Fear of the Chair

An Honors Thesis (HONRS 499)

By

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Abstract

This thesis is a study about what causes dental phobia and what dentists are doing to effectively work with patients who have dental fears. There are many different explanations as to why one acquires a phobia and in the first part of the thesis, I examine these psychological methods as well as the different techniques and treatments being developed in order to treat such phobias. Ultimately, finding a supportive dentist is a necessary and vital component to overcome dental fears. Thus, for the second part of the thesis, I sought to find out the attributes that a dentist must acquire to become successful in empathizing with patient fears with a research project surveying the opinions and experiences of practicing dentists in the Muncie and Anderson area.
Acknowledgements

- I want to thank Dr. Robert Fischer for his guidance and assistance throughout the duration of this project. He played such a supportive role during the writing and brainstorming process.

- I also want to thank all of the dentists who took the time to participate in the research project because their input made for the most vital and interesting part of this thesis.
Honors Thesis - Fear of the Chair

The dreaded dental chair... feared by many of all ages. He whosoever is seated in the chair will be drilled, prodded, and injected to uncomfortable and unsustainable limits. But, is this the true fear of dental phobic patients? Is it the fear of physical pain, or is it a psychological fear of the very atmosphere of a dental office that contributes to such a terrified notion about a dental checkup?

There are a number of different reasons as to why someone may acquire a dental fear. It could be a fear of needles, loss of control, gagging, choking, embarrassment, or even of the dentist and of the office itself. “Studies addressing dental fear and phobia have noted that fear of pain is a primary reason people avoid dental treatment” (Rowe). It is important to understand the cause of a phobia before it can possibly be treated. With that understanding, one can undergo a number of different treatment techniques to manage their fear. Treatment of dental phobic patients is vital, as “severe dental anxiety with phobic avoidance of dental care has a negative impact on oral health, reduces quality of life and has a negative impact on psychosocial functioning” (Abrahamsson 654). So it is important that one does not avoid treatment, as dental problems can increase in severity, and problems such as cavities, infection, and tooth loss can result.

One of the most popular ways of treatment for phobias is behavior modification, in which fearful patients learn the opposite effects of their initial fears. “Several cognitive and behavioral techniques [are] used to identify and change patients’ anxiety-related images and thoughts...” (Vassend 585). This technique is one of the best forms of treatment for a less severely phobic patient, but it also requires a great amount of time and dedication put forth by patients to achieve the desired results. It can be made
possible if delicately applied by the dentist himself, for a dentist can use positive reinforcement, distraction, and desensitization techniques.

A second form of treatment is applied relaxation, in which attention and fear of the dental situation is directed, not to other things, but into the mind as a way of distracting oneself. With this type of procedure, "patient[s] [are] to interrupt the treatment and initiate relaxation" (Vassend 586). Along with relaxation, the hypnosis technique is used in which one acquires a state of mind with reduced awareness of what is going on outside of the body. Achieving a state of hypnosis can result in controlling gag reflex and some pain, but a downside to such a practice is that "treatment outcome depend[s] on regular practice" (Vassend 586). Ultimately, relaxation and hypnosis are beneficial in taking fears away from thought for more successful dental procedures.

As a result of Willumsen's study, found in his article, *Effects of Dental Fear Treatment on General Distress*, it is the ultimate goal of the patient to undergo dental treatment without the use of nitrous oxide sedation (Vassend 586). However, many patients who cannot relax or have bad gag reflex use such a technique to remain comfortable and under control when in the chair. Sedation can be taken orally, intravenously, or as an inhalant, commonly known as "laughing gas." Although sedation may be the best idea for a more severe dental phobic patient, it may not be the right solution for others who fear a loss of control, have had bad dental experiences, or have a lack of trust for dentists in general.

Perhaps one of the most imperative treatment techniques is simply the methods that can be utilized by the dentist himself. The dentist has a responsibility to assess, not only the physical, but the psychological needs of his patients as well. It should be clear
to a patient what is to be expected at any given moment, thus good communication is a vital tool for dentists (Rowe). A dentist is responsible for making a patient comfortable by doing everything from making an excellent first impression to establishing a friendly dental environment to promote relaxation.

Approximately 10 to 12 million people in the United States are severe dental phobics with an additional 35 million who are very anxious (Rowe 187). In order to reduce dental anxiety, it is important to understand how this fear developed or was learned by the patient. The idea is that fears are learned, thus they can be unlearned. One way of learning to be afraid is through conditioning. An example of conditioned learning is a patient who has directly suffered trauma or the threat of trauma and has learned to avoid or act out in a dental situation. With the notion that fear is conditioned, dental phobia could be treated with counter-conditioning, in which a patient is taught a positive response to the feared stimuli. Another form of learning is vicarious or modeling, in which a patient learns to be afraid of the dentist from the observations of others, possibly through parental modeling or the media.

Ultimately, someone may acquire a dental fear for a number of different reasons. It could be a fear of needles, loss of control, gagging, choking, embarrassment, or even of the dentist and of the office itself. “Studies addressing dental fear and phobia have noted that fear of pain is a primary reason people avoid dental treatment” (Rowe 187). Sometimes anxiety is unreasonable and irrational, reaching a point where it becomes destructive. It can also prove difficult to recognize, as some people who are internally terrified will remain controlled, while others may fidget or incidentally lash out. Hence, fearful patients can be difficult to manage and can cause stress to the dentist and staff.
In view of that, some practitioners believe that a pharmacological approach in dealing with patients is preferred. This is called pharmacosedation, or the act of making calm with the use of drugs, most commonly with nitrous oxide. Although sedation, commonly referred to as “laughing gas”, might be the best remedy for a more severe dental phobic patient, it may not be the right solution for others who fear a loss of control, have had bad dental experiences, or have a lack of trust for dentists in general. Research suggests that the use of gas on patients during a stressful situation may cause a patient to become more disruptive during future visits (Do 4). Nonetheless, the use of drugs does not help a patient to overcome their fear. In order to do that, behavior must change.

There is a lot to be reaped by applying psychology in the dentistry profession. Psychology helps one to understand his own behavior and motivations, as well as the patient’s, thus enabling dentists to deal more effectively with those suffering from anxiety. Psychosedation is the act of making calm through psychology, and there are many preventative techniques that can be used by dentists to build self-efficacy in patients, especially children. The building of self-efficacy takes place through performance accomplishment, vicarious experiences, emotional arousal, and verbal persuasion (Do 4). The strongest technique is performance accomplishment, in which repeated personal success leads to strong self-efficacy. Vicarious experiences occur when one observes another engaging in something fearful without any consequences. Emotional arousal takes place when the lowering of physical or emotional sensations raises performance success. The weakest technique to building a patient’s self-efficacy is verbal persuasion, in which one is led to believe that they can cope.
The use of these techniques by the dentist in order to build a patient's perception of their capabilities of performance can be referred to as iatrosedation, which is the act of making calm by the doctor's behavior. There are three approaches that a dentist can take to build a patient's self-efficacy (Berggren 1359). The first approach is a cognitively oriented approach. It is achieved by the modification of maladaptive thinking. The goal is to alter and restructure the negative cognition of patients and to enhance control over those negative thoughts. It involves the changing of beliefs or generalizations by providing the patient with information that helps to restructure their image of a dental visit and give them some control over the situation. Providing information to a patient results in a better understanding of the procedures and treatment, which can significantly reduce anxiety. The patient should always know what to expect so that unpleasant surprises will never be experienced.

As introduced earlier, vicarious experiences and modeling are ways that one might have learned to fear the dentist. Thus, those are also effective ways in which a dentist can alter a patient's cognitions from fear to reassurance by learning through the delivery of information. Two forms of modeling that a dentist can use to show a patient positive coping skills and give a sense of performance accomplishment is by filmed modeling or participant modeling. Filmed modeling is when a video demonstrating a dental procedure is observed, including coping skills which can be adapted into a patient's own behavior. Successful treatment is observed and one can learn how to cope by watching others. Participant modeling utilizes the same technique as filmed modeling, but involves the patient functionally. A patient can practice with techniques such as deep-breathing and imagery along with the model patient. A dentist can utilize this type
of learning by providing a video program in the waiting room of an office or show film
clips before a procedure is performed. Also, a dentist can invite a patient to observe first-
hand a procedure performed on an experienced model patient, while providing adequate
information as to what is being done and how a patient can cope and relieve anxiety
while it's being done.

The second approach in building self-efficacy is the behavior approach. Behavior
modification is based on classical conditioning, operant conditioning, and social learning,
all in which fearful patients can learn the opposite effects of their initial fears. This
technique is one of the best forms of treatment for a less severely phobic patient, but it
also requires a great amount of time and dedication put forth by patients and dentists to
achieve the desired results. Some modification can be made possible if delicately applied
by the dentist by using such techniques as positive reinforcement, distraction, and
desensitization. Systematic desensitization is a widely used technique that uses
relaxation to counteract a feared stimulus (the dentist, needle, specific procedure, etc.)
through gradual exposure to the feared stimulus (Berggren 1360). It can involve
gradually exposing a patient to a fear from least threatening to most threatening.
Relaxation directs the attention of fear and the dental situation, not to other things, but
into the mind as a way of distracting oneself or providing oneself with calming imagery.
Along with relaxation, the hypnosis technique is used in which one acquires a state of
mind with reduced awareness of what is going on outside of the body. Achieving a state
of hypnosis can result in controlling gag reflex and some pain, but results are dependent
on regular practice.
The third and most important approach in building a patient's self-efficacy is the eclectic approach. It is based upon the notion that the fundamental prerequisite for treatment of dental fear is a good patient-dentist relationship. It is important for a dentist to adjust to a patient's needs by shifting between professional and personal roles. Unlike other phobias, dental phobic sufferers are expected to subject themselves to regular and repeated exposure to threatening stimuli, thus a dentist must acquire emotional intelligence by communicating his attentiveness, concern, acceptance, supportiveness, and involvement to the patient. A dentist should develop proactive strategies for addressing and coping with a patient by being empathetic and establishing trust and confidence. It is also important for a dentist to pay attention to the patient's feelings and ask questions in order to avoid administering pain.

Good communication is a vital tool for dentists so that patients know what to expect at any given moment. Communication may not happen because a dentist might expect that a patient will tell him if he is anxious, while a patient might assume that the dentist will address a matter that is important (Rowe 190). The result of this is a lack of communication which is vital to establishing trust. With trust, a dentist can give his patient's a sense of control. Ways that a dentist can ensure communication are by finding out what hurts and to be gentle, reducing the noise level in the office, as sound sensitivity elevates anxiety, reducing unpleasant tastes and the sight of instruments, and by reducing fear concerning infection by wearing masks and gloves. Good communication may ultimately be the single most important skill that a dentist can utilize to relieve fear in their patients.
One way for a dentist to help in relieving a patient’s anxiety is by creating an inviting office setting; an atmosphere of relaxation, education, and enjoyment. One more recently developed form of education and relaxation of patients is through the use of magic in the dentist office (Schwartz 2). Magic is used, not only for practice marketing, but as a way to reduce stress and fear. It has been used for thousands of years to entertain, impress, and motivate, and tricks are now being designed for chair-side use, with the focus on educating patients about procedures. It can also be used with children as a type of reward for displaying good behavior. Magic is just one of the many possible initiatives that a dentist can use to improve the morale of his patients and relieve fear through a fun, distracting atmosphere.

Despite all of the different treatment methods that can ease a person from their dental phobia, the most important thing that one can do is find a supportive dentist; a dentist who can be trusted and will help their patient to overcome fear or the anticipation of such. Finding the right dentist for oneself can ultimately be the treatment that one needs to conquer their fear, and it is the responsibility of the dentist to ensure that a patient is comfortable so that adequate treatment will be administered and regular dental visits will be made for one’s lifetime.
Research Project

Purpose:

This research project is a study about what causes dental phobia and what dentists are doing to effectively work with patients who have such fears. I am seeking to find out the attributes that a dentist must acquire to become successful in empathizing with patient fears by surveying the opinions and experiences of practicing dentists in the Muncie and Anderson area. This project will provide data that will reveal what practicing dentists have experienced, such as the particular phobias they have encountered in their patients, the reasons they have found to cause such phobias, and the methods that they find useful in dealing with patients who exhibit behaviors as a result of their phobia.

Methods:

Research data was obtained from the responses of dentists via a mailed survey. Letters were sent to practicing dentists containing a cover letter, explaining the research project, a survey including a list of four questions, and a self-addressed stamped envelope for return of the responses. (See Appendix A and B). Fifty letters were sent to practicing dentists working in the Muncie and Anderson, Indiana area that were located from the local dentist search engine, www.dentists.com. The data was collected as the dentists who chose to participate returned their pre-addressed answers. These answers were sorted and compiled according to each question. (See Appendix C). The data remained anonymous and no dentist names were used nor will their answers be identified back to themselves. Their responses to the survey serve as an additional basis on which to draw conclusions about the best method of dealing with phobias in dentistry.
Results:

Eighteen dentists participated in the survey. The first question dealt with the degree of formal training the dentists had received in dealing with patient phobias. Four dentists answered that they had received some sort of training in handling psychological phobias, five dentists answered that they had received training with sedation, and nine dentists answered that they had not received any formal training in the area of phobias.

The second question sought to discover what dentists felt was the leading cause or form of acquiring dental phobias. Some responses included more than one answer. Sixteen answers suggested that fears were acquired from bad past experiences with a dentist, 10 answers were that fears came about from a friend or family member’s phobia, and one dentist answered that some patient fears result from no cause whatsoever.

The third question seeks to find out if problems have risen for dentists due to dental phobias and what those specific phobias are of. Several fears were listed by some of the dentists. Fifteen dentists answered that fear is a problem with at least some of their patients; 14 being afraid of injections or needles, 8 being afraid of pain, 4 being afraid of the smells or noise of the drill, 3 being afraid of the unknown, 2 being afraid of embarrassment or choking/gagging, and 1 being afraid of being out of control. Three dentists answered that fear is not a problem with their patients.

The final question seeks to find out the methods that the dentists use to deal with their phobic patients and how well those methods work. Fourteen dentists mentioned effective communication, explanation of the procedure, and reassurance, 10 dentists use sedation (some as a last resort after other methods have failed), 6 dentists mentioned having a gentle, caring attitude/patience, and 3 dentists use humor or music.
Conclusions:

The results from the first question of the survey show that a high number of dentists have not received any formal psychology training on how to deal effectively with phobic patients. Formal education can consist of any education, conferences, or lectures dealing with the psychology of fears. Of the eighteen dentists who participated, four specified having had some sort of education on phobias and nine had no formal training. With a question specifically asking about formal training in handling phobias, five dentists answered that they had training with pre-medication and sedation, indicating that sedation is taught to be a way of dealing with phobic patients. As previously discussed in the literature review, patients whose fears are dealt with by medication are not relieving their fears or changing their behaviors based on the fears that they have (Do 4). Thus, it would be beneficial if, along with the sedation training, dentists are required to learn about the psychology behind the fears that are being masked with the use of drugs, and learn how patients can learn how to overcome their fears with the help of a dentist’s communication and reassurance.

A rather large consensus was reached by 16 out of the 18 dentists suggesting that they believed that fears were acquired from bad past experiences with a dentist, whether as a child or as an adult. Ten responses also indicated that fears came about from learning from a friend or family member’s bad past experiences. Thus, whether vicariously learned or directly learned, this data suggests that fears came about from having bad/painful experiences, discouraging patients for their next dental appointment. One dentist answered that some patients have fears that don’t seem to result from any specific cause. Another dentist listed “irrational fears” in the third survey question as
being a type of fear that patients have. From the literature review it was found that 
anxiety is sometimes unreasonable and irrational, but that it can also just be a case where 
it is difficult to recognize, as some people internalize their fears and refrain from 
displaying fearful, fidgeting behavior (Rowe 187). This is where excellent 
communication between a dentist and patient is vital in order to keep both parties 
informed and without stress or fear.

Although three dentists had experienced no problem as a result of patient phobias, 
fifteen out of eighteen dentists suggested that dental phobias are a problem with at least 
some of their patients. Many of them expressed that phobic patients are a minority, 
though. Such fears that were listed by those dentists included fear of needles, pain, 
smells, noises, the unknown, embarrassment, choking/gagging, and being out of control. 
An overwhelming majority said that a fear of needles or injections is the most common 
fear their patients have. Approximately half the amount that indicated a fear of needles 
also indicated that there was a fear of pain. According to Rowe, as cited in the literature 
review, studies have shown that a fear of pain is the primary reason that people avoid 
dental treatment. This data indicates that a fear of needles is the most common fear, but, 
as one of the participating dentists suggested, a fear of needles is associated with pain. 
Thus, the fear of needles could be thought of as a specific type of fear that results in pain, 
in which one is ultimately fearful of pain being the end result from the needle.

Finally, dentists were asked to share the methods that they find most effective in 
dealing with patients who have fears. Many specific answers were given, but 
collectively, fourteen dentists mentioned some use of communication as being the most 
important tool in dealing with patients. Many specified that an explanation of procedures
and reassurance throughout the procedure is most effective in putting patients at ease. More specifically, six of the dentists added that not only descriptive communication, but gentle, caring, and unwearied communication was a way to build trust with their patients and, ultimately, relieve them of fears. Two dentists also used humor in addition to communication as a way to ease the patient and make them feel more comfortable with a fun and inviting atmosphere. This is a promising result of the data because it was conclusive from the literature review that the most beneficial thing that a dentist can do to ease their patients and ultimately help them to overcome their fears is to communicate effectively with them and let them know what is happening step by step so that they can feel more in control of the situation.

Still, over half of the dentists that participated suggested that sedation is a useful method when dealing with some patients. Many of them were careful to explain that the use of medication was used rarely and only in the more severe phobic cases. This is an understandable response, as it can be difficult for dentists to address fears and attempt to alleviate fears during a single dental visit, and sedation may be the only way for a procedure to happen without a fear being confronted psychologically.

Overall, the research project resulted in agreeable data with that of the literature review portion of the thesis. It is apparent that phobias are a problem in the dental profession, and that dentists must utilize effective communication skills in order to deal with patients without the use of sedation. Thus, it can be concluded that formal training in dental phobias or at least some minor education in psychology, emphasizing building communication skills and the psychology behind fears, would be useful for those in the
dental profession. It is my hope that dentistry and psychology can be interlaced to solve the problem of dental phobia.

Suggestions for Further Research

Berggren, Ulf. "Long-Term Management of the Fearful Adult Patient Using Behavior Modification and Other Modalities." Journal of Dental Education 65 (2001): 1357-1368. This paper reviews reports on the treatment of fearful adult dental patients with special emphasis on behavioral and cognitive methods and long-term follow-up. Considering the high number of fearful individuals visiting dentists regularly, a better knowledge of such methods would improve dental care for the majority of these patients.

Cinotti, William R., and Arthur Greider. Applied Psychology in Dentistry. St. Louis: C.V. Mosby, 1964. This book presents the notion that dentists must strive for self-improvement and they must consciously and conscientiously learn about their patients through the study of psychology. Psychology is a fundamental knowledge that is necessary for dentists to integrate into treatment with the added knowledge of how people learn along with mental and emotional health. With psychology, a dentist can better understand his patients, thus enabling him to deal more effectively with them.

Dental Fear Central. 2004-2006. 3 October 2006 <http://www.dentalfearcentral.org>. This website offers a detailed analysis of the different types of dental phobia and how a dentist can manage such anxiety. It offers practical advice given by the
patients who suffer from anxiety and includes articles with psychological insight to manage fear from scientists and dentists themselves.

Do, Catherine. “Applying the Social Learning Theory to Children with Dental Anxiety.” The Journal of Contemporary Dental Practice 6 (2004): 126-135. This article seeks to apply Albert Bandura’s social learning theory to reduce dental anxiety in children. The social learning theory holds that children can learn through observations of others or by watching another person’s experience of a situation. Suggestions for applications within the dental office are discussed, such as the tell-show-do technique, voice control, hand-over-mouth, and nitrous oxide to control disruptive behaviors in children.


Mandri, Olivia. “8 Techniques Used By Dentists To Help Phobic Patients Manage Visits.” SimplySearch4it! 2006. 3 October 2006 <http://articles.simplysearch4it.com/article/31726.html>. The author offers techniques to help phobic patients manage dental visits by suggesting the asking of questions, operating of a “painless practice”, offering of foresight about potential pain, and working at the pace of the patient.
Literature Cited


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Dear Sir or Madam:

As a senior honors student at Ball State University, I am working on an Honors Thesis for my graduation in May. My research project focuses on the importance of an understanding of psychology in the dental profession to better deal effectively with dental phobic patients (phobias including fears of dentists, pain, needles, etc). I am gathering information concerning issues that practicing dentists are facing and the methods currently being used to work with patient fears and anxieties.

I have included a questionnaire addressing the issues of dealing with dental phobia. I would greatly appreciate your participation and ask that you return your responses numbered on the index cards in the enclosed self-addressed stamped envelope. The survey should require approximately 15 minutes of your time. All responses will be kept anonymous.

If you have any questions, please feel free to contact me, (260) 466-1332.

Thank you for your time and cooperation. I appreciate your response and am looking forward to the results of this research project.

Sincerely,

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Study Title  Fear of the Chair

Study Purpose and Rationale
The purpose of this research project is to examine the types of fears the dentists encounter in their patients and the ways that they feel are most effective in dealing with such fears.

Inclusion/Exclusion Criteria
To be eligible to participate in this study, you must be an accredited dentist.

Participation Procedures and Duration
For this project, you will be asked to answer four questions about your experiences with dental fears. It will take approximately 15 minutes to complete the questions.

Data Confidentiality or Anonymity
All data will be maintained as anonymous and no identifying information such as names will appear in any publication or presentation of the data.

Storage of Data
Paper data will be stored in a locked desk drawer in the researcher’s home until June 1, 2009 and will then be shredded. The data will also be entered into a disk drive and stored on the researcher's password-protected computer until June 1, 2009 and then deleted. Only the researcher and advisor will have access to the data.

Risks or Discomforts
The research is of minimal risk. You may choose not to answer any question that makes you feel uncomfortable.

Benefits
Benefits may be accrued to society through the gain of useful methods and advice given from dentists that other dentists in society or those suffering from dental phobia can gain knowledge about how to deal more effectively with fears of going to the dentist.

Voluntary Participation
Your participation in this study is completely voluntary.

IRB Contact Information
For one’s rights as a research subject, you may contact the following: Research Compliance, Sponsored Programs Office, Ball State University, Muncie, IN 47306, (765) 285-5070, irb@bsu.edu.
Appendix B

Questions:

1. Have you received any formal education/training concerning how to effectively deal with patient phobias? If so, please explain.

2. What do you feel is the leading cause of form of acquiring dental phobias?

3. Do you feel dental phobias are a problem with your patients? If so, what are the specific fears that your patients have had?

4. What do you feel are the best methods of dealing with dental phobic patients? Do you use any of these methods and do they work well for you?
Appendix C

Answers to the Questionnaire

1. **Have you received any formal education/training concerning how to effectively deal with patient phobias? If so, please explain.**

Yes - my Pediatric dentistry Residency.

Trained in active listening, but not "formally" (no such degree).

No.

Yes, I’m a Continuing Education Junkie and a Fellow of the Academy of General Dentistry with over 1400 hours of C.E. logged in 26 years of private practice. I’ve had several courses that touched on phobias and handling of problem patients.

No formal education...all on the job!

No.

Sedation.

Not really. I had a private practicing dentist show me a method of shaking a persons cheek a jar when giving an injection that can reduce the discomfort. I still use this method 26 years later. Other than that, I have read articles or other material about how to try and treat patients with phobias.

I have not received any additional training concerning how to deal with patient phobias other than what I received in dental school.

No.

Most of the training has been directed at sedation protocols for these patients.

Yes, I had some training in dental school.

I have taken a course in Oral Conscious Sedation. One topic covered in the comprehensive course was what to say/what not to say to dental phobic patients.

Sedation techniques.

I received no formal training in school or in post graduate courses.

1) Use of calm reassuring talk
2) Sometimes using nitrous oxide as a method to calm a patient.
3) Use of a pre-op sedative such as valium if real scared.

No, I did not receive formal training in school regarding addressing psychological phobias. However, I was well trained in the areas of pain management as well as premedication.

Yes: Surgical & anesthesia residency.

2. What do you feel is the leading cause of/form of acquiring dental phobias?

Parents phobias.

Public opinion, less modern dentistry involving past experiences.

Usually it is due to an early bad experience although a few seem to have no cause whatsoever.

Most commonly, patients with phobias start with negative pediatric experiences and then grow those fears through reinforcement interacting with other fearful patients. They literally spend time fantasizing about how traumatic the experiences CAN be. And of course their mind is always more graphic and traumatic than any reality they’ve ever experienced.

Fear past down from parents and/or siblings.

Bad experiences!

Family/friends discussions of past bad experiences and personal treatments resulting in pain.

I feel the leading cause is how they were treated as a child. Almost all of my patients who are afraid recount a story of how badly they were treated by a dentist as a child. That fear really seems to linger into adulthood.

I feel the leading cause of dental phobias is the patient having had a bad experience at the dentist’s office. Some also develop a phobia just from hearing of someone else’s bad experience.

1) bad childhood experience
2) incorrect information from family or friends.

Causes: A. Aquired from a phobic parent.
       B. Poor experience early in life.
Past bad dental experiences either as a child or adult.

Previous painful dental experiences.

It is a learned response usually from a) parent or respected elder creating problem
b) bad experience at young age.

Usually there is a history of trauma/pain in the dental office – whether it was from an appointment as a young patient or as an adult patient, the experience does not escape the patient’s memory banks.

There really are a variety of cases
1) Bad past experience(s) either as a child or an adult.
2) Experience of either family members, relatives, or others telling them of their bad experiences and thereby scaring the individual.

-People having traumatic/negative past experiences at the dentist-or-hearing about other people’s bad experiences.
-Fear of needles (injections) is another concern.

Previous bad experience (especially as a child) & fear of the unknown.

3. Do you feel dental phobias are a problem with your patients? If so, what are the specific fears that your patients have had?

Yes – most/all patients are afraid of “shots.”

Not really.

They are a problem occasionally. They are afraid something is going to hurt or that they are going to throw up when we take an impression.

With some small part of my patient base, absolutely. Many are fearful before we begin but few are actually phobic and require alternative treatments like sedation or conscious sedation. The specific fears frequently involve massive needles, or instruments of torture and destruction (as they call them) and sometimes their real fear is that they’re going to embarrass themselves.

D.P. are a problem for patients with the most notable being the needle.

No – we only see children – use premed or nitrous oxide.
Most patients have little to no fear. Rarely do I see extremely phobic pts. Needle and pain phobias.

I am fairly lucky with my patients in that they don't have many phobias. The ones that do are mainly afraid of the needle for anesthetic or that if they say it hurts that I won't stop and will continue to work on them even if it hurts. (P.S. I am nice and don't do that!)

Some of my patients have phobias. People are mainly fearful of the needle, pain and the noise of the drill.

Yes, with some patients.
1) afraid of the needles or pain
2) feel out of control
3) not knowing what to expect.

Many patients are fearful some to the extent that they avoid all dental treatment. Most control their anxiety or are able to will some light sedation. They are fearful of all types of things, injections, cutting process, impressions, rubber drill, smells etc.

Yes, patients have a fear of pain, fear of needles. It can make it difficult to work on them when they are anxious.

Dental phobias are present in many of my patients. My patients are afraid of needles. They always associate injections with pain.

As an orthodontist – No.

Of the 7800+ patients I have, I may only premedicate or use nitrous oxide a dozen or so times throughout the course of the year. As far as “specific fears,” pain usually tops the list, followed by fears of the injection, the drilling, the needles, fear of choking/gagging.

A very small percentage
1) Needles and receiving a “shot”
2) Drilling sound
3) Possibility of pain

a. yes, a large % of dental patients have some fear/concerns
b. specific fears: injections, surgical procedures, encountering pain, general fear of unknown.

Always! Injections, inter-op and post-op, irrational fears.
4. What do you feel are the best methods of dealing with dental phobic patients? Do you use any of these methods and do they work well for you?

I try to explain to them that the fear of “shots” is normal and that they will get through it.

**Communication.** Making sure the patient is fully aware of all that is going to happen.

If they are crying, we sometimes find that getting them to stop is impossible so we tell them to just keep crying and we’ll do our work anyway.
We also try to keep talking to them and asking them questions (when are hands are not in their mouths) to keep them distracted.
We also try to be funny and make them laugh.

Inform before we perform anything. Display, explain, discuss, and let them choose to proceed or DON’T proceed. Conscious sedation is used frequently. Anesthesia wasn’t available in this area until recently and adds over $900 per hour to simple common procedures. But I have at least 3 patients for whom that is an option the next time they need fillings.

Honesty, caring attitude. Explaining the physical/solution and/or treatment. Yes works well for the majority of my pt.s - only as a last resort do I medicate.

Premed
Nitrous
Talking and explaining
Procedure using “our” dental language with children.

Explaining procedures and giving the pt a sense of control. If they feel discomfort those are asked to let us know so we can help them.

I feel the best method is to use patience and discuss their fears with them. In my practice, we feel our patients are like our family, and we schedule plenty of time with each one to discuss any problems and to be able to take our time in treating them if they are having any discomfort. I use some pre-medication, but not much. Patience and caring seem to work the best.

I try and relax them through conversation. Many times I use humor. I explain what I am going to do before I do it, to help gain trust. If I sense extreme anxiety, I will suggest they use nitrous oxide gas to help sedate them.

1) Develops interpersonal support and trust before starting any major treatment
2) always explain the procedure before perform.
3) slow down the procedure when indicated.

Methods most frequently use are sedation: A – oral and/or inhalation

B – I.V. sedation.
I sometimes use anti-anxiety meds and we have them listen to music sometimes. This seems to help some patients.

The best method is to be gentle. I use this method and it calms phobic patients 70-80% of the time.

Talk the patient through the problem.

Methods of dealing with dental phobic patients
  a. Establish good communication with patient
  b. Identify the actual fear/s
  c. Once the phobia is identified we just “talk” to the patient. Reassurance is the best tool I have. If this does not work, we pre-medicate with valium/hacction and/or nitrous oxide. As I said before, we only do the latter a dozen or so yearly.

1) Talking to the patient – in a very relaxed, confident, and comforting tone.
2) Building a relationship with them, sort of treating them with kid gloves, with continual reassurance.
3) Sometimes the use of nitrous oxide.
4) Sometimes the use of pre-op sedative such as a valium 5mg.
--All of these methods do work quite well!

a. Best ways to allay fear(s):
- patient education
- relaxed environment
- practicing good dentistry
- nurturing staff/caring doctor
- premed/nitrous oxide gas for those with extreme anxiety
b. Yes, I use all of the above wherever indicated and these techniques are generally successful.

-Yes. TLC & various forms of sedation along with discussion and an understanding of the patients phobias.
Institutional Review Board

DATE: April 29, 2009

TO: Alexis Makridakis

FROM: Ball State University IRB

RE: IRB protocol # 116195-1

TITLE: Fear of the Chair

SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF EXEMPT STATUS

DECISION DATE: April 29, 2009

The Institutional Review Board reviewed your protocol on April 29, 2009 and has determined the procedures you have proposed are appropriate for exemption under the federal regulations. As such, there will be no further review of your protocol, and you are cleared to proceed with the procedures outlined in your protocol. As an exempt study, there is no requirement for continuing review. Your protocol will remain on file with the IRB as a matter of record.

While your project does not require continuing review, it is the responsibility of the P.I. (and, if applicable, faculty supervisor) to inform the IRB if the procedures presented in this protocol are to be modified or if problems related to human research participants arise in connection with this project. Any procedural modifications must be evaluated by the IRB before being implemented, as some modifications may change the review status of this project. Please contact Amy Boos at (765) 285-5034 or akboos@bsu.edu if you are unsure whether your proposed modification requires review or have any questions. Proposed modifications should be addressed in writing and submitted electronically to the IRB (http://www.bsu.edu/irb) for review. Please reference the above IRB protocol number in any communication to the IRB regarding this project.

Reminder: Even though your study is exempt from the relevant federal regulations of the Common Rule (45 CFR 46, subpart A), you and your research team are not exempt from ethical research practices and should therefore employ all protections for your participants and their data which are appropriate to your project.