



MANAGEMENT OF DENTAL ANXIETY IN DENTAL CLINIC

Dental Science

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KEYWORDS

Introduction,

Dental anxiety and fear are common and potentially problematic, both for the patient and for the dental team in managing such patients. Furthermore, dental fear still presents a major barrier to the uptake of dental treatment¹. This article will take as its premise an assumption that anxiety manifests at different levels and that consequently management of dental anxiety involves both assessment and proportionate intervention. Methods for undertaking both assessment and management are outlined.. Many anxious or phobic patients will accept dental treatment if managed by sympathetic staff with the assistance of psychological therapies². A proportion of the population will, however, require sedation to help them accept dental treatment. It should be remembered that whilst fear of dentistry is commonplace there are other reasons why patients may refuse dental care: the patient may have behavioural problems or lack the capacity to understand the proposed treatment. When managing patients who are reluctant to have dental treatment it is important to understand the difference between anxiety and phobia³.

Phobia

Phobia: an irrational fear of a particular object or situation – the fear response is excessive and disproportionate to the threat posed. The stimulus is comparatively small compared to the severity of the reaction. This is a lasting abnormal fear that is usually deep rooted in a patient's emotions and often its origin cannot be explained, although this is not always the case. The patient has little or no control over the phobia and logical thought is not a feature. A phobia can significantly change a patient's behavior. Embarrassment and shame are often present^{4,5}.

Anxiety

Anxiety: a human emotion which causes feelings of apprehension, tension and discomfort and is associated with increased activity of the sympathetic nervous system. Anxiety is a learnt response. Anxiety can be beneficial (eg it is often anxiety that precipitates a candidate to study for examinations), but anxiety is not always a helpful state to be in. An anxious patient is in a state of unease. Anxiety can be measured by using self-reported questionnaires such as the Modified Dental Anxiety Scale⁶. Dental anxiety has implications for both the patient and the dental team. A variety of studies have shown that the prevalence of dental anxiety is high, affecting up to one third of the UK population. The 1998 Adult Dental Health Survey identified that 32% of dentate patients in the UK population 'always feel anxious about going to the dentist'. This figure rises to 46% in dentate patients who only attend when they have some trouble with their teeth⁷. It is interesting to note that 59% of dentate patients reported that they attended for regular dental checkups. Anxiety therefore remains a

barrier to dental care in a significant proportion of the population. Approximately 10% of the population avoids dental care because dental treatment provokes overwhelming feelings of anxiety which exceed the sufferer's ability to cope; such patients have dental phobia^{8,5}.

THE NATURE OF DENTAL FEAR

Before making any decision regarding the use of specific anxiety management approaches, it is important to be aware of the nature of a person's dental anxiety and fear because this can be a crucial determining factor in managing the problem^{9,10}. While it has generally been regarded that the underlying cause of anxiety is the result of direct negative dental experiences, the nature of dental anxiety is more complicated than what is commonly presumed. For example, it has been proposed, and evidence suggests, that how a person perceives the dental environment is a considerably more important determinant of dental fear and avoidance than having had a previous distressing experience at a dental visit. Avoidance of dental care might also be an aspect of some other condition, such as fear of social evaluation (as in social phobia), fear of germs (as in obsessive compulsive disorder) or fear of being away from the safety of home (as in panic disorder with or without agoraphobia)¹¹. Dental anxiety and fear might also focus on various aspects of the treatment experience, and specific concerns might be independent of other possible concerns.

Spectrum of symptoms

Patients who are anxious or phobic about dental treatment may have generalized concerns about many aspects of dentistry or they may have very specific worries, such as a fear of injections. Their patients have a fear of the unknown or feel that they may lose control. Anticipation of pain during dental treatment is a frequently reported reason for dental anxiety and fear. Anxiety may be based around one or more previous distressing experiences, such as pain, but it is not always possible to identify specific traumatic life events^{12,6}.

Impact on quality of life

Research has shown that many patients who have high levels of dental anxiety also display other fears or psychological problems and these may adversely influence treatment outcome. Dental anxiety can have a profound detrimental impact on the quality of life of the sufferer. One study by Cohen et al. has shown that the impact of dental anxiety on people's lives can be divided into the five categories outlined below: Physiological disruption – eg dry mouth, increased heart rate, sweating. Cognitive changes – eg negative and even catastrophic thoughts and feelings, unhelpful beliefs and fears. Behavioural changes – eg alteration of diet, attention to oral hygiene, avoidance of dental environment, crying, aggression. Health changes – eg sleep disturbance, acceptance of poor oral health. Disruption of social roles –

eg reduced social interactions and adverse affects on performance at work. Family and personal relationships can also be adversely affected¹³.

Anxiety management

The management of anxious/phobic patients is dependent upon the severity of the condition and the treatment that needs to be undertaken. The medical history of the patient also influences management. It is important to control anxiety in patients who have systemic disease that is aggravated or triggered by stress, for example hypertension, epilepsy or asthma. The spectrum of patient management varies from psychological or behavioural approaches to the use of pharmacological agents such as anxiolytic drugs or general anaesthesia (GA)¹⁴.

Behavioural techniques

Behavioural techniques are employed as a matter of routine by many dentists, and are perhaps most evident when children are being treated. Positive reinforcement is frequently used as shown by the delivery of praise to an appropriately behaved patient¹⁵. The age and emotional development of a child must always be taken into account when deciding upon which techniques to use. Anxious patients should always be given a stop signal as this transfers an element of control to the patient. A commonly used signal is simply raising a hand and it can be helpful for the patient to rehearse this briefly before treatment. The dental team must always respond appropriately to such signals. The trust of a patient can take a long time to build up but can be very quickly undermined or destroyed. Behavioural management can be time consuming and expertise is required^{16,14}. Dentists who have access to a clinical psychologist are very much at an advantage. Patients with needle phobias can often be cured of their phobia by employing a systematic desensitization programme.

Much of the preceding discussion of non-pharmacological management approaches for dental fear and anxiety is as applicable to children as it is to adults.

However, children also present their own set of unique challenges for the clinician. Also, the effectiveness of some of the abovementioned approaches will be greater or lesser when working with children. In this regard, the developmental level of the child might be of critical relevance. In particular, reinforcement and distraction might work well for all children while providing more information about the treatment procedures might be less valuable depending upon the age and interest of the child. There are also behaviour management approaches which are particularly suitable for children rather than adults, and these shall be discussed below.

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