Abstract
The relationship between a dental professional and the patient is the heart of what keeps the practice thriving and patients returning. Most patients trust the staff members and establish a "dental home" in which they feel cared for and safe. For some people, a history of personal trauma, anxiety, or substance use can paralyze them during a dental appointment. The fear of a dental appointment or professional may be so overwhelming, a patient may behave in an exaggerated manner in the chair or avoid going to the dentist altogether. Awareness of potential stressors that provoke these behaviors, including the neurobiological responses to trauma, can help dental professionals provide optimum service with empathy and compassion.

Educational Objectives:
At the conclusion of this educational activity participants will be able to:
1. Describe the reactions of patients who have dental fear due to past non-dental related trauma.
2. Explain biological and physiological effects of trauma in the human brain.
3. Associate psychological symptoms of trauma with dental anxiety.
4. Identify practical applications for dental professionals to alleviate dental fear.

Author Profiles
Kandice Swarthout-Roan, RDH, BS, has practiced clinical dental hygiene for 16 years and is part-time faculty in the dental hygiene program at Collin College, McKinney, Texas. Priya Singhvi, MS, LPC-I, LMFT-A, has been working in the field of psychology and education for over 11 years. Priya currently serves as P.A.L. sponsor, wellness educator, and full-time counselor at a private school in Addison, Texas.

Author Disclosure
Kandice Swarthout-Roan and Priya Singhvi have no commercial ties with the sponsors or providers of the unrestricted educational grant for this course.
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Abstract
The relationship between a dental professional and the patient is the heart of what keeps the practice thriving and patients returning. Most patients trust the staff members and establish a “dental home” in which they feel cared for and safe. For some people, a history of personal trauma, anxiety, or substance use can paralyze them during a dental appointment. The fear of a dental appointment or professional may be so overwhelming, a patient may behave in an exaggerated manner in the chair or avoid going to the dentist altogether. Awareness of potential stressors that provoke these behaviors, including the neurobiological responses to trauma, can help dental professionals provide optimum service with empathy and compassion.

Problem Assessment
Dental professionals recognize that building a relationship with patients cultivates trust, which is critical for the patient to make informed decisions about treatment and return for future appointments. For some patients, the bond with the hygienist, assistant, or dentist may be a matter of life or death in their minds. When a person has suffered a severe traumatic experience, he or she may perceive little to no control when placed in a vulnerable situation including a dental appointment. In this vulnerable state, the patient may suddenly, sometimes without knowing why, react with fear and anxiety in the chair. Dental fear manifests in many ways, sometimes leaving the clinician confused and frustrated and the patient further traumatized. The vicious cycle of dental fear and avoidance suggests that intense fears lead to dental avoidance, poor oral health, fewer office visits, increased need for treatment, and greater perceived vulnerability. The patient gets trapped in this cycle of fear and continues to avoid appointments or feels extremely anxious at the mere thought of going to the dentist. The delay in seeking treatment due to dental fear can greatly impact the patient’s quality of life. The recognition of dental fear and the potential underlying causes may enable the dental professional to help patients reduce or stop the cycle.

In 1946, Coriat described dental fear as “an excessive dread of anything done to the teeth.” He suggested that this anticipatory anxiety was not based on the actual pain, but on a psychological meaning deeper than the actual dental treatment. He named this anxiety, based in expectation and dread, “tooth neurosis.” He said that the fear of dental treatment is unique because it is rooted in unknown fear and real danger. The patient is well aware that real danger is possible, but in most cases little or no pain is experienced. The combination of the perceived and real fear can escalate the anticipatory anxiety to a level beyond the patient’s ability to process.

Reactions to dental treatment include severe fear and anxiety during a dental appointment. Prior experiences may be the source of the dental fear including; adult survivors of childhood sexual abuse (CSA), posttraumatic stress disorder (PTSD), substance abuse, and anxiety disorders.

Childhood Sexual Abuse
Approximately 20% of all females seeking dental treatment are survivors of CSA. Another study reported that among women with high levels of dental fear, 34% experienced childhood molestation, 15% reported attempted rape, and 13% reported rape or incest. Three-fourths of women with a history of oral penetration associated with CSA had very high levels of dental fear. Women with CSA had higher levels of dental fears than those in the normative sample. It is crucial for dental professionals to increase their awareness of this issue to ensure optimum patient care. During a typical day at the office it is likely that a survivor of CSA will be treated.

Childhood sexual abuse is a serious issue that, for most individuals, is based in shame and may remain undisclosed for a lifetime. CSA can affect oral health in many ways with the most serious of the consequences manifesting as psychological issues. The patient may have reduced self-esteem, difficulty in interpersonal relationships, and reduced initiative. When these factors continue unresolved, a dental appointment may be a fearful situation. The patient feels extremely vulnerable during an appointment, which results in a sense of helplessness. In order to avoid helplessness and vulnerability, the patient may choose to circumvent dental appointments until he or she is in severe pain or in an advanced disease state, increasing the vicious cycle. Others will seek dental treatment in spite of their fear, but suffer from anxiety without always understanding the etiology. Treating fearful dental patients can develop into a stressful situation for the provider and patient. As clinicians become more aware of the signs and symptoms of CSA-based fear, they can modify their approach to the patient, provide a less stressful visit, and potentially help patients reduce their fear long term.

As a dental professional, it is important to recognize survivors of CSA to understand extreme reactions during an appointment. CSA is typically a secret for the patient. They may not connect their dental fear to past experiences.

Posttraumatic Stress Disorder
Posttraumatic stress disorder is characterized as an anxiety disorder. This course will focus on PTSD as a separate entity from the other anxiety disorders because of the need to raise
awareness of its impact on human lives and the dental appointment.

The Diagnostic and Statistical Manual for Mental Disorders (DSM-IV-TR) defines posttraumatic stress disorder (PTSD) as:

“the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one’s physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or close associate.”

Many people believe that PTSD happens only to members of the military that have been in combat situations. PTSD can affect anyone at any time when faced with serious or perceived danger. The potential events leading to PTSD other than military related events include: violent personal assault, kidnapping, terrorist attack, torture, incarceration, natural or manmade disasters, automobile accidents, life-threatening illness, murder of a loved one, and peer suicide. Other events such as witnessing another person suffer harm can trigger PTSD. The actual event does not cause trauma, but rather how the event was experienced, which helps to explain why some people can overcome unthinkable situations without PTSD symptoms, while others cannot. Posttraumatic stress disorder is different from other mental health diagnoses due to four types of symptoms: reexperiencing, avoidance, numbing, and arousal. PTSD breaks down the entire system, leaving the patient in survival mode and chronically hypervigilant.

When a dental professional is unaware of a patient’s PTSD diagnosis, he or she may be surprised that dental treatment can trigger any of the referenced four symptoms. “Tooth neurosis” can be a reaction to a specific danger that is either an internal or external threat. A patient with PTSD may respond to a perceived threat in the dental chair due to a hypervigilant state.

Disclosure of PTSD may not be revealed in the health history for many reasons ranging from the patient not thinking the information is relevant to simply not realizing he or she suffers from PTSD.

Anxiety Disorders

Eighteen percent of American adults suffer from anxiety disorder, ensuring that dental professionals occasionally treat patients with significant anxiety disorder that manifests in the dental chair.

Individuals with anxiety disorders are more likely to have higher levels of dental fear than patients without these disorders. Anxiety disorders include a wide range of symptoms and specific diagnoses. The American Psychiatric Association lists the following anxiety disorders in the DSM-IV-TR:

- Panic attack
- Agoraphobia
- Panic attack without agoraphobia
- Agoraphobia without history of panic attack
- Specific phobia
- Social phobia
- Obsessive-compulsive disorder
- Posttraumatic stress disorder
- Acute stress disorder
- Generalized anxiety disorder
- Anxiety disorder due to a medical condition
- Substance-induced anxiety disorder
- Anxiety disorder not otherwise specified

All of these disorders present with diverse symptoms, but they are all rooted in irrational dread and fear. These fears can be acquired through classical conditioning, modeling, and stimulus generalization. Classical conditioning occurs when a person experiences similar events that transpire within a close time proximity, stimulating an anxious or fearful response. Modeling is when someone develops fear based on observations of others’ phobias. Stimulus generalization is a phenomenon that occurs when a response to one stimulus can be provoked by a separate but similar stimulus. The patient may not be able to conceptualize the onset or etiology of their fear, but it can be very real and powerful.

Anxiety disorders may be easy to recognize during the health history update because many patients with anxiety disorders will be medicated. The general categories of medications include: selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, monoamine oxidase inhibitors (MAOIs), and beta blockers. Gentle, open-ended questions may facilitate the patient’s disclosure of anxiety medications and may assist in identifying a patient with an anxiety disorder.

At least 40 million American adults suffer from anxiety disorders in a given year. Some anxiety disorders are acute in nature, causing situational disturbances. Other more serious forms of anxiety disorders may grow increasingly worse and last a lifetime, requiring medication and counseling, and are associated with depression and substance abuse (U.S. Department of Health and Human Services, 2009).

Participants with anxiety disorder were surveyed for dental fear and 36.9% of the participants reported moderate to severe dental fear.

Substance Abuse

Substance abuse may not be widely recognized by dental professionals as a source of anxiety for the patient. When describing a patient with substance abuse, some dental professionals may tend to think of a drug-seeking patient, which results in mistrust and lack of compassion. Though it is important to recognize when a patient is seeking narcotics, it is also important to be knowledgeable of how a person with substance abuse issues can present as an anxious patient.
The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR) defines substance abuse as: A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
2. Recurrent substance use in situations in which it is physically hazardous.
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

A patient can easily get caught in the vicious cycle when struggling with substance abuse. For most, avoidance of dental appointments until severe dental issues arise is common because the clinically significant impairment or distress (as described in the DSM-IV-TR) overrides the need for self-care. The patient may have significant dental neglect due to the substance-related manifestations of behavior and feelings. The patient may tend to neglect his or her personal needs while engaging in risky and impulsive behaviors. When the patient finally does seek dental care, he or she is in pain and may feel highly embarrassed by the neglect and events leading to the emergency appointment. Most likely, substance abusing patients will not disclose their addictive behaviors. They will proceed with anxiety about the treatment and worry that their addiction will be discovered by the dentist or hygienist.

Neuroscience of Dental Fear
The neurobiological response to various stressors can fluctuate from patient to patient. A dental professional’s awareness of the brain processes that react to stimuli can enhance understanding of the patient’s and clinician’s actions.

The impact of sexual abuse, in addition to other influences, on biological stress systems and the development of the brain are complex and challenging to separate. There are social, psychological, and cognitive effects that may result after a person has experienced sexual abuse. As seen in Figure 1, a person could experience anxiety symptoms similar to those of posttraumatic stress disorder. The secondary symptoms may include unregulated disturbances on several biological systems which, as time elapses, could result in malfunctioning brain development and exaggerated symptom offear and anxiety during a dental appointment.

The anatomy of PTSD anxiety or overwhelming stress is multifaceted. During the amplified traumas of child abuse incidents, the neuroendocrine axes and several neurotransmitter systems are stimulated. Exposure to stress influences several systems: the immune system, neurotransmitter systems, and neuroendocrine systems—which are linked to regulate reactions to standard stimuli in addition to acute and prolonged stressors.

The neurobiological effects of childhood sexual abuse and trauma are very similar to the direct and indirect effects experienced during a dental appointment. The neurobiological effects of PTSD are similar to the fear-based reactions to dental anxiety, so behaviors may be amplified during a dental appointment.

“The essential symptoms of pediatric PTSD and generalized anxiety disorder are social worries and associated autonomic hyperarousal….Social cues may trigger PTSD symptoms of hypervigilance.” Childhood sexual abuse is a trauma associated with social situations. Therefore, cues that may remind patients of the trauma are relational and can come without intention (e.g., looking directly at a person, inflection of voice, etc.).

Hypotheses for posttraumatic stress disorder in adult populations indicate that these neurobiological stress response systems develop in abnormal ways, which can result in permanent, damaging effects.

The neurobiological effects of PTSD are very similar to the direct and indirect effects experienced during a dental appointment. If you are treating a patient with PTSD, these biological responses may be exaggerated and could place the patient at risk.

Compromised Immune System
Unfavorable experiences during childhood and adolescence are strongly correlated with several acute health problems in adulthood, including poor self-rated health and hygiene. Patients with poor oral hygiene that exhibit a lack of self-care for health issues are more likely to need a dental appointment. These patients are more likely to require additional dental work during an appointment or have severe pain that will force them to seek dental treatment.

The effects of sexual abuse and trauma on health and immunity merits future research in pediatric populations.
Increased Generalized Fear and Reduced Sociability

Primate studies have shown that children reared in an unstable environment developed insecure attachment behavior patterns, evidenced by reduced social competence and heightened fearful behaviors. Individuals who have been raised in an unstable environment may develop into dental patients that appear to have increased fear of the dentist in addition to being unsociable.

Patient Presentation

The aforementioned issues should serve as a guide for knowledge and awareness so the clinician can make adjustments to provide optimum care. The clinician should not use these recommendations to make a diagnosis or confront the patient about a possible concern. In fact, a practitioner may spend years treating a patient who presents with an emotional or mental health issue without patient disclosure.

If an individual statistically combines the number of patients that may have experienced sexual abuse (20%), or an anxiety disorder (18%), the magnitude of these afflictions becomes very apparent. In any given day, a dentist or hygienist could have patients that suffer from dental related anxiety. Knowledge and awareness are key components to making appointments a success.

Childhood Sexual Abuse

Patients who have dental fear due to a history of CSA may experience a lack of trust, fear of loss of control, struggle with factors relating to communication, and have difficulty receiving negative information. It may be challenging to remain still or quiet during the appointment. Dental treatment may provoke PTSD symptoms, flashbacks, and dissociation. Dissociation is “a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment” which becomes the patient’s way of coping during a time of crisis.

Patients who dissociate may present clinically in ways that are surprising or frustrating to the clinician. Many patients have an intense fear of being in a supine position, of the dentist or hygienist touching their lips or putting anything in their mouths, and being in close proximity to the clinician. Patients may react with panic, tension in the body, crying, reluctance to open their mouth, a sense of distrust toward the clinician, and a need to know what is happening. To the hygienist or dentist, this behavior may seem extreme or unnecessary during a simple procedure, but to the patient the appointment can be perceived as a matter of life or death in that moment. The reaction of the patient sometimes elicits frustration and a feeling of powerlessness for the clinician as well as the patient. Despite the clinician’s best attempt to ease the patient, the patient may seem inconsolable. These events may also unfold even when a fearful patient is told they need a simple procedure.

Hygienists have reported anecdotally being surprised when a patient gets extremely emotional after being told they need a single-surface composite filling. To the hygienist, this may be an exaggerated response. To the female patient, the fear of having a male dentist close to her with his hands in her mouth is more than she can tolerate. Specifically, the dentist is referenced here as male because statistics show most abusers are male, making a male dentist more threatening to a female patient. Willumsen’s research also revealed that 56.3% of women in the study suffering from dental fear reported oral penetration during sexual abuse. It was concluded that these past experiences evoked severe anticipatory anxiety prior to the dental visit and created a situation of fear of loss of control and fear of an “intimate” situation with the dentist.

It should be noted that not all victims of CSA suffer from dental fear. Traumatic experiences do not always result in psychological issues for the patient. As clinicians it is important to be aware of these potential aspects of patient’s experiences. It is also crucial to remember that CSA is a secret for most victims and if behavior is indicative of childhood sexual abuse, the clinician handles it with respect and compassion.

Posttraumatic Stress Disorder

Patients suffering with PTSD may look very similar to those who are survivors of CSA. Sexual trauma and PTSD may go hand in hand because victims of CSA may have PTSD due to the extent of the trauma.

Reexperiencing the traumatic event is also called “flashback.” The individual is haunted with vivid recurring thoughts, memories, dreams, or nightmares. These experiences are very real to the individual. They may actually reexperience the trauma in their minds, transporting them to a place of intense fear and helplessness. Avoidance is the act of purposefully avoiding thoughts, activities, or conversations that remind the individual of the event. Reduced responsiveness or numbing occurs when individuals detach themselves from activities or interests that were formerly enjoyed. Some will experience symptoms of dissociation or psychological separation. Arousal or increased anxiety occurs because the person feels a sense of hyperalertness, is startled easily, has trouble concentrating, and may develop sleep disorders. He or she may also experience extreme levels of guilt surrounding the event.

Information about these symptoms may be ascertained in the health history, but often patients do not share it or they are not aware that something during the dental appointment could trigger maladaptive responses.

Pain and sensitivity in the dental chair may elicit emotional and/or physical responses such as increased heart rate, chills, panic, or uncontrollable shaking. The procedures during a dental appointment can be a trigger for patients due to pain, lights, sounds, and smells. The loss of connection and highly aroused state when the patient experiences one of these triggers...
puts him or her in survival mode, creating a stressful situation for the patient and provider. It is not the dental clinician’s responsibility to diagnose PTSD, but when symptoms are recognized, the hygienist, assistant or dentist can make the proper adjustments to accommodate the patient.

Anxiety Disorders
Anxiety can be described as an ambiguous awareness of danger that increases breathing, body temperature, and muscle tension. It prepares or alerts people to adapt to a “fight or flight” situation. For some, the anxiety becomes incapacitating and prevents the enjoyment of everyday life events. Individuals with anxiety and phobia disorders more frequently report intensified dental fear than those without such conditions.

The relationship between individuals with phobias and a tendency to attach exaggerated meaning to their experiences may lead to the expression of inappropriate behavior during a dental visit. The perceived threat is intense and he or she is in a vulnerable position with loss of control. Similar to survivors of CSA and PTSD, a patient with an anxiety disorder may become extremely overwhelmed by being in the supine position. The dental experience can be fearful to someone without an anxiety disorder due to the unknown and anticipated pain and discomfort.

Behaviors consistent with dental fear due to an anxiety disorder can present as a patient who is suddenly tearful, cries or yells out when minimal dental work is being performed, becomes aloof or angry once they are seated in the chair, has somatic symptoms such as shaking or sweating, tenses up, and/or has difficulty keeping his or her mouth open. The patient may even move his or her head abruptly and erratically during a procedure, creating a dangerous situation. These same behaviors may also be present in a survivor of CSA.

Since it is not the clinician’s responsibility to diagnose the psychological etiology, it is important that he or she proceeds with awareness and compassion. Only by establishing trust can the patient start a journey toward decreasing intense dental fear.

Substance Abuse
The patient suffering from any type of substance abuse will likely avoid dental treatment as long as possible due to self-neglect and fear their addiction will be discovered. This patient is likely to seek care after a dental emergency occurs. There is a high risk of periodontitis, caries, missing teeth, and other oral disease among persons with substance addiction. Also, there may be an increased risk for problems with pain management during dental procedures as the anesthetic may be perceived as ineffective.

Based on the elevated incidence of disease and decreased effectiveness of oral anesthesia, a patient actively or formally addicted to a substance may suffer from severe anxiety about dental treatment. The anxiety could stem not only from the perceived threat of pain during treatment, but also the anticipated embarrassment when others witness the oral condition. With multifaceted levels of potential shame and fear due to neglect and risky behavior, it is crucial to build a trusting relationship with this patient. It is likely that he or she will require a great deal of empathy and compassion to return for a non-emergency visit. A patient actively or formally addicted may show similar symptoms to someone with an anxiety disorder. Anxiety disorders are often dual diagnosed with substance abuse.

Coping with Dental Anxiety
The link between consequences of trauma and an experience in the dental office may manifest in a variety of ways including resistance to being placed in the horizontal position, fear of having objects placed over the face, sudden outbursts of crying without apparent reason, difficulty opening wide, severe gagging, and an involuntary turning of the head away from the clinician as he or she approaches the mouth.

Regrettably, dentists and hygienists can exacerbate the dental experience due to lack of knowledge and/or comprehension of the processes that are the root of the patient’s actions. Patients who have been victims of childhood sexual abuse or assault may have flashbacks when in the dental chair due to the restrictive environment of a confined office or chair. The most harmful reaction is the frustrated dental professional who attempts to take control of the situation or inadvertently makes insensitive comments. Demeaning the patient or dealing with the situation authoritatively may deteriorate the patient’s state of mind and may reactivate the traumatic event.

Effects on the Dental Professional
The concept of emotional labor is defined as “the practice of controlling one’s emotions on the job, [which] may be integral to performing the job, but may have unintended consequences for the practitioner.” Emotional labor becomes particularly draining for the professionals who are invested in the patient’s well-being. Thinking about patients after they have left the dental office has been strongly linked with interpersonal, psychological, and vocational stress. In addition, dental professionals carry the burden of frequently being required to inflict discomfort in order to appropriately execute dental treatments. Emotional labor has been correlated with individual and organizational concerns including employee attrition, diminished performance at work, and burnout.

If a patient presents with symptoms that are associated with childhood sexual abuse, trauma, anxiety, or substance abuse, a dental professional is more likely to experience high levels of emotional labor. It is important for dentists and hygienists to protect themselves from these vocational and psychological strains. Some techniques utilized to alleviate emotional labor include deep acting and surface acting. Deep acting is less psychologically exhausting than surface acting.
for dental professionals. Deep acting denotes altering an individual’s perception of an experience or distracting attention and refocusing on positive cognitions to actually augment the underlying emotions.20 For example, a dentist who is irritated by a patient telling him or her to stop every few seconds could understand the situation from the patient’s point of view to reduce the feelings of irritation. In addition, operating from a framework of empathy is less taxing on the dental professional and even builds rapport with the patient. Surface acting, however, refers to changing only the visible representation of a reaction to an experience without actually modifying thoughts. For example, a dental hygienist could pretend to be excessively amiable or completely repress feelings by smiling through a painful procedure. Surface acting was linked to feeling numb or drained emotionally. Another aspect to keep in mind is that the dental profession is well-respected, appreciated, and gives back to the community; this conceptualization can buffer psychological stressors.20

Techniques to Integrate

Being a well-informed, aware dental professional is the first step to ensure optimal care for patients. Moreover, some additional procedures may be employed that have implications for training, educating, and coping for dental professionals and practices.

Informing patients. The dental professional may inform all patients (regardless of whether or not they display the symptoms of fear, anxiety, etc.) of practices that encourage compassion and open communication in the dental appointment. If space allows, let patients know that they can bring a family member or friend to dental appointments. Notify patients that they can request extra time for appointments if they anticipate anxiety. Some fearful patients will naturally take more time so it is better to be informed in advance to accommodate busy schedules. Ask if the patient would like to operate the suction when the space and procedure allows. This may help the patient regain a sense of control. If symptoms of trauma history appear to be present, inform the patient that the dentist can offer clear explanations before and during a procedure. Offer patients the option to bring headphones, or play soothing music throughout the dental office. Give the patient the option to provide a nonverbal gesture to signify when anxiety is increased and/or to cease the procedure.

Using sedation. Sedation can be a very beneficial tool for some patients with anxiety. Dr. Carmen Santos21 indicated that most sexual abuse survivors would rather not be sedated. For individuals who have experienced trauma, the utilization of sedatives could increase feelings of helplessness and loss of control at a time when the patient is already in a compromised position.

For patients with a substance abuse history, the use of sedation should be carefully considered. For some patients, the use of sedation could trigger feelings of being high or of addiction. As such, some dental patients in recovery may prefer to abstain from using sedation, even during particularly painful procedures.

When sedation is necessary it is mandatory for a relative or friend to accompany the patient. Ask about any previous experiences of using sedation and if there are any ways to provide more comfort for the patient. In addition, communicating with empathy and compassion can relieve fear and anxiety.

Building the relationship. Patients frequently report that a compassionate, empathetic dental professional who displays patience and active listening was the turning point in reduction of dental fear.21 Empathy has been defined as the “process by which observers attempt to project themselves into an observed person or object.”12 Generally, in psychotherapy, the treatment outcome of the client depends more heavily on the perceived empathy of the professional, rather than the professional’s actual skill level, techniques, or education. The relationship between two individuals is much more powerful than the intervention. The most beneficial action a dental professional can take is to invest in building rapport with a patient, regardless if he or she is exhibiting symptoms of past abuse, trauma, or anxiety.

Effective Communication

How can dental professionals begin to build the relationship with fearful patients and communicate empathetically and effectively? In order to facilitate empathy, a person must be aware of one’s own emotions and start from a place of deep acting and understanding, rather than judgment. The question, “What are my expectations of others; my coworkers, my boss, my patients” and in turn “How does that reflect my expectation of self?” The heart of compassion is really acceptance.7 When people learn to accept themselves and others, compassion and empathy naturally follow. It is important to be mindful of how the dental professional would like to act, regardless of how a patient is acting or reacting. In order to reduce emotional labor and cultivate a healthy, happy work environment, the dental professional must model and advocate effective, empathetic exchanges. This kind of communication is conveyed through understanding, listening, reflecting feeling, and asking open-ended questions.

Understanding. Before approaching a potentially fearful patient, it is important to pause and evaluate the level of self-awareness. Greater understanding of self can be developed by asking questions including: “What am I feeling?” or “What are the thoughts I am having? Why?” and even more importantly when interacting with patients, “How am I approaching this conversation?” If dental professionals are cognizant of these emotions and thoughts prior to communication, they are empowered to think about what is truly the desired outcome and take appropriate action.
Actively listening. Certain behaviors immediately indicate active listening to the dental patient. These include providing focused, intermittent eye contact; nodding the head in affirmation; maintaining soft body language; and having a warm, engaged expression. Before, during, and after contact with dental patients, ask questions such as, “What is the patient feeling?” or “What are the thoughts the patient may be having?” and “Why might the patient be acting this way?” Helping patients to become empowered, especially those who experience dental anxiety, requires listening to them, thoughtfully considering what is being said, and expressing appropriate, consistent nonverbal indicators.

Other nonverbal indicators can be expressed by sitting the patient up, removing the mask and gloves. Extremely fearful patients feel powerless when lying back in the chair. An attempt to be empathetic while maintaining them in a supine or semisupine position may be ineffective.

Reflecting feelings. The ability to reflect what a fearful patient is expressing back to him or her takes some practice, but is a key component to communicating effectively. Mirroring a patient’s emotions helps build the relationship, acknowledges and validates his or her feelings without minimizing the effect. It also conveys understanding and empathy, and assists the patient in the expression of additional feelings. For example, a patient may ask, “Are we done yet? Are we almost finished? How long is this going to take?” Rather than simply replying with an objective answer, consider responses such as “You sound a bit nervous about how long this procedure may take.” Reflecting the feeling of “nervous” can allow for patients to feel heard, rather than rushed. This will further build the relationship with the fearful patient, hopefully resulting in reduced fear and more frequent visits.

Reflection of feeling is the key component in helping the patient feel understood and heard. Many times, patients feel minimized or dismissed when they are told “it will be okay” or “it is just a simple procedure.” If the patient has a traumatic past that stimulates memories in the dental chair, the feeling of being misunderstood can be amplified.

Reflecting feelings, even those with a negative connotation such as fear, sadness, or frustration, is one of the most effective ways to build rapport with patients. For example, when patients show the symptoms of a traumatic past, they are more likely to feel understood when the clinician can try to reflect an emotion. The hygienist may say, “It seems like you are afraid today. How can I best support you during this appointment?” This opens the door for further communication and begins to alleviate anxiety for both the patient and hygienist. When a patient with dental fear is not properly attended to, he or she may feel alone and withdraw. Reflection of feeling or joining with the patient is the first step for healing and diminishing the fear.

Conclusion
Many factors should be considered when easing a patient’s concerns, especially those who suffer from past traumatic experiences. When clinicians are aware of the impact that a patient’s mental health can have on the dental appointment, are cognizant of the symptomology of trauma, and are informed about how to proceed with empathy and compassion, the patient may be more likely to consistently attend appointments and receive optimal dental care.

References

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Notes
1. The “vicious cycle” is:
   a. The progression of periodontal disease
   b. Avoiding the dentist due to intense fear which leads to an increased need for dental work
   c. Bacteria formation due to poor oral hygiene
   d. Over-exaggerate behaviors during a dental visit

2. After a person has experienced sexual abuse, the outcomes may affect a person:
   a. Psychologically
   b. Socially
   c. Cognitively
   d. All of the above

3. The core of dental anxiety is rooted in:
   a. Expectation and dread
   b. Fear of the “drill”
   c. Childhood memories of the dentist
   d. Fear of an aggressive hygienist

4. When the symptomatic nervous system (SNS) is stimulated by acute anxiety or fear, the body responds with the following reaction:
   a. Rest and digest
   b. Parasympathetic stimulation
   c. Fight or flight
   d. None of the above

5. What percentage of women seeking dental care are survivors of childhood sexual abuse?
   a. 80%
   b. 34%
   c. 20%
   d. 8%

6. Why is it important for dental professionals to be aware of the neurobiological effects of childhood sexual abuse and trauma?
   a. So the dental professional can accurately diagnose the patient
   b. Because the effects are similar to the effects experienced during a dental appointment
   c. So the hygienist can ask the patient directly if she or he has experienced trauma or sexual abuse
   d. All of the above

7. All of the following are symptoms of posttraumatic stress disorder except:
   a. Flashbacks
   b. Avoiding situations
   c. Numbing
   d. Hearing voices

8. A patient who seems isolated and unsociable during a dental appointment:
   a. Usually requires a root canal
   b. Can be best described as an extrovert
   c. May have been raised in an unstable environment
   d. Is likely experiencing psychosis

9. Posttraumatic stress disorder can affect:
   a. Combat soldiers
   b. Someone who has witnessed a murder
   c. Someone who has experienced a natural disaster
   d. All of the above

10. The brain structure that regulates fear, anxiety, and social inhibition is the:
    a. Amygdala
    b. Cortex
    c. Corpus callosum
    d. White matter

11. Tooth neurosis is:
    a. Fear of teeth
    b. Fear of anything being done to the teeth
    c. Brushing and flossing excessively
    d. Nightmares about losing teeth

12. Unfortunately, dental professionals have exacerbated the dental experience for the fearful patient by:
    a. Respecting with frustration
    b. Attempting to take control of the situation
    c. Assuming they know why the patient is reacting
    d. All of the above

13. Patients with dental fear due to CSA may display which of the following behaviors during a dental visit:
    a. Crying
    b. Amplified response after learning they need dental work
    c. Fear of leaning back in the chair
    d. All of the above

14. Changing perception of an experience or redirecting attention to positive thoughts is called:
    a. Emotional labor
    b. Deep acting
    c. Surface acting
    d. Cognitive impairment

15. The most objective way for a clinician to detect an anxiety disorder in a patient is:
    a. The patient lists anxiety medications on health history
    b. The patient seems nervous
    c. The patient states that he or she is nervous
    d. The patient is sweating

16. In regard to dental fear, it is the clinician’s responsibility to:
    a. Diagnose the patient with a mental disorder
    b. Ask the patient if he or she has an anxiety disorder
    c. Be aware of a patient’s behavior and respond with compassion and empathy
    d. Refer the patient to another dentist or hygienist

17. Lack of trust, fear of loss of control, and struggles with communication may be factors for a patient who:
    a. Has a toothache
    b. Has dental fear due to childhood sexual abuse or other trauma
    c. Is new to the practice
    d. Has not been to the dentist in many years

18. A patient that struggles with self-regulation of behaviors and neglects self-care may be suffering from:
    a. Anxiety disorder
    b. Trauma from abuse
    c. Substance abuse
    d. PTSD

19. A dental practice can inform patients of practices that encourage compassion and tolerance, including:
    a. Informing patients that appointments only have a 30-minute time slot, which should go by quickly
    b. Encouraging patients to come alone so that less people are in the room
    c. Offering patients to bring music to the dental appointment
    d. Trusting the clinician and feeling safe during the appointment

20. The use of sedation should:
    a. Always be utilized for patients with previous childhood sexual abuse because it will put them at ease
    b. Be encouraged for past substance abuse users because it gives them a familiar high
    c. Be used if any patient has previously had sedation
    d. Be discussed with the patient and offered in conjunction with support

21. For a survivor of trauma with high dental anxiety, the most important part of a dental appointment is:
    a. Removing every piece of calculus
    b. That the hygienist use impeccable advanced instrumentation
    c. Trusting the clinician and feeling safe during the appointment
    d. Receiving thorough OHIO

22. Dental clinicians sometimes mistake dental fear due to an anxiety disorder as:
    a. The patient’s unwillingness to cooperate
    b. Shame and embarrassment
    c. Fear due to past experiences
    d. PTSD

23. Anticipatory anxiety refers to:
    a. Reaction to actual dental pain
    b. Anger about pain experienced after a dental appointment
    c. Perceived threat about the possibility of future pain or discomfort
    d. The reduction of anxiety with the use of nitrous oxide

24. In a study on dental fear, what percentage of those surveyed reported moderate to severe dental anxiety:
    a. 25%
    b. 36.9%
    c. 12.2%
    d. 8.5%

25. A person who suffers from substance abuse may avoid the dentist until he or she is in pain because:
    a. Their insurance is running out
    b. They have a Groupon
    c. They have a Groupon
    d. They decided to improve the health and appearance of their teeth

26. Emotional labor correlates to:
    a. Interpersonal, psychological, and vocational stress
    b. The need for midday naps
    c. Crying in the darkroom
    d. Clinicians frequently changing jobs

27. Changing only the visible representation of a reaction to an experience without actually modifying thoughts is:
    a. Emotional labor
    b. Deep acting
    c. Surface acting
    d. Artificial empathy

28. An effective way to empower a fearful patient during an appointment is to:
    a. Ask them to fill out paperwork before they get to your office
    b. Help them feel as if they have control over the appointment
    c. Inform them that you are very busy and this will be a short appointment
    d. Refer them to a clinician that has experience working with fearful patients

29. Patients with substance abuse history may avoid sedation because:
    a. The sedatives may trigger familiar feelings of being high
    b. They may have flashbacks of previous trauma
    c. They do not have anyone to drive them home
    d. Dentists usually don’t recommend sedation for substance abuse patients

30. The process by which observers attempt to project themselves into an observed person or object is called:
    a. Perceived reality
    b. Empathy
    c. Emotional osmosis
    d. Telepathy
The Roots of Dental Fears

Educational Objectives

1. Describe the reactions of patients who have dental fear due to past non-dental related trauma.
2. Explain biological and physiological effects of trauma in the human brain.
3. Associate psychological symptoms of trauma with dental anxiety.
4. Identify practical applications for dental professionals to alleviate dental fear

Course Evaluation

1. Were the individual course objectives met? Yes No

2. To what extent were the course objectives accomplished overall? 5 4 3 2 1

3. Please rate your personal mastery of the course objectives. 5 4 3 2 1

4. How would you rate the objectives and educational methods? 5 4 3 2 1

5. How do you rate the author’s grasp of the topic? 5 4 3 2 1

6. Please rate the instructor’s effectiveness. 5 4 3 2 1

7. Was the overall administration of the course effective? 5 4 3 2 1

8. Please rate the usefulness and clinical applicability of this course. 5 4 3 2 1

9. Please rate the usefulness of the supplemental webliography. 5 4 3 2 1

10. Do you feel that the references were adequate? Yes No

11. Would you participate in a similar program on a different topic? Yes No

12. If any of the continuing education questions were unclear or ambiguous, please list them.

13. Was there any subject matter you found confusing? Please describe.

14. How long did it take you to complete this course?

15. What additional continuing dental education topics would you like to see?

PLEASE PHOTOCOPY ANSWER SHEET FOR ADDITIONAL PARTICIPANTS.