



# Evaluating Psychosocial Function in Elderly Dental Patients

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**ABSTRACT** Comprehensive dental care for older adults includes an understanding of, and sensitivity to, the psychosocial changes with age that can influence oral health care, including emotional functioning, anxiety, depression, cognitive functioning, alcohol and substance use, social support, and elder abuse and neglect. A case vignette highlights the contribution of an interdisciplinary psychosocial assessment to the oral health care of elderly patients.

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**M**ore people are living longer due in large part to improved public health and scientific advances that limited life-threatening diseases. In just five years, the baby boom generation will begin to turn 65, and by 2030, an estimated one in five people will be age 65 or older. Medical breakthroughs in preventive dentistry such as water fluoridation have contributed to the ability of aging baby boomers to maintain more of their natural teeth over the life course than previous cohorts of older adults.<sup>1</sup> This is perhaps a double-edged sword in that with age, the rate of caries increases. Some of the contributing bio-psycho-social factors include exposure of soft root surfaced to the presence of periodontal disease; use of medications that impair salivary flow; diseases that impede oral hygiene due to motor or cognitive deficits, or mood disorders; limited financial resources for healthy food choices and preventive

care; and limited social support for help with oral health care needs.

While the oral health of older adults looks good overall, when the group is disaggregated, there is great variability in the amount of dental care older adults receive. Some older adults receive care every six months while others have not visited a dentist in more than 20 years.<sup>2</sup> Dental visits are especially low among minorities, oldest-old, and those in institutions. According to the California Health Interview Survey, 68 percent of Californians age 65 and over reported visiting a dentist or hygienist in the past year. Among minority groups, 56 percent of Latino and 55 percent of black older adults reported visiting a dentist or hygienist in the past year.<sup>3</sup>

The current trend in geriatric dentistry is to take a holistic clinical approach that helps older individuals achieve the best possible health and highest level of function. This requires an interdisciplinary approach that not only assesses the biological aspects, but also the psychosocial elements that can influence oral health care.<sup>4</sup> It requires working as part of a team

of health professionals to meet the overall needs of the older patient. Dealing with elderly patients requires an understanding of, and sensitivity to, physical and psychosocial changes with age. Not remembering appointments, having difficulty climbing stairs, having vision and/or hearing problems, and dental problems or oral disorders can influence the quality of life an older person can achieve and maintain.

These physical and cognitive losses can then lead to social loss by limiting the ability to participate fully in social activities. For example, feeling embarrassed about the function and appearance of new dentures can cause an older person to avoid conversation or eating with others, thus limiting social contact. Good dental practice with older patients includes a basic knowledge of geriatric psychosocial issues that may influence the patient-provider relationship and general treatment plan as well as an appreciation and understanding of the contributions of other disciplines to the health care of older adults. This article presents a brief description of each of the psychosocial areas that may influence a dentist's treatment plan. These areas often involve the coordination of services with other health and social service providers to manage aging patients with complex health issues.

### Emotional Functioning

Emotional health in any culture involves being able to experience and express emotions appropriately and having control over emotions to the extent that one is not overwhelmed by them. Some emotional reactions during the dental visit may include crying, fear, anger, or intense anxiety. It is important to consider the wide variability in culturally approved patterns of emotional expressiveness and to differentiate individual patterns of emotional reactions from cultural factors.

### Anxiety

While it is estimated that 1 in 10 older adults suffer from an anxiety disorder, anxiety is not a normal part of aging.<sup>5</sup> Being worried and feeling anxious for brief periods of time in life is an expected reaction to stressful life events such as changing living situations, losses of loved ones, chronic health problems, or financial worries. However, when worry becomes overwhelming, causing disruption in ability to function, an anxiety disorder may develop. The most common

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form of anxiety is Generalized Anxiety Disorder, manifesting as constant worry about everyday problems for at least six months.<sup>6</sup> Restlessness, fatigue, and difficulty concentrating are often associated with this type of anxiety. Other, more severe forms include panic disorder, phobias, post-traumatic stress disorder, and obsessive-compulsive disorder.<sup>6</sup> Although anxiety is the most common form of mental illness among older adults, it is often undetected and untreated.<sup>5</sup>

One reason so many older adults suffer in silence is the perceived shame and embarrassment associated with mental illness in general.<sup>7,8</sup> As a result, anxiety may be masked in the form of more complaints regarding physical ailments. A patient with generalized anxiety disorder may appear overly concerned about a

fairly routine procedure, jumping to the worst-case scenario, and requiring a lot of reassurance regarding even a simple prophylaxis exam. Geriatric mental health resources can be found through the American Psychological Association, the National Association of Social Workers, and the National Mental Health Association.

### Depression

Similar to anxiety, depression is also undetected and untreated among older adults due to a perceived stigma of mental illness.<sup>9</sup> Many older adults are reluctant to tell family or health care providers about symptoms of depression, believing these show a personal failing or personal weakness. Elderly patients who are depressed are more likely to complain to their physician of physical problems than to mention depressive symptoms (such as mood changes) and may manifest depression as weight loss, general aches and pains, or difficulty sleeping.<sup>10</sup> Conventional signs of depression in young individuals, such as changes in attention span, concentration, and memory, may be misdiagnosed in elderly persons as signs of cognitive impairment. As with anxiety, depression is also not a normal part of the aging process. Rather, grandpa's grumpiness and irritability may be a symptom of depression.

While it is normal to react to difficult life circumstances, especially multiple losses, one expects to return to a normal level of functioning over time. When this does not occur, depression may be a factor. Although more women report symptoms of depression than men, it affects both men and women of all socioeconomic, racial, and ethnic backgrounds. For some older adults, depression is a chronic condition they have dealt with throughout their lives. For others, depression is a new experience brought on by medical illness, stress-

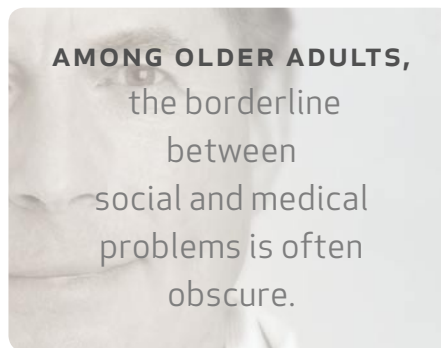
ful events, and/or multiple losses.

Some of the signs and symptoms of depression to screen for in older adults include poor sleeping patterns, change in appetite with weight gain or loss, lack of energy or fatigue, inability to concentrate, and loss of interest in usual activities.<sup>6</sup> Both psychotherapy and pharmacology have proven to be effective treatments. For more detail regarding mood disorders, the reader is referred to the *Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-R*, which provides an overview of symptoms that help guide a diagnosis. Resources for more information on depression in older adults include the American Psychological Association, the National Institute of Mental Health, and the American Association of Geriatric Psychiatry.

### Cognitive Functioning

Among older adults, the borderline between social and medical problems is often obscure. Cognitive impairment can become an issue for the clinician, patient, and care provider, depending on the decision-making capacity and the type of decision the person is facing. For example, a person with some cognitive impairment may have the capacity to consent to a minor dental procedure such as having a tooth filled, but may not be able to decide between a dental implant and full dentures, where multiple advantages and disadvantages need to be weighed. Consequences related to cost, function, aesthetics, and comfort may be too complex for some people with impaired decision-making capacity to manage. Some of the signs of memory loss include repeating the same phrase, questions or stories in a conversation, the inability to name the day of week, year, or who is current president, and an inability to remember routine tasks, or forgetting how to do routine tasks such as morning medications or brushing teeth.

Proper diagnosis is crucial with signs of memory loss to distinguish between reversible, short-term symptoms due to factors such as medication reaction, dehydration, or poor nutrition, and permanent memory loss due to Alzheimer's disease, or other vascular dementias. Screening cognitive function is often done by geriatricians, neurologists, psychiatrists, psychologists, social workers, therapists, and other health professionals



as part of their general clinical evaluation.<sup>11</sup> For a detailed description of the various instruments used in assessing cognitive function, mood and behavior, Ashla discussed and compared commonly used measures.<sup>11</sup> Other resources include the Alzheimer's Disease Education and Referral Center, and the American Association of Geriatric Psychiatry.

### Alcohol/Substance Use

While illegal substance abuse is considerably lower in older adults as compared to younger patient groups, this may change as baby boomers age. In the mean time, alcohol use continues to be an overlooked area of psychosocial health, especially among older adults.<sup>12</sup> It is estimated that up to 10 percent of elderly men and 2 percent of elderly women meet the criteria for alcohol dependency. The National Institute on Alcohol Abuse and

Alcoholism recommends no more than one drink per day for men and women 65 years of age or older.<sup>13</sup> Unexpected medication responses (drug interactions), poor nutrition and personal neglect, frequent falls, and cognitive problems, can all be signs of undetected alcohol use. It is important for dentists to take careful medication histories, perhaps having patients bring all medicine (prescribed, herbal, or other home remedies) to the dental visit. Enoch and Goldman suggested that a simple screen for problem drinking is to ask these three questions:

- On average, how many days per week do you drink alcohol?
- On a typical day when you drink, how many drinks do you have?
- What is the maximum number of drinks you have had on a given occasion during the past month?<sup>12</sup> These three questions can also be asked with regard to marijuana use, the most commonly used illicit drug.

Mental health and substance abuse social workers, counselors, and psychologists are the professionals most likely to assess and treat individuals with substance abuse problems, including abuse of alcohol, tobacco, or other drugs. Such services include individual and group therapy, outreach, crisis intervention, social rehabilitation, and training in skills of everyday living. They work in hospitals, substance abuse treatment centers, individual and family services agencies, or may have private practices in the community. Resources for substance abuse include the Substance Abuse and Mental Health Services Administration, and the National Institute on Drug Abuse.

### Social Support

Assessing an elderly patient's social function includes a social history, including questions related to the type of living

situation, marital status, sexual orientation, employment/retirement status, formal education, financial resources, and both formal and informal social support. Attention to an elderly patient's social function often provides clues to overall well-being.<sup>8,14-17</sup> The most well-intentioned treatment plan has the potential to be undermined if a patient lacks the social support or financial resources to fill prescriptions, make healthy food choices, or obtain transportation to dental appointments.

Whereas routine dental/oral health examinations inquire about past and present smoking behavior, similar inquiry regarding an elderly person's social support network remains rare even though research evidence indicates that social isolation can be as much a health risk as smoking.<sup>14,15</sup> A basic screening of social support or social isolation includes a general idea of the number of people in the person's social network, as well as the quality of the relationships.<sup>11-13</sup> For example, knowing an elder comes from a large family does not say much about how good the relationships are within the family. Besides size, frequency of contact is important. Knowing an elderly patient is seen by a reliable family member or friend on a daily basis as opposed to sporadic visits may influence care planning.

Clarifying how many family members or friends the elder can count on for help or confide in is qualitatively different than merely noting how many family members or friends the elder has.<sup>9,18,19</sup> Finally, social ties are not always supportive and can be a source of increased stress for older adults.

Lubben and colleagues suggested a brief social network screen of six questions:

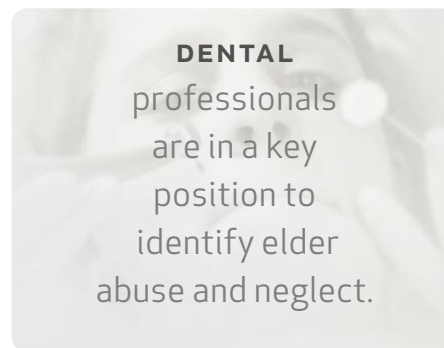
- How many relatives do you feel close to such that you could call on them for help?
- How many relatives do you feel at ease with that you can talk about private matters?

- How many of your friends do you see or hear from at least once a month?

- How many friends do you feel close to such that you could call on them for help?

- How many friends do you feel at ease with that you can talk about private matters?<sup>20</sup>

A wide variety of programs and social services agencies are available to reduce social isolation among older adults living in the community or in assisted living.



Area Agencies on Aging and local senior centers are good resources for linking seniors to programs such as phone care or phone alert programs, home-delivered meal programs, adult day care, in-home supportive services, in-home nursing assistance, and caregiver support groups.

### Elder Abuse and Neglect

Dental professionals are in a key position to identify elder abuse and neglect, yet among health care clinicians, they are the least likely to suspect elder abuse and neglect.<sup>21</sup> This is especially disturbing as all health care professionals, including dental professionals are mandated by law to report suspected abuse. Approximately 75 percent of all physical domestic violence results in injuries to the head, neck, and/or mouth areas of the body are clearly visible to the dental team during examinations and treatment.<sup>21</sup> The dentist may be the

one health care provider with a long-standing relationship with the elderly patient and family that has the opportunity to see a patient and caregivers over the course of many months and years, enabling the detection of elder abuse or neglect. In addition to a 2004 *Journal of the California Dental Association* issue dedicated to family violence, two recent articles published by the Academy of General Dentistry offer helpful suggestions for the screening and monitoring of older patients.<sup>22-24</sup> Psychosocial signs of physical abuse in elderly dental patient are fears of lying down for treatment, having objects put into their mouths, having a dentist's hand covering their nose or mouth, not being able to breathe or swallow, gagging or being sick, or fear that the dentist may become annoyed or angered.

Herron and Byron suggested the following screening questions for elderly dental patients that may be victims of abuse:

- Have you been hurt by a loved one or care provider?
- Have you ever felt pressured or forced to do things against your will?
- Are you afraid of anyone at your home or care facility?
- Do you ever need help when alone and cannot get in touch with anyone?
- Do people assist you with caring for your teeth?
- Do people assist you with your meals?
- Are you ever hungry and unable to get food or water?
- Do people assist you when you are sick or don't feel well?
- Do you feel your medications are available when you need them?<sup>24</sup>

There are a number of resources available to dental professionals as mandated reporters of suspected elder abuse or neglect. Elder abuse or neglect is reported to either local law enforcement or to a local Adult Protective Services agency

found on the APS Web site: <http://www.dss.cahwnet.gov/pdf/apscolist.pdf>, or by calling Adult Protective Services Statewide at (888) 436-3600. Additionally, the University of California Irvine Center of Excellence in Elder Abuse and Neglect provides local and statewide resources: [www.centeronelderabuse.org](http://www.centeronelderabuse.org).

### A Case Vignette

Bob Smith, a retired federal employee, and his wife of more than 40 years, Gloria, had been seeing their family dentist regularly for more than 20 years. Out of character, they missed their last two scheduled appointments. At Mr. Smith's rescheduled appointment, Dr. Green, aware of the missed appointments, asked if the patient had "been traveling."

"I wish," Mr. Smith responded. "Gloria fell down the back steps and broke both wrists." She was in the hospital for three weeks; just came home Saturday."

"How is she doing?" Dr. Green asked, remembering Mrs. Smith's severe osteoporosis.

"Not so good. You know, she can't carry or hold things; can't even make herself a cup of tea."

"That's tough," said Dr. Green. "Are your children able to help out a bit, or friends?"

"Well, the kids both moved to Arizona last year; got better jobs. And, we don't see a lot of our friends too often. A lot of them have health problems too. It's not like it used to be."

### Dr. Green's Response

"Whenever an elderly patient misses an appointment, a red flag goes up, and I want to explore the reason. It could be illness, finances, or even belief in some new miracle cure off the Internet. In this case, I've learned about several new stresses in the lives of both of my patients that may impact on their oral condition and their ability

and motivation for self-care. Certainly, I will ask my appointment clerk to promptly schedule a time for me with Gloria. If her hand skills are compromised, she may need some mechanical and pharmacotherapeutic aids to help her maintain good oral hygiene. But Bob concerns me too. He seems isolated from old friends, and he and Gloria now lack the usual convenient support from their children. Bob seems to be looking back nostalgically rather than actively addressing

**"WHENEVER AN ELDERLY patient misses an appointment, a red flag goes up, and I want to explore the reason."**

the immediate problems. My recommendation is they hire a visiting nurse or home health aid until Gloria can do more around the house. Having someone else in the home will also expand their social interactions. I will consult with Gloria's physician to get a professional prognosis on her regaining full mobility and inquire about the need for additional referrals such as a physical therapist, visiting nurse, social worker, or home-chore worker. When Gloria returns for her appointment, I will find out if the recommended services are being provided, and talk with Gloria about how she is coping with her disability and need for help with activities of daily living and self-care."

### Summary

This case vignette highlighted the importance of Dr. Green's communication skills and his understanding of the psychosocial context of patient care. He is sensi-

tive to changes in the behavior patterns of his patients, and is skillful in asking open-ended questions that reward him with more than "yes-no" answers. He reflected the frustration and sadness that Bob felt about his wife's injury and slow recovery, which encouraged Bob to reveal a bit more of his state of mind. Dr. Green heard a warning sign of depression and isolation and thought to himself about a plan of action. He recognized the regimen of daily oral health and hygiene is influenced by events and emotions in the lives of his patients.

While dental consumers, especially aging baby boomers, have become more assertive and knowledgeable over the years, allowing for more information-sharing between dentist and patients, there are still certain areas of patient-provider communication that are notoriously poor, including discussing health behavior changes, mental illness, alcoholism, and end of life issues.<sup>9</sup>

Good chairside skills require dentists to approach their older patients with the understanding that successful aging depends on not just the prevention of disease and disability, but also on the attainment of optimal psychosocial functioning in order to participate in rewarding social activities to the end of one's life course. Knowing what psychosocial issues are important when dealing with elderly dental patients, feeling comfortable with asking questions regarding psychosocial health, and knowing who to refer patients to when the psychosocial issue is beyond the scope of dental practice helps both the patient and dental provider attain goals to improve quality of life through good oral health in later life. ■■■■

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