrasing. For example, the comment, "I am a horrible patient," does not give much insight into the patient's intent. By probing further the dentist may discover specific fears or behaviors that the patient has deleted in the opening generalization. As a matter of routine, the dentist should be alert to such cues and use the interview to clarify and work through the patient's comments. As the interview proceeds, trust and rapport are built as a mutual understanding develops and levels of fear decrease.

12. Why is open-ended questioning useful as an interviewing format?

Questions that do not have specific yes or no answers give patients more latitude to express themselves. More information allows a better understanding of patients and their problems. The dentist is basically saying , " Tell me more about it . " Throughout the interview the clinician listens to any cues that indicate the need to pursue further questioning for more information about expressed fears or concerns. Typical questions of the open-ended format include the following: "What brings you here today?," "Are you having any problems?," or "Please tell me more about it."

13. How can the dentist help the patient to relate more information or to talk about a certain issue in greater depth?

A communication technique called facilitation by reflection is helpful. One simply repeats the last word or phrase that was spoken in a questioning tone of voice. Thus when a patient says, "I am petrified of dentists," the dentist responds, "Petrified of dentists?" The patient usually elaborates. The goal is to go from generalization to the specific fear to the origin of the fear. The process is therapeutic and allows fears to be reduced or diminished as patients gain insight into their feelings.

14. How should one construct suggestions that help patients to alter their behavior or that influence the outcome of a command?

Negatives should be avoided in commands. Positive commands are more easily experienced, and compliance is usually greater. To experience a negation, the patient first creates the positive image and then somehow negates it. In experience only positive situations can be realized; language forms negation. For example, to experience the command "Do not run!," one may visualize oneself

sitting, standing, or walking slowly. A more direct command is "Stop!" or "Walk!" Moreover, a negative command may create more resistance to compliance, whether voluntary or not. If you ask someone not to see elephants, he or she tends to see elephants first. Therefore, it may be best to ask patients to keep their mouth open widely rather than to say, "Don't close," or perhaps to suggest, "Rest open widely, please."

A permissive approach and indirect commands also create less resistance and enhance compliance. One may say, "If you stay open widely, I can do my procedure faster and better," or "By flossing daily, you will experience a fresher breath and a healthier smile." This style of suggestion is usually better received than a direct command.

Linking phrases—for example, "as," "while," or "when"—to join a suggestion with something that is happening in the patient's immediate experience provides an easier pathway for a patient to follow and further enhances compliance. Examples include the following: 'As you lie in the chair, allow your mouth to rest open. While you take another deep breath, allow your body to relax further." In each example the patient easily identifies with the first experience and thus experiences the additional suggestion more readily.

Providing pathways to achieve a desired end may help patients to accomplish something that they do not know how to do on their own. Patients may not know how to relax on command; it may be more helpful to suggest that while they take in each breath slowly and see a drop of rain rolling off a leaf, they can let their whole body become loose and at ease. Indirect suggestions, positive images, linking pathways, and guided visualizations play a powerful role in helping patients to achieve desired goals.

15. How do the senses influence communication style?

Most people record experience in the auditory, visual, or kinesthetic modes. They hear, they see, or they feel. Some people use a dominant mode to process information. Language can be chosen to match the modality that best fits the patient. If patients relate their problem in terms of feelings, responses related to how they feel may enhance communication. Similarly, a patient may say, "Doctor, that sounds like a good treatment plan' or "I see that this disorder is relatively common. Things look less frightening now." These comments suggest an auditory mode and a visual mode, respectively Responding in similar terms enhances communication.

16. When is reassurance most valuable in the clinical session?

Positive supportive statements to the patient that he or she is going to do well or be all right are an important part of treatment. Everyone at some point may have doubts or fears about the outcome. Reassurance given too early, such as before a thorough examination of the presenting symptoms, may be interpreted by some patients as insincerity or as trivializing their problem.

The best time for reassurance is after the examination, when a tentative diagnosis is reached. The support is best received by the patient at this point.

17. What type of language or phrasing is best avoided in patient communications?

Certain words or descriptions that are routine in the technical terminology of dentistry may be offensive or frightening to patients. Cutting, drilling, bleeding, injecting, or clamping may be anxiety-provoking terms to some patients. Furthermore, being too technical in conversations with patients may result in poor communication and provoke rather than reduce anxiety. It is beneficial to choose terms that are neutral yet informative. One may prepare a tooth rather than cut it or dry the area rather than suction all of the blood. This approach may be especially important during a teaching session when procedural and technical instructions are given as the patient lies helpless, listening to conversation that seems to exclude his or her presence as a person.

18. What common dental-related fears do patients experience?

- Pain
- Drills (e.g., slipping, noise, smell)
- Needles (deep penetration, tissue injury, numbness)
- Loss of teeth
- Surgery

19. List four elements common to all fears.

- Fear of the unknown
- Fear of physical harm or bodily injury
- Fear of loss of control
- Fear of helplessness and dependency

Understanding the above elements of fear allows effective planning for treatment of fearful and anxious patients.

20. During the clinical interview, how may one address such fears?

According to the maxim that fear dissolves in a trusting relationship, establishing good rapport with patients is especially important. Secondly, preparatory explanations may deal effectively with fear f the unknown and thus give a sense of control. Allowing patients to signal when they wish to pause or speak further alleviates fears of loss of control. Finally, well-executed dental technique and clinical practices minimize unpleasantness.

21. How are dental fears learned?

Most commonly dental-related fears are learned directly from a traumatic experience in a dental or medical setting. The experience may be real or perceived by the patient as a threat, but a single event may lead to a lifetime of fear when any element of the traumatic situation is reexperienced. The situation may have occurred many years before, but the intensity of the recalled fear may persist.

Associated with the incident is the behavior of the past doctor. Thus, in diffusing learned fear, the behavior of the present doctor is paramount.

Fears also may be learned indirectly as a vicarious experience from family members, friends, or even the media. Cartoons and movies often portray the pain and fear of the dental setting. How many times have dentists seen the negative reaction of patients to the term "root canal," even though they may not have had one?

Past fearful experiences often occur during childhood when perceptions are out of proportion to events, but memories and feelings persist into adulthood with the same distortions. Feelings of helplessness, dependency, and fear of the unknown are coupled with pain and a possible uncaring attitude on the part of the dentist to condition a response of fear when any element of the past event is reexperienced. Indeed, such events may not even be available to conscious awareness.

22. How are the terms generalization and modeling related to the conditioning aspect of dental fears?

Dental fears may be seen as similar to classic Pavlovian conditioning. Such conditioning may result in **generalization** , by which the effects of the original episode spread to situation with similar elements. For example, the trauma of an injury or the details of an emergency setting, such as sutures or injections may be generalized to the dental setting. Many adults who had tonsillectomies under ether anesthesia may generalize the childhood experience to the dental setting, complaining of difficulty with breathing or airway maintenance, difficulty with gagging, or inability to tolerate oral injections. Modeling is vicarious learning through indirect exposure to traumatic events through parents, siblings, or any other source that affects the patient.

23. Why is understanding the patient's perception of trol of fear and stress?

According to studies, patients perceive the dentist as both the controller of what the patient perceives as dangerous and as the protector from that danger. Thus the dentist's behavior and communications assume increased significance. The patient's ability to tolerate stress and to cope with fears depends on the ability to develop and maintain a high level of trust and confidence in the dentist. To achieve this goal, patients must express all the issues that they perceive as threatening, and the dentist must explain what he or she can do to address patient concerns and protect them from the perceived dangers. This is the purpose of the clinical interview. The result of this exchange should be increased trust and rapport and a subsequent decline in fear and anxiety.

24. How are emotions evolved? What constructs are important to understanding dental fears?

Psychological theories suggest that events and situations are evaluated by using interpretations that are personality-dependent (i.e., based on individual history and experience). Emotions evolve from this history. Positive or negative coping abilities mediate the interpretative process (people who believe that they are capable of dealing with a situation experience a different emotion during the initial event than people with less coping ability). The resulting emotional experience may be influenced by vicarious learning experiences (watching others react to an event), direct learning experiences (having one's own experience with the event), or social persuasion (expressions by others of what the event means).

A person's coping ability, or self-efficacy, in dealing with an appraisal of an event for its threatening content is highly variable, based on the multiplicity of personal life experiences. Belief that one has the ability to cope with a difficult situation reduces the interpretations that an event will be appraised as threatening, and a lower level of anxiety will result. A history of failure to cope with difficult events or the perception that coping is not a personal accomplishment (e.g., reliance in external aids, drugs) often reduces self-efficacy expectations and interpretations of the event result in higher anxiety.

25. How can learned fears be eliminated or unlearned?

Because fears of dental treatment are learned, relearning or unlearning is possible. A comfortable experience without the associated fearful and painful elements may eliminate the conditioned fear response and replace it with an adaptive and more comfortable coping response. The secret is to uncover through the interview process which elements resulted in the maladaptation and subsequent response of fear, to eliminate them from the present dental experience by reinterpreting them for the adult patient, and to create a more caring and protected experience. During the interview the exchange of information and the insight gained by the patient decrease levels of fear, increase rapport, and establish trust in the doctor-patient relationship. The clinician needs only to apply expert operative technique to treat the vast majority of fearful patients.

26. What remarks may be given to a patient before beginning a procedure that the patient perceives as threatening?

Opening comments by the dentist to inform the patient about what to expect during a procedure—e.g., pressure, noise, pain—may reduce the fear of the unknown and the sense of helplessness. Control through knowing is increased with such preparatory communications.

27. How may the dentist further address the issue of loss of control?

A simple instruction that allows patients to signal by raising a hand if they wish to stop or speak returns a sense of control.

28. What is denial? How may it affect a patient's behavior and dental treatment-planning decisions?

Denial is a psychologic term for the defense mechanism that people use to block out the experience of information with which they cannot emotionally cope. They may not be able to accept the reality or consequences of the information or experience with which they will have to cope; therefore, they distort that information or completely avoid the issue. Often the underlying experience of the information is a threat to self-esteem or liable to provoke anxiety. These feelings are often unconsciously expressed by unreasonable requests of treatment.

For the dentist, patients who refuse to accept the reality of their dental disease, such as the hopeless condition of a tooth, may lead to a path of treatment that is doomed to fail. The subsequent disappointment of the patient may involve litigation issues.

29. Define dental phobia.

A phobia is an irrational fear of a situation or object. The reaction to the stimulus is often greatly exaggerated in relation to the reality of the threat. The fears are beyond voluntary control, and avoidance is the primary coping mechanism. Phobias may be so intense that severe physiologic reactions interfere with daily functioning. In the dental setting acute syncopal episodes may result.

Almost all phobias are learned. The process of dealing with true dental phobia may require a long period of individual psychotherapy and adjunctive pharmacologic sedation. However, relearning is possible, and establishing a good doctor-patient relationship is paramount.

30. What strategies may be used with the patient who gags on the slightest provocation?

The gag reflex is a basic physiologic protective mechanism that occurs when the posterior oropharynx is stimulated by a foreign object; normal swallowing does not trigger the reflex. When overlying anxiety is present, especially if anxiety is related to the fear of being unable to breathe, the gag reflex may be exaggerated. A conceptual model is the analogy to being "tickled." Most people can stroke themselves on the sole of the foot or under the arm without a reaction, but when the same stimulus is done by someone else, the usual results are laughter and withdrawal. Hence, if patients can eat properly, put a spoon in their mouth, or suck on their own finger, usually they are considered physiologically normal and may be taught to accept dental treatment and even dentures with appropriate behavioral therapy.

In dealing with such patients, desensitization becomes the process of relearning. A review of the history to discover episodes of impaired or threatened breathing is important. Childhood general anesthesia, near drowning, choking, or asphyxiation may have been the initiating event that created increased anxiety about being touched in the oral cavity. Patients may fear the inability to breathe, and the gag becomes part of their protective coping. Thus, reduction of anxiety is the first step; an initial strategy is to give information that allows patients to understand better their own response.

Instruction in nasal breathing may offer confidence in the ability to maintain a constant and uninterrupted air flow, even with oral manipulation. Eye fixation on a singular object may dissociate and distract the patient's attention away from the oral cavity. This technique may be especially helpful for taking radiographs and for brief oral examinations. For severe gaggers, hypnosis and nitrous oxide may be helpful; others may find use of a rubber dam reassuring. For some patients longer-term behavioral therapy may be necessary.

31. What is meant by the term anxiety? How is it related to fear?

Anxiety is a subjective state commonly defined as an unpleasant feeling of apprehension or impending danger in the presence of a real or perceived stimulus that the person has learned to the response may be grossly exaggerated. Such feelings may be present before the encounter with the feared situation and may linger long after the event. Associated somatic feelings include sweating, tremors, palpations, nausea, difficulty with swallowing, and hyperventilation.

Fear is usually considered an appropriate defensive response to a real or active threat. Unlike anxiety, the response is brief, the danger is external and readily definable, and the unpleasant somatic feelings pass as the danger passes. Fear is the classic "fight-or-flight" response and may serve as an overall protective mechanism by sharpening the senses and the ability to respond to the danger. Whereas the response of fear does not usually rely on unhealthy actions for resolution, the state of anxiety often relies on noncoping and avoidance behaviors to deal with the threat.

32. How is stress related to pain and anxiety? What are the major parameters of the stress response?

When a person is stimulated by pain or anxiety, the result is a series of physiologic responses dominated by the aut000mic nervous system, skeletal muscles, and endocrine system. These physiologic responses define stress. In what is termed adaptive responses, the sympathetic responses dominate (increases in pulse rate, blood pressure, respiratory rate, peripheral vasoconstriction, skeletal muscle tone, and blood sugar; decreases in sweating, gut motility, and salivation). In an acute maladaptive response the parasympathetic responses dominate, and a syncopal episode may result (decreases in pulse rate, blood pressure, respiratory rate, muscle tone; increases in salivation, sweating, gut motility, and peripheral vasodilation, with overall confusion and agitation). In chronic maladaptive situations, psychosomatic disorders may evolve. The accompanying figure illustrates the relationships of fear, pain, and stress. It is important to control anxiety and stress during dental treatment. The medically compromised patient necessitates appropriate control to avoid potentially life-threatening situations.

33. What is the relationship between pain and anxiety?

Many studies have shown the close relationship between pain and anxiety. The greater the person's anxiety, the more likely it is that he or she will interpret the response to a stimulus as painful. In addition, the pain threshold is lowered with increasing anxiety. People who are debilitated, fatigued, or depressed respond to threats with a higher degree of undifferentiated anxiety and thus are more reactive to pain.

34. List four guidelines for the proper management of pain, anxiety, and stress.

1. Make a careful assessment of the patient's anxiety and stress levels by a thoughtful inter view. Uncontrolled anxiety and stress may lead to maladaptive situations that become life-threatening in medically compromised patients. Prevention is the most important strategy.

2. From all information gathered, medical and personal, determine the correct methods for control of pain and anxiety. This assessment is critical to appropriate management. Monitoring the patient's responses to the chosen method is essential.

3. Use medications as adjuncts for positive reinforcement, not as methods of control. Drugs circumvent fear; they do not resolve conflicts. The need for good rapport and communication is always essential.

4. Adapt control techniques to fit the patient's needs. The use of a single modality for all patients may lead to failure; for example, the use of nitrous oxide sedation to moderate severe emotional problems.

35. Construct a model for the therapeutic interview of a self-identified fearful patient.

1. Recognize a patient's anxiety by acknowledgment of what the patient says or observation of the patient's demeanor. Recognition, which is both verbal and nonverbal, may be as simple as saying, "Are you nervous about being here?" This recognition indicates the dentist's concern, acceptance, supportiveness, and intent to help.

2. Facilitate patients' cues as they tell their story. Help them to go from generalizations to specifics, especially to past origins, if possible. Listen for generalizations, distortions, and deletions of information or misinterpretations of events as the patient talks.

3. Allow patients to speak freely. Their anxiety decreases as they tell their story, describing the nature of their fear and the attitude of previous doctors. Trust and rapport between doctor and patient also increase as the patient is allowed to speak to someone who cares and listens.

4. Give feedback to the patient. Interpretations of the information helps patients to learn new strategies for coping with their feelings and to adopt new behaviors by confronting past fears. Thus a new set of feelings and behaviors may replace maladaptive coping mechanisms.

5. Finally the dentist makes a commitment to protect the patient—a commitment that the patient may have perceived as absent in past dental experiences. Strategies include allowing the patient to stop a procedure by raising a hand or simply assuring a patient that you are ready to listen at any time.

36. Discuss behavioral methods that may help patients to cope with dental fears and related anxiety.

1. The first step for the dentist is to become knowledgeable of the patient and his or her presenting needs. Interviewing skills cannot be overemphasized. A trusting relationship is essential. As the clinical interview proceeds, fears are usually reduced to coping levels.

2. Because a patient cannot be anxious and relaxed at the same moment, teaching methods of relaxation may be helpful. Systematic relaxation allows the patient to cope with the dental situation. Guided visualizations may be helpful to achieve relaxation. Paced breathing also may be an aid to keeping patients relaxed. Guiding the rate of inspiration and expiration allows a hyperventilating patient to resume normal breathing, thus decreasing the anxiety level. A sample relaxation script is included below.

Relaxation Script

The following example should be read in a slow, rhythmic, and paced manner while carefully observing the patient's responses. Backing up and repeating parts are beneficial if you find that the patient is not responding at any time. Feel free to change and incorporate your own stylistic suggestions.

Allow yourself to become comfortable. . . and as you listen to the sound of my voice, I shall guide you along a pathway of deepening relaxation. Often we start Out at some high level of excitement, and as we slide, down lower, we can become aware of our descent and enjoy the ride. Let us begin with some attention to your breathing…taking some regular, slow…easy…breaths. Let the air flow in…and out... air in... air out... until you become very aware of each inspiration... and... expiration [Very good. Now as you feel your chest rise with each intake and fall with each outflow,

notice how different you now feel from a few moments ago, as you comfortably resettle yourself in the chair, adjusting your arms and legs just enough to make you feel more comfortable.

Now with regularly paced, slow, and easy breathing, I would like to ask that you become aware of your arms and hands as they rest [where you see them, e.g., "on your lap"] Move them slightly. [Next become aware of your legs and feel the chair's support under them. . . they may also move slightly. We shall begin our total body relaxation in just this way .. . becoming aware of a part and then allowing it to become at ease.. . resting, floating, lying peacefully. Start at your eyelids, and, if they are not already closed, allow them to become free and rest them downward. . . your eyes may gaze and float upward. Now focusing on your

forehead . . . letting the subtle folds become smoother and smoother with each breath. Now let this peacefulness of eyelids and forehead start a gentle warm flow of relaxing energy down over your cheeks and face, around and under your chin, and slowly down your neck. You may find that you have to swallow . . . allow this to happen, naturally. Now continue this flow as a stream ambling over your shoulders and upper chest and over and across to each arm [and when you feel this warmth in your fingertips you may feel them move ever so slightly. [for any movement] Very good.

Next allow the same continuous flow to start down to your lower body and over you waist and hips reaching each leg. You may notice that they are heavy, or light, and that they move ever so slightly as

you feel the chair supporting them with each breath and each swallow that you take. You are resting easily, breathing comfortably and effortlessly. You may become aware of just how much at ease you are now, in such a short time, from a moment ago, when you entered the room. Very good, be at ease.

3. Hypnosis, a useful tool with myriad benefits, induces an altered state of awareness with heightened suggestibility for changes in behavior and physiologic responses. It is easily taught, and the benefits can be highly beneficial in the dental setting.

4. Informing patients of what they may experience during procedures addresses the specific fears of the unknown and loss of control. Sensory information—that is, what physical sensations may be expected—as well as procedural information is appropriate. Knowledge enhances a patient's coping skills.

5. Modeling, or observing a peer undergo successful dental treatment, may be beneficial. Videotapes are available for a variety of dental scenarios.

6. Methods of distraction may also improve coping responses. Audio or video programs have been reported to be useful for some patients.

37. What are common avoidance behaviors associated with anxious patients?

Commonly, putting off making appointments followed by cancellations and failing to appear are routine events for anxious patients. Indeed, the avoidance of care can be of such magnitude that personal suffering is endured from tooth ailments with emergency consequences. Mutilated dentition often results.

38. Whom do dentists often consider their most "difficult" patient?

Surveys repeatedly show that dentists often view the anxious patient as their most difficult challenge. Almost 80% of dentists report that they themselves become anxious with an anxious patient. The ability to assess carefully a patient's emotional needs helps the clinician to improve his or her ability to deal effectively with anxious patients. Furthermore, because anxious patients require more chair time for procedures, are more reactive to stimuli, and associate more sensations

with pain, effective anxiety management yields more effective practice management.

39. What are the major practical considerations in scheduling identified anxious dental patients?

Autonomic arousal increases in proportion to the length of time before a stressful event. A patient left to anticipate the event with negative self-statements and perhaps frightening images for a whole day or at length in the waiting area is less likely to have an easy experience. Thus, it is considered prudent to schedule patients earlier in the day and keep the waiting period after the patient's arrival to a minimum. In addition, the dentist's energy is usually optimal earlier in the day to deal with more demanding situations.

40. What behaviors on the dentist's part do patients specify as reducing their anxiety?

- Explain procedures before starting.
- Give specific information during procedures.
- Instruct the patient to be calm.
- Verbally support the patient: give reassurance.
- Help the patient to redefine the experience to minimize threat.
- Give the patient some control over procedures and pain.
- Attempt to teach the patient to cope with distress.
- Provide distraction and tension relief.
- Attempt to build trust in the dentist.
- Show personal warmth to the patient.

Corah N: Dental anxiety: Assessment, reduction and increasing patient satisfaction. Dent Clin North Am 32:779—790, 1988.

41. What perceived behaviors on the dentist's part are associated with patient satisfaction?

- Assured me that he would prevent pain
- Was friendly
- Worked quickly, but did not rush
- Had a calm manner
- Gave me moral support
- Reassured me that he would alleviate pain
- Asked if I was concerned or nervous
- Made sure that I was numb before starting to work

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